



## December 2010 Medicaid Bulletin

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

**Attention: All Providers****CPT Procedure Code 93351**

CPT procedure code 93351 [echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision] was a new CPT code effective with date of service January 1, 2009. However, some claims have been denied for

- invalid place of service when billed with inpatient hospitalization.
- EOB 3112 (Supply of injectable contrast material for use in echocardiograph, requires echocardiography procedure on the same day) when billing HCPCS code A9700 with procedure code 93351.

For claims that meet timely filing criteria, if you received a denial for procedure code 93351 for invalid place of service or with EOB 3112 for dates of service on or after January 1, 2009, please resubmit the denied charges as a new claim (not as an adjustment request) for processing.

**HP Enterprise Services****1-800-688-6696 or 919-851-8888****Attention: All Providers****Payment Error Rate Measurement in North Carolina**

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

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

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

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

**Program Integrity****DMA, 919-647-8000**

**Attention: All Providers****Update on the N.C. Health Information Technology Plan and Schedule****Background**

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

**Schedule for EHR Incentive Payments**

DMA is creating a system called North Carolina Medicaid Incentive Payment System (NC MIPS) that will accept registration data from providers, perform the processing to verify the eligibility of providers to receive an incentive payment, and calculate the payment amount. Providers will be able to begin registration with NC MIPS beginning January 1, 2011, via a web page linked from DMA's website. On April 1, 2011, NC MIPS will begin processing the actual payments and funds will be sent to those providers who have met the eligibility requirements of the EHR Incentive Payment Program.

**Additional Information**

Frequently asked questions (FAQs) on the Final Rule are available on DMA's EHR web page. These questions and answers provide an excellent overview of the main provisions of the Medicaid providers EHR Incentive Program. Additional FAQs are also available from CMS (<http://questions.cms.hhs.gov/app/answers/list/p/21,26,1058>).

DMA Provider Services will be utilizing a special provider newsletter titled *The Provider Insider* to highlight generally known rules and conditions of the EHR incentive program and to guide providers through the process for funding. Refer to upcoming Medicaid bulletins for more information on this resource.

The CSC EVC Call Center will also answer questions at this toll-free number: 1-866-844-1113.

**CSC, 1-866-844-1113**

[NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov)

**Attention: All Providers****Changes to the EOB Code Crosswalk to HIPAA Standard Codes**

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 <http://www.ncdhhs.gov/dma/hipaa/EOBcrosswalk.htm>.

New 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****C**hange of Ownership

A change of ownership is constituted by

- a. an exchange of monies or an asset purchase, both of which result in the assignment of a new tax identification number;
- b. a stock purchase, which may not result in the assignment of a new tax identification number;
- c. a change in a shareholder's/partner's percentage of interest in ownership;
- d. a transfer of title and property to another party; or
- e. a merger of the provider corporation into another corporation or the consolidation of two or more corporations resulting in the creation of a new corporation.

To report a change of ownership, the new owner must submit a new enrollment application. The provider enrollment application is available from the NC Tracks website at <http://www.nctracks.nc.gov/provider/providerEnrollment/>. The previous owner must submit a Medicaid Provider Change Form indicating the termination of participation due to a change of ownership. The Medicaid Provider Change Form is available from the NC Tracks website at <http://www.nctracks.nc.gov/provider/cis.html>.

Providers do not have the option of obtaining a new Medicaid provider number; the new owner must retain the previous owner's Medicaid provider number. Please note that a letter of liability is not required for processing the change of ownership when the new owner assumes the previous owner's Medicaid provider number.

**Exception:** The following types of providers will be assigned a new number based on the Medicare number that is assigned to them for a change of ownership.

- Dialysis centers
- Home health agencies
- Hospice services
- ICF/MRs
- Nursing facilities
- Psychiatric hospitals
- Rural health clinics

Claims payment is reported to the tax identification number associated with the Medicaid provider number. If the previous owner has outstanding claims that are processed after the effective date of enrollment of the new owner, the payment will be reported to the new owner's tax identification number. It is the responsibility of the owners to monitor payments for services rendered prior to the change of ownership. Additionally, the new owner shall hold DMA harmless for payment of claims to the previous owner prior to the execution of a valid Medicaid Administrative Participation Agreement.

The False Claims Act prohibits anyone from billing for services that they did not provide. Providers who bill for services that they did not provide "will be subject to the provisions of that act" and will be investigated for fraud.

If you have questions regarding change in ownership, please contact the CSC EVC Call Center. Customer service agents are available Monday through Friday, 8:00 a.m. through 5:00 p.m., at 1-866-844-1113.

**CSC, 1-866-844-1113**

**Attention: All Providers*****F*alse Claims Act Education Compliance for Federal Fiscal Year 2009**

On September 29, 2010, DMA notified providers who received a minimum of \$5 million in Medicaid payments during the last federal fiscal year (October 1 through September 30) that they must submit a Letter of Attestation to Medicaid in compliance with the Section 6023 of the Deficit Reduction Act (DRA) of 2005. (A complete list of providers who meet this requirement is available on DMA's False Claims Act Database web page at <http://www.ncdhhs.gov/dma/fcadata/default.htm>.) Providers were instructed to complete and return the Letter of Attestation to HP Enterprise Services within 30 days of the date of the notification.

If you are receiving claim denials with EOB 1679 (Medicaid Payments Suspended For Non-Compliance of False Claim Act Please Submit Attestation), this means that HP Enterprise Services has not received your Letter of Attestation. To resolve this denial, please complete and submit the Letter of Attestation to HP Enterprise Services by mail or by fax. (A copy of the Letter of Attestation may be obtained on DMA's False Claims Act web page at <http://www.ncdhhs.gov/dma/fca/>.)

HP Enterprise Services  
Attn: PVS-False Claims Act  
P.O. Box 30968  
Raleigh NC 27622

Fax: 919-851-4014

Providers may resubmit denied claims for processing once HP Enterprise Services receives the Letter of Attestation. The False Claims Act Database (<http://www.ncdhhs.gov/dma/fcadata/default.htm>) can be used to verify that the Letter of Attestation has been received and processed.

If you have any further questions, please contact HP Enterprise Services at 1-800-688-6696, menu option 3.

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

**Attention: All Providers*****H*Health Check/Early and Periodic Screening, Diagnosis, and Treatment  
Billing Guide**

The amended Health Check Billing Guide 2010 is now available on DMA's web page at <http://www.ncdhhs.gov/dma/healthcheck/>. The clinical guidelines approved by the N.C. Physicians Advisory Group (NC PAG) supersede the previously published Health Check Billing Guide 2010.

**Health Check/EPSTD Managed Care**  
**DMA, 919-855-4780**

**Attention: All Providers****Pregnancy Medical Home Project**

DMA is continuing to work in partnership with Community Care of North Carolina (CCNC) and other community stakeholders including providers, local health departments, and the Division of Public Health, on the pregnancy medical home (PMH) project. The CCNC networks will receive a per-member per-month (PMPM) fee to hire an Obstetrician Champion (OB Champion) and an OB Nurse Coordinator. Once these employees are hired, they will begin recruiting PMH providers. Their roles are as follows:

- OB Champion
  - ◆ educate and recruit practices about the pregnancy home model;
  - ◆ provide education about how to achieve the performance measures that will be applied to pregnancy homes;
  - ◆ serve as a resource for PMH providers with questions related to this project; and
  - ◆ work with pregnancy home providers to promote best practice maternity care.
  
- OB Nurse Coordinator
  - ◆ assist practices and community providers with the implementation of the PMH project;
  - ◆ work with providers and other local agencies to make the system changes necessary for the implementation of the PMH project within the network;
  - ◆ provide technical and clinical support to participating PMHs; and
  - ◆ serve as a consultant for the contractors providing pregnancy case management.

Work is also continuing on the development of the pregnancy case management roles and responsibilities. The new case management model is an aggressive, one-on-one and highly clinical approach to providing services to the pregnant Medicaid recipients at greatest risk for poor birth outcome. This is a collaborative effort between the pregnancy home and case manager to ensure that pregnant Medicaid recipients receive proper care and services as needed. Both PMH and non-PMH providers will be able to refer pregnant Medicaid patients for case management assessment at any time they are concerned that the patient is at risk for a poor pregnancy outcome and might benefit from individualized case management. Each pregnancy medical home will have an assigned case manager who will determine the level of need for each high-risk pregnancy. Case managers are expected to closely monitor the pregnancy through regular contact with the physician and patient to promote a healthy birth outcome. Upon delivery, the case manager will be responsible for referring the recipient to primary care or family planning services, depending on her eligibility.

This is a great opportunity to educate Medicaid recipients on the importance of care during their pregnancy. With your help, we can have healthier babies in North Carolina!

Please watch for additional information in future Medicaid bulletins.

**Managed Care Section****DMA, 919-855-4780**

**Attention: All Providers****Enrollment Fee Reminders**

As mandated by Session Law 2009-451, beginning September 1, 2009, the N.C. Medicaid Program implemented a \$100 enrollment fee for all new enrollments and at 3-year intervals when providers are re-credentialed.

**APPLICANTS SHOULD NOT SUBMIT PAYMENT WITH THEIR APPLICATION.** Upon receipt of your enrollment application, an invoice will be mailed to you if the fee is owed. An invoice will only be issued if the tax identification number in the enrollment application does not identify the applicant as a currently enrolled Medicaid provider.

Providers are reminded that payment

- is due immediately upon receipt of an invoice for the enrollment fee;
- should be remitted to the address on the invoice and not directly to CSC; and
- is accepted by check or money order made payable to DMA.

Please make every effort to remit payment promptly. Applications will not be processed if payment is not received. If payment is not received within 30 days of the date on the invoice, your application will be voided and you will be required to reapply.

**CSC, 1-866-844-1113**

**Attention: All Providers****Implementation of the National Correct Coding Initiative**

The Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), as amended by the Health Care and Education Recovery Act of 2010 (P.L. 111-152), together referred to as the Affordable Care Act (ACA) requires state Medicaid programs to be compliant with the National Correct Coding Initiative (NCCI) in claims processing by March 31, 2011.

NCCI was developed by CMS and used in Medicare Part B claims processing to prevent improper payments when a provider would submit incorrect code combinations or to avoid payments of units of service that are medically unlikely to be correct (e.g., claims for excision of more than one gallbladder or more than one pancreas). The two components of NCCI are procedure-to-procedure edits and medically unlikely edits (MUE). The NCCI edits supersede the Medicaid State Plan, all N.C. Medicaid policies, bulletin articles, and other previous guidance provided on procedure-to-procedure and units-of-service edits.

In addition, DMA will also implement standard correct coding edits to supplement the NCCI edits. Upon implementation, an explanation and justification for all correct coding edits will be available on a claim-level basis through N.C. Electronic Claims Submission (NCECS) Web Tool. DMA will notify providers through the Medicaid Bulletin when NCCI system and other correct coding edits are slated for implementation. Additional information is also available on DMA's NCCI web page (<http://www.ncdhhs.gov/dma/provider/ncci.htm>) and the CMS website at <http://www.cms.gov/MedicaidNCCICoding/>.

**HP Enterprise Services**

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

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

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

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

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

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

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

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

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

**MIC Audit Process**

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



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

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

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

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

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

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

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

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

(2) improving the communication and transparency of the MIP; and (3) educating outside entities of the evolving functions of the MIP.

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

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

**Program Integrity**  
**DMA, 919-647-8000**

### ***Attention: All Providers***

## ***Prior Approved Bariatric Surgery***

DMA is aware that there are recipients who may have received prior approval for a bariatric surgery in 2010 who may not have had that surgery. Providers are reminded that prior approved bariatric surgery must be completed by December 31, 2010. Recipients with valid prior approvals should be contacted to allow adequate time for surgery scheduling and completion prior to December 31, 2010.

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

**Attention: All Providers****Medicaid Recipient Appeal Process/Early and Periodic Screening, Diagnosis, and Treatment Seminars**

Medicaid **Recipient** Appeal Process/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) seminars are scheduled for the month of January and February 2011. Seminars are intended to address the Medicaid **recipient** appeal process when a Medicaid service is denied, reduced or terminated. The seminar will also focus on an overview of EPDST – Medicaid for Children.

**Pre-registration is required.** Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

Providers may register for the seminars by completing and submitting the online registration form (<http://www.ncdhhs.gov/dma/provider/seminars.htm>). Please include a valid e-mail address for your return confirmation. Providers may also register by fax using the form below (fax it to the number listed on the form). Please include a fax number or a valid e-mail address for your return confirmation. Please indicate on the registration form the session you plan to attend. Providers will receive a registration confirmation outlining the training materials that each provider should bring to the seminar.

Sessions will begin at 9:00 a.m. and end at 4:00 p.m. Providers are encouraged to arrive by 8:45 a.m. to complete registration. Lunch will not be provided at the seminars. However, there will be a scheduled lunch break. **Because meeting room temperatures vary, dressing in layers is strongly advised.**

**Seminar Dates and Locations**

<b>Date</b>	<b>Location</b>
January 20, 2011	<b>Wilmington</b> Hampton Inn – Medical Park 2320 South 17 <sup>th</sup> Street Wilmington NC 28401
January 25, 2011	<b>Raleigh</b> Jane S. McKimmon Center 1101 Gorman Street Raleigh NC 27606
January 27, 2011	<b>Greenville</b> Hilton Greenville 207 SW Greenville Boulevard Greenville NC 27834
February 1, 2011	<b>Greensboro</b> Clarion Hotel Airport 415 Swing Road Greensboro NC 27409

Date	Location
February 3, 2011	<p><b>Charlotte</b>                      Crowne Plaza                      201 South McDowell Street                      Charlotte NC 28204</p> <p><b>Note: There is a parking fee of \$6.00 per vehicle for parking at this location.</b></p>
February 10, 2011	<p><b>Asheville</b>                      Mountain Area Health Education Center                      501 Biltmore Avenue                      Asheville NC 28801</p>

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

**Medicaid Recipient Appeal Process/Early and Periodic Screening, Diagnosis and Treatment  
 January/February 2011 Seminar Registration Form**  
*(No Fee)*

Provider Name and Discipline \_\_\_\_\_

Medicaid Provider Number \_\_\_\_\_ NPI Number \_\_\_\_\_

Mailing Address \_\_\_\_\_

City, Zip Code \_\_\_\_\_ County \_\_\_\_\_

Contact Person \_\_\_\_\_ E-mail \_\_\_\_\_

Telephone Number ( \_\_\_\_\_ ) \_\_\_\_\_ Fax Number \_\_\_\_\_

**1** or **2** person(s) will attend the seminar at \_\_\_\_\_ on \_\_\_\_\_  
 (circle one) (location) (date)

**Please fax completed form to: 919-851-4014**

**Please mail completed form to:  
 HP Provider Services  
 P.O. Box 300009  
 Raleigh, NC 27622**

**Or register online by utilizing the link available within the bulletin**

**Attention: All Providers****N.C. Mental Health, Developmental Disabilities, and Substance Abuse Services Health Plan Waiver (Formerly, Piedmont Cardinal Health Plan)**

This is an update to the June 2010 Medicaid Bulletin. Effective July 1, 2010, additional services were added to the N.C. Mental Health, Developmental Disabilities and Substance Abuse Services (MH/DD/SAS) Health Plan operated by Piedmont Behavioral Healthcare (PBH). Except for emergency services, all MH/DD/SAS providers must obtain prior authorization from PBH to qualify for reimbursement of services provided to Medicaid recipients who, for Medicaid purposes, are residents of the PBH five-county catchment area.

The service listed below was omitted from the June 2010 Medicaid Bulletin.

**Alcohol and/or Substance Abuse Structured Screening**

- 99409

This service is included in the MH/DD/SAS Health Plan beginning with dates of service July 1, 2010, when

- the service is provided by a psychiatrist;
- the Medicaid recipient is a resident, for Medicaid purposes, of the PBH catchment area; and
- the Medicaid recipient's primary diagnosis is in the 290 through 319 range.

If the conditions listed above are met, psychiatrists must obtain prior authorization from PBH to qualify for reimbursement for these services.

The following services were incorrectly listed in the June 2010 Medicaid Bulletin and are **not** covered by PBH.

**Care Plan Oversight: Domiciliary Care, Rest Home, Assisted Living and Home**

- 99339
- 99340

**Prolonged Services Outside Customary Services**

- 99358
- 99359

**Injections: Diagnostic/Preventive/Therapeutic**

- 96379

**Behavioral Health and Waiver Development  
DMA, 919-855-4260****Attention: Critical Access Behavioral Health Agencies and Local Management Entities****Peer Support Services Status**

CMS has approved the addition of Peer Support Services as a covered Medicaid service. The implementation date has not yet been determined. Further information will be provided in future correspondence and publications.

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

**Attention: Critical Access Behavioral Health Agencies****P**erformance Bonds

The NC DHHS Policies and Procedures for Critical Access Behavioral Health Agencies (<http://www.ncdhhs.gov/mhddsas/cabha/>) requires Critical Access Behavioral Health Agencies (CABHAs) to obtain a performance bond within 30 days of certification or, for those CABHAs that were certified prior to the adoption of the policy, within 30 days of the adoption of the policy. Implementation of this requirement has been delayed until further notice. Providers will be notified of the implementation of the requirement through the Medicaid Bulletin and the DHHS Implementation Updates.

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

**Attention: CAP/MR-DD Service Providers and Local Management Entities****U**tilization Review for CAP/MR-DD Services

The contract with the statewide utilization review vendor will expire on January 19, 2011. The new contract will not include utilization review for CAP/MR-DD services. Utilization review of these services will be performed at the local level. DMA, in collaboration with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, recently sent out a request for response from qualified local management entities (LMEs) that are interested in providing utilization review functions for CAP/MR-DD services for recipients who reside in the LME's catchment area. Several LMEs responded and the review of their proposals was completed on October 25, 2010. Pathways and Crossroads have been selected to perform the CAP/MR-DD function, along with Eastpointe LME and The Durham Center. Counties that are not in the catchment areas for these LMEs will be assigned to one of the four LMEs for the performance of the CAP/MR-DD utilization review function.

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

**Attention: CAP/C Case Managers and CAP/C Service Providers****V**ideo Conference Seminars for CAP/C Case Managers and CAP/C Service Providers

A video conference seminar for CAP/C case managers and CAP/C service providers is scheduled for the month of February 2011. Information presented at this video conference seminar will include a review of authorization services and related processes for CAP/C. This will be an interactive video conference seminar providing virtual training with live video and audio communication. The video conference seminar sites and dates will be announced in the January 2011 Medicaid Bulletin.

Pre-registration will be required. Due to limited seating, registration will be limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

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

**Attention: N.C. Health Choice Providers****N.C. Health Choice Non-Covered Policies**

Effective December 1, 2010, the following policies are no longer covered by N.C. Health Choice:

- Bone Morphogenic Protein
- Brachytherapy, Intracoronary
- Canalith Repositioning for Benign Paroxysmal Vertigo
- Capsule Endoscopy, Wireless
- Collagen Implantation
- Electroencephalography Stereotactic Approach
- Enhanced External Counterpulsation (EECP)
- Intravascular Ultrasound Imaging
- Isolated Limb Perfusion
- Magnetoencephalography / Magnetic Source Imaging
- Mohs Micrographic Surgery
- Non-Invasive Measurement of Cardiac Hemodynamics in the Outpatient Setting
- Periurethral Bulking Agents for the Treatment of Urinary Incontinence
- Pulsed Irrigation of Fecal Impaction
- Radiofrequency Facet Joint Denervation
- Selective Internal Radiation Therapy for Tumors of the Liver
- Treatment of Hyperhidrosis
- Ultrasound Screening for Abdominal Aneurysm
- Vertebroplasty and Kyphoplasty Percutaneous

For a complete list of policies that are not covered by N.C. Health Choice refer to the Non-Covered Health Choice Policies web page at <http://www.ncdhhs.gov/dma/hcmp/noncovered.html>.

**Cinnamon Narron, N.C. Health Choice  
DMA, 919-855-4100**

**Attention: Radiology Services****Update to Radiation Therapy Treatment Delivery Procedure Codes (77371 through 77418)**

Radiation therapy treatment delivery CPT procedure codes (codes 77371 through 77418) represent the technical component of these procedures. In the past, DMA instructed providers to bill these codes with the TC (technical component) modifier. This has caused some claims to either deny for inappropriate procedure code/modifier combination or to reimburse the provider incorrectly.

System work has been completed to allow billing of these procedure codes without the TC modifier and to pay correctly. This is effective with date of service July 1, 2010. The instructions for refiling claims are as follows:

- If you received a denial for dates of service on or after July 1, 2010, when submitting a claim with one of these codes without the TC modifier, please resubmit the denied charges as a new claim (not as an adjustment request) for processing.
- If you submitted a claim effective with date of service on or after July 1, 2010, with one of these codes with the TC modifier and you received payment, please submit an electronic adjustment to replace your previous claim.

**HP Enterprise Services****1-800-688-6696 or 919-851-8888****Attention: Personal Care Services Providers****Independent Assessment Updates and Reminders**

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

The Provider Interface allows personal care services (PCS) agencies to receive and respond to recipient referrals, view independent assessments and decision notices, and perform other reporting functions using a secure internet-based system instead of by fax. Use of the Provider Interface improves document tracking and reduces the time required to process and exchange documents with The Carolinas Center for Medical Excellence (CCME).

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

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

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

**CCME, 1-800-228-3365**



**Attention: Nurse Practitioners and Physicians****Epoetin Alfa (Epogen/Procrit, HCPCS Code J0885) and Darbepoetin Alfa (Aranesp, HCPCS Code J0881): New Billing Guidelines**

Effective with date of processing January 1, 2010, DMA began systematically checking claims billed for Epogen/Procrit (J0885) and Aranesp (J0881) for appropriate diagnosis codes in accordance with the Food and Drug Administration guidelines. The N.C. Medicaid Program cannot reimburse for drugs or services considered to be investigational or experimental.

ICD-9-CM diagnosis code **285.3** (Antineoplastic chemotherapy induced anemia) was inadvertently omitted from the list of diagnosis codes for these drugs in the claims processing system. Claims denied for diagnosis code 285.3 for dates of service January 1, 2010, and after may be resubmitted as a new claim. Effective with date of service January 1, 2010, diagnosis code 285.3 should be used instead of V58.11.

**Epogen/Procrit or Aranesp**

The ICD-9-CM diagnosis codes required when billing for J0885 [epoetin alfa, (for non-ESRD use)], 1000 units or J0881 [darbepoetin alfa, 1 mcg (non-ESRD use)] are

- 042 [Human immunodeficiency virus (HIV) disease]; or
- 795.71 (Nonspecific serologic evidence of HIV); or
- V08 (Asymptomatic HIV infection status); or
- 238.72 (low grade myelodysplastic syndrome lesions); or
- 238.73 (high grade myelodysplastic syndrome lesions); or
- 238.74 (myelodysplastic syndrome with 5q deletion); or
- 238.75 (myelodysplastic syndrome, unspecified); or
- 238.76 (myelofibrosis with myeloid metaplasia); or
- 238.79 (other lymphatic and hematopoietic tissues); or
- 285.0 (sideroblastic anemia); or
- 285.21 (anemia in chronic kidney disease)\*; or
- 285.29 (anemia of other chronic disease)\*; or
- 285.3 (antineoplastic chemotherapy induced anemia)\*; or
- 585.2 [chronic kidney disease, stage II (mild)]; or
- 585.3 [chronic kidney disease, stage III (moderate)]; or
- 585.4 [chronic kidney disease, stage IV (severe)]; or
- 585.5 (chronic kidney disease, stage V); or
- 585.9 (chronic kidney disease, unspecified).

**Note:** The ICD-9 CM codes listed with an asterisk must be billed with a second diagnosis:

- 285.21 – must also be billed with the appropriate chronic kidney disease ICD-9 CM code (585.2; 585.3; 585.4; 585.5; or 585.9) indicative of the patient's condition.
- 285.29 – also bill with the diagnosis code of the chronic disease causing the anemia.
- 285.3 – must also be billed with the ICD-9-CM code indicative of the specific malignancy for which the patient is undergoing treatment [140.0 through 239.9 **except for** 205.00 through 205.92 (myeloid malignancies)].

**HP Enterprise Services**

**1-800-688-6696 or 919-688-6696**

**Attention: HIV Case Management Providers****HIV Case Management Provider Training Sessions**

DMA and The Carolinas Center for Medical Excellence (CCME) want to remind those providers who have not yet registered for the mandatory supervisory training that there is still space available for the **December 14 and 15, 2010, sessions**. A prerequisite for attending the supervisory training is that the official agency/program administrator has attended the New Certification/Application Process training on either November 15, 2010, or November 16, 2010.

We are pleased to announce that training on the **New Policy Requirements for HIV Case Managers** is scheduled for **January 11 and January 12, 2011, and January 13, and January 14, 2011** (see schedule below). **These trainings are limited to those HIV case managers who are employed by providers who are currently enrolled with Medicaid to provide HIV Case Management.**

Date	Session Topic	Required Attendees
December 14 and 15, 2010	New Policy Requirements	HIV CM Program Supervisors
January 11 and 12, 2011	New Policy Requirements	HIV Case Managers
January 13 and 14, 2011	New Policy Requirements	HIV Case Managers

All of the trainings will be located at the McKimmon Center in Raleigh, North Carolina. Registration information for the December 2010 and January 2011 training is available on CCME's website at <http://www.thecarolinascenter.org/hivcm>.

As a reminder, training on the certification and application process for those agencies currently not enrolled to provide HIV Case Management will begin once CCME and DMA complete the training schedule for those agencies currently enrolled to provide this service.

Information on trainings to be conducted in the future will be published in upcoming Medicaid Bulletins and on CCME's website (<http://www.thecarolinascenter.org/events> or <http://www.thecarolinascenter.org/hivcm>).

**CCME, 1-800-682-2650**

**Attention: Pharmacists and Prescribers****End-Dated Coverage of Generic Colchicine**

Effective with date of service November 16, 2010, Medicaid end-dated coverage of generic single-ingredient oral colchicine products. Colcrys, the brand-named colchicine, has been changed to a preferred product on the Preferred Drug List and is available without prior authorization. The Food and Drug Administration (FDA) determined that the single-ingredient oral colchicine products are unapproved new drugs and cannot be marketed without appropriate FDA approval.

**HP Enterprise Services**

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

**Attention: Pharmacists and Prescribers*****D*iscontinuation of Focused Risk Management Program**

DMA will discontinue the Focused Risk Management (FORM) program as of December 15, 2010. The FORM review will no longer be required, and pharmacies will no longer receive the professional service fee related to this program. Recipients aged 21 years and older who require more than 11 unduplicated prescriptions each month will continue to be restricted to a single pharmacy through the Recipient Opt-in Program.

**HP Enterprise Services****1-800-688-6696 or 919-851-8888****Attention: Pharmacists and Prescribers*****R*emoval of Active Pharmaceutical Ingredients and Excipients as Covered Outpatient Drugs**

CMS has provided policy clarification regarding the inclusion of active pharmaceutical ingredients (APIs) and excipients in the drug rebate program. An API is a bulk drug substance, which is defined by the Food and Drug Administration (FDA) as any substance that is represented for use in a drug and that, when used in the manufacturing, processing, or packaging of a drug, becomes an active ingredient of the drug product [21 CFR. 207.3(a)(4)]. APIs may be included in extemporaneously compounded prescriptions and may serve as the active drug component in a compounded formulation.

In accordance with the foregoing, APIs do not meet the definition of a covered outpatient drug as defined in section 1927(k)(2) of the Social Security Act (Act). As such, APIs are not subject to the requirements of the Medicaid Drug Rebate (MDR) Program. In addition, excipient products used in compounds (e.g., aquaphor, petrolatum, etc.) are non-drug products and, as a result, should not be reported to the MDR Program.

To the extent possible, CMS has identified the APIs and excipients that are listed in the MDR system. CMS is notifying manufacturers that the National Drug Codes (NDCs) do not qualify as covered outpatient drugs and, as a result, will be deleted from the MDR product file of covered outpatient drugs effective January 1, 2011. CMS will notify all state Medicaid programs regarding the removal of these products. The list of identified API and excipient NDCs can be found on the Policy & Reimbursement's Spotlight web page at [http://www.cms.gov/Reimbursement/02\\_Spotlight.asp#TopOfPage](http://www.cms.gov/Reimbursement/02_Spotlight.asp#TopOfPage). Please note that this is not a definitive list.

The compounding powders and other products listed on the CMS website will not be rebate eligible effective January 1, 2011 and therefore will no longer be covered in the Medicaid Outpatient Pharmacy Program.

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

**Attention: All Providers****Outpatient Specialized Therapies: Documentation Standards**

Refer to Medicaid's Clinical Coverage Policy 10A, *Outpatient Specialized Therapies*, for specific policy references.

**A. Therapy Order Requirements**

1. Recipient's Name, first and last
2. Name of Ordering Practitioner  
Ordering practitioner shall be an acceptable practitioner for the provider type:
  - Medical doctor, doctor of osteopathic medicine, doctor of podiatric medicine, certified nurse midwife, physician assistant or nurse practitioner for providers other than a home health agency.
  - Medical doctor or doctor of osteopathic medicine for a home health agency.  
Authority: CCP 10A, Sec 7.2, c.
3. Identifiable Signature  
Orders shall include signature and date; electronic signatures and printed dates are acceptable. Refer to Section E below for more information about electronic records.  
Authority: CCP 10A, Sec 5.1, e and 7.2, c
4. Date of Order, including month, date, and year. An order is not valid without a signature date.
  - Time limited orders (i.e., orders specifying duration of less than 6 months) are valid beginning from the date of the first treatment therapy encounter after the date on the order, for the time period and/or number of visits specified.
  - Orders that are not time-specific are valid for six months from the date of the order (or the effective date, if specified, and after the signature date).
  - Retroactive orders (accepted only when Medicaid is issued retro-actively) must state that the order is "retro" to a previous time period, and is valid for a maximum of six months from the start date.  
Authority: CCP 10A, Sec 5.1, f.
5. Therapy Ordered
  - Therapy discipline shall be specified.  
**OR**
  - Diagnosis and skilled treatment intervention shall be specified.
6. "Verbal Orders" are acceptable and shall include the following components:
  - Documentation shall state that order was provided verbally.
  - Date verbal order received: The order would be effective from the date it was received, unless the order specified a later effective date; ideally, verbal orders shall be documented the date they were received but may be documented the following day.  
Authority: CCP 10A, Sec 5.1, e
  - Name of ordering practitioner and person receiving order, first and last names

**B. Written Plan of Care Requirements**

**All plan of care elements must be incorporated in the same document.**

Authority: CCP 10A, Sec 5.1, b, 7.2, b

1. Recipient's Name, first and last
2. Date of Plan of Care (POC), including month, date, and year. Every service date shall be covered by a valid POC, which shall be renewed or revised at least every six months.  
Authority: CCP 10A, Sec 5.1, f
3. Specific Content of Services: Refers to the therapy-specific intervention(s), including planned modalities, therapeutic techniques, and/or treatment approaches, requiring the skill of a licensed therapist and which target achievement of the stated goals (i.e., what the therapist plans to do to elicit patient responses).

Specific content of services shall be individualized and comprehensive for each patient; a general reference to the therapeutic discipline or service is not sufficient (e.g., “physical therapy” or “articulation therapy” is insufficient). Examples of interventions that may be a part of the POC include, but are not limited to, the following:

- a. Physical Therapy: a) therapeutic exercise, b) functional training in self care and home management, c) functional training in work, community and leisure integration or reintegration, d) manual therapy techniques, e) prescription, application and as appropriate, fabrication of devices and equipment, f) airway clearance techniques, g) integumentary repair and protection techniques, h) electrotherapeutic modalities, and i) physical agents and mechanical modalities.
  - b. Speech Therapy: Coarticulation techniques, auditory discrimination training, scaffolding technique of print reference, syntax expansion techniques
  - c. Occupational Therapy: Fine motor training, joint mobilization techniques to increase functional ROM.
  - d. Respiratory Therapy: Chest percussion, training in use of peak flow meter.  
Authority: CCP 10A, Sec 5.1, d
4. Frequency and Length of Visits: Session length and/or duration of services (e.g., “2 times per week for 6 weeks,” “every other week for 60 minute sessions”).  
Authority: CCP 10A, Sec 5.1, e
  5. Defined Therapy Goals: shall state what skills will be targeted while performing therapy with a patient.  
Authority: CCP 10A, Sec. 5.1, c.

### C. Written Daily Visit Note Requirements

**Each element must be present in a note for each billed date of service.**

1. Recipient’s Name, first and last
2. Discipline Specified
3. Date of Service, including month, date, and year
4. Session Length: In minutes (e.g., specify 47 minutes or 1:10pm – 1:57pm).  
Authority: CCP 10A, 7.2, a, d, e, Basic Medicaid Billing Guide, pg. 3-5.
5. Authenticating Clinician’s Signature and Designation
  - Clinicians shall legibly sign the note.
  - Supervision and co-signatures shall be documented, as required by licensure.
  - Providers that maintain patient records by computer may use electronic signatures on valid supporting documentation for Medicaid claims if such entries are appropriately authenticated and dated. (See Additional Requirements, Section E below for further information.)  
Authority: CCP 10A, 7.2, f, Basic Medicaid Billing Guide, pg. 3-5, N.C. Gen. Stat. §90-412.
6. Description of Services (intervention and outcome/client response): This is the intervention(s) provided by the therapist in combination with the client's response to the provided intervention(s). Interventions which are documented and described sufficiently would convey the abilities, unique body of knowledge and services that can only be provided by the licensed therapist. Description of services shall be a separate entry from any goals listed on the visit note. Isolated reports of percentages of accuracy, in combination with the goals, **do not** satisfy the “description of services” requirement. The following excerpts serve as examples of this requirement and would be incorporated in a more comprehensive note:
  - a. Physical Therapy: Pt seen for gait training to facilitate weight shift to left lower extremity and allow right unloading and limb advancement. Pt ambulated 20’ with minimal assistance and tactile cues at the pelvis.

- b. Speech Therapy: Treatment included imitation, modeling of behavior, and tactile cues to elicit turn taking during structured pragmatic activities (e.g., “go fish”). Patient was most responsive to tactile cues and was able to take turns with moderate cueing and 60% accuracy. At end of session, instructed Mom about family activities and effective cues that could be used to elicit turn taking.
- c. Occupational Therapy: Recipient was seen for proprioceptive and vestibular input to improve regulation of the sensory system, & techniques were provided to facilitate self regulation. Decreased emotional outbursts and improved attention (increased from 3 to 5 minutes without any verbal cueing) was noted after techniques were implemented. Mother was instructed in sensory diet recommendations to be completed daily.
- d. Respiratory Therapy: Pt and caregiver instructed in technique for using peak flow meter, including verbal and written instructions. Patient demonstrates adequate technique when pt’s mother provides cueing for optimal lip closure.  
Authority: CCP 10A, Sec 7.2, d, Basic Medicaid Billing Guide, pg 3-5.

**D. Written Evaluation/Re-evaluation(s) Requirements**

The provider’s documentation shall contain a written report with each test performed or a summary listing all test results.

Authority: CCP 10A, Sec 7.2, g.

**E. Additional Requirements**

1. Providers using electronic signatures shall maintain policies regarding the use of electronic documentation addressing the security of records and the unique signature, sanctions against improper/unauthorized use, and reconstruction of records in the event of a system breakdown. For more information see the CMS website at <http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/securityruleguidance.html>.  
Authority: North Carolina law at N.C. Gen. Stat. §90-412
2. If services are provided by a Clinical Fellow, the provider shall maintain records identifying the supervising speech and language pathologist.

**F. Notice**

All providers shall also follow individual policies and regulations specific to their provider and therapy type. The guidelines listed in this document do not address all billing, coding, clinical and/or documentation requirements, but highlight policy requirements addressed in The Carolinas Center for Medical Excellence’s post payment review.

**Nora Poisella, Clinical Policy and Programs  
DMA, 919-855-4310**

**Attention: All Providers**

**Clinical Coverage Policies**

The following new or amended clinical coverage policies are now available on DMA’s website at <http://www.ncdhhs.gov/dma/mp/>:

- A-2, *Over-the-Counter Products (12/1/10)*

These policies supersede previously published policies and procedures. Providers may contact HP Enterprise Services at 1-800-688-6696 or 919-851-8888 with billing questions.

**Clinical Policy and Programs  
DMA, 919-855-4260**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Proposed Clinical Coverage Policies

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

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

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

## 2010/2011 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
December	11/24/10	12/1/10
	12/2/10	12/7/10
	12/9/10	12/14/10
	12/16/10	12/22/10
January	1/6/11	1/11/11
	1/13/11	1/19/11
	1/20/11	1/27/11

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

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

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Melissa Robinson  
Executive Director  
HP Enterprise Services