# December 2011 Medicaid Bulletin

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## *Attention: All Providers*

# *Medical Record Requests for Program Integrity Post Payment and Prepayment Reviews*

Division of Medical Assistance (DMA) is authorized by Section 1902 (a) (27) of the Social Security Act and 42 CFR §431.107 to access patient medical records for purposes directly related to the administration of the Medicaid Program. In addition, when applying for Medicaid benefits, each recipient signs a release which authorizes access to his/her Medicaid records by DMA and other appropriate regulatory authorities. Therefore, no special recipient permission is necessary for release of records to DMA for post-payment reviews. Federal regulations and provider agreements with the DMA require the provider to keep any records necessary to disclose the extent of services furnished including but not limited to all information contained in recipient financial and medical records, agency personnel records and other agency administrative records.

A Provider on post payment review will receive an initial medical record request that requires copies of recipient records be sent to DMA or its agents within ten (10) business days of the provider's receipt of the initial letter. If records are not received by DMA or its agents within the allotted time, a final request will be sent, which states that the provider is required to provide the requested records by the end of the 5th business day from receipt of the final request letter. Failure to comply with this final request may result in a determination that the provider agency was improperly paid for all services under review for the requested dates of service. In addition, failure to produce records will be considered a credible allegation of fraud and subject the provider to immediate payment suspension and possible termination from Medicaid participation.

A Provider on prepayment review will receive medical record requests as noted above, for all recipients where they submit a claim for payment to Medicaid. With prepayment review, the initial medical records request allows five (5) business days for response. If records are not received within the allotted time, a final request will be sent that requires records to be received within five (5) business days of receipt of the letter. Payment of the claims will be denied if the documentation is not received.

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

## *Attention: All Providers*

## *Update to Provider Self Audit Process*

In 1999, the Division of Medical Assistant (DMA) Program Integrity started a Provider Self-Audit process, which offered Medicaid providers an opportunity to conduct internal compliance audits and have a mechanism for reporting their outcomes directly to Medicaid. The Provider Self-Audit process is noted in NC Session law 2011- 399. With the expanding use of self-audits, providers will now be able to access DMA's forms and instructions on the DMA website.

NC Session Law 2011-399 offers providers the opportunity to conduct a self audit as a method for contesting the outcome of certain Program Integrity audits. As part of a provider investigation, DMA and its agents review a random sample of claims from the "universe" of claims submitted by a provider from a selected period of time. Errors identified in the sample may be extrapolated across the full universe of claims. In cases where a "low risk" or "moderate risk" provider is notified of tentative findings of errors that could result in extrapolation, they may contest the extrapolation by conducting a self-audit. Providers should carefully review NC Session Law 2011-399, N.C.G.S. § 108C-5(n) "Payment suspension and audits utilizing extrapolation." for further details.

Providers may obtain Provider Self Audit forms and instructions at http://www.ncdhhs.gov/dma/piletters.htm

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

## *Attention: All Providers*

# *Letter of Attestation*

As previously announced in the September 2011 Medicaid bulletin, the Division of Medical Assistance (DMA) will no longer notify providers who received a minimum of $5 million in Medicaid payments during the federal fiscal year (October 1, 2009 through September 30, 2010).

As a condition of participation in the Medicaid and N.C. Health Choice programs, all providers are required to complete and sign the Letter of Attestation, irrespective of the amount received in Medicaid payments during the fiscal year.

The letter of attestation will be required initially from newly enrolling and re-enrolling providers; once enrolled all providers will be required to submit the letter of attestation annually.

In accordance with Session Law 2011-399, § 108C-9 requires the revised provider attestation to contain a statement that the provider:

- "has met the minimum business requirements necessary to comply with all federal and State requirements governing the Medicaid and Children's Health Insurance programs,
- does not owe any outstanding taxes or fines to the U.S. or North Carolina Departments of Revenue or Labor or the Employment Security Commission,
- does not owe any final overpayment, assessment, or fine to the North Carolina Medicaid or North Carolina Health Choice programs or any other State Medicaid or Children's Health Insurance program, and
- has implemented a corporate compliance program as required under federal law."

DMA is currently modifying the Letter of Attestation to include statements regarding educating employees, contractors, and agents about federal and state fraud and false claims laws and the whistleblower protections available under those laws, and to include additional statements as required in the Affordable Care Act and Session Law 2011-399. To avoid any delay in reimbursement, providers should review their corporate compliance programs and be prepared to submit the signed revised Medicaid Letter of Attestation. All providers will receive further guidance on completing and submitting attestations for Medicaid. Information will be available in upcoming Medicaid bulletins and on the "What's New" page of the DMA's website at http://www.ncdhhs.gov/dma/provider/index.htm.

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

## *Attention: All Providers*

# *Recredentialing of Medicaid Providers*

As the Enrollment, Verification, and Credentialing (EVC) vendor for North Carolina's Medicaid program, CSC must recredential existing Medicaid providers a minimum of every 3 years to ensure that all provider information is accurate and up-to-date. Effective November 1, 2011, the EVC Operations Center began recredentialing 100 providers as part of a 1-month project and will recredential 11,000 providers every 6 months thereafter. This process includes a thorough examination of a provider's background, credentials, and qualifications to ensure the provider continues to meet North Carolina's Medicaid participation guidelines. It will also reduce fraud by ensuring a provider's record is current and accurately reflects all adverse actions taken against the provider.

Providers will be able to complete their renewals electronically, which will;

- reduce processing time for staff,
- shorten the amount of time a provider spends on completing the application, and
- give providers sufficient notice to remain enrolled in the Medicaid program.

Contract renewals will generate electronically for all enrolled Medicaid providers 75 days prior to the 3-year anniversary date of enrollment or the date of the last contract renewal.

To make this process as simple as possible, CSC has pre-populated a recredentialing application with the information currently on file for each provider. Within 30 days of receiving the invitation letter, providers must verify their Medicaid Provider information and submit any additional information requested via the online recredentialing application, following the instructions in the letter. **CSC will not mail recredentialing applications to providers**.

It is critical that providers verify and/or provide all information required in the recredentialing application. Failure to complete this application and provide all requested information within 30 days from the date of the re-enrollment letter will result in termination from the NC Medicaid program.

In accordance with NC Session Law 2009-451, Section 10.58.A, CSC must charge a recredentialing fee of $100. CSC will notify providers by mail with instructions on how to make payment of the recredentialing fee, if applicable. Providers will also be charged a $505 application fee required by Section 6401(a) of the Affordable Care Act (ACA), as amended by section 10603 of the ACA, amended section o1866 (j), to cover the costs of screening and to carry out screening and other program integrity efforts.

**EVC Operations Center**
**CSC, 866-844-1113**

## *Attention: All Providers*

# *Implementation of Additional Correct Coding Edits: Professional Duplicates*

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

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

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

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

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

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

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

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

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

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

## *Attention: All Providers*

## *Bevacizumab (Avastin, HCPCS Procedure Code J9035)—Update to Billing Guidelines*

Effective with date of service January 1, 2012, the N.C. Medicaid program will discontinue coverage of Avastin for breast carcinoma. Claims paid for Avastin for breast carcinoma on or after date of service January 1, 2012, may be recouped.

Certain ICD-9-CM diagnosis codes will remain covered for Avastin.

- One of the following diagnosis codes must be billed with **V58.11** (encounter for chemotherapy):
  - **153.0** through **154.8** (malignant neoplasm of the colon, rectum, recto-sigmoid junction, and anus); or
  - **162.2** through **162.9** (unresectable, locally advanced, recurrent or metastatic non-squamous, non–small-cell lung carcinoma); or
  - **191.0** through **191.9** (malignant neoplasm of brain)**;** or
  - **189.0** through **189.1** (malignant neoplasm of kidney).

- Diagnosis code **362.52** (wet age-related macular degeneration) may be billed for Avastin, but does **not** require V58.11

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

## *Attention: All Providers*

# *NC Medicaid EHR Incentive Program Steps for Eligible Professionals*

The NC Medicaid Electronic Health Record (EHR) Incentive Program provides the opportunity for eligible professionals (EPs) to receive up to $63,750 in incentive payments over six years for participating in the program. The payment for the first year is $21,250 and requires EPs to adopt, implement or upgrade to certified EHR technology. Subsequent years address Meaningful Use standards and participants receive payments of $8,500 per year for up to five years.

The process for EPs to receive a Year One incentive payment includes the following steps:

1. **Eligibility -** Determine eligibility for the program using the eligibility wizard located at http://www.cms.gov/EHRIncentivePrograms/15_Eligibility.asp.
2. **CMS Registration -** Register with the Centers for Medicare and Medicaid Services (CMS) at http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp.
3. **A/I/U -** Adopt, implement, or upgrade to a certified EHR system. The Office of the National Coordinator for Health Information Technology (ONC) maintains a comprehensive listing of all certified technologies that is currently available at http://onc-chpl.force.com/ehrcert. New vendors and products are certified and added to the list as they become available.
4. **Confirmation -** NC Medicaid will verify information provided from CMS and send a welcome email to providers with an invitation to begin the attestation.
5. **Attestation -** Once a provider receives a welcome email inviting them to begin the attestation process with the NC Medicaid Incentive Payment System (NC-MIPS), the provider can log onto the NC-MIPS portal, located at https://ncmips.nctracks.nc.gov/, and complete the attestation process.
6. **EP Attestation -** EPs attest to information about their practice, patient encounters and certified EHR system. Attestation guides are available at https://ncmips.nctracks.nc.gov/ to assist in the process. Additional assistance is available from the call center at 1-866-844-1113. Providers must print and sign a copy; and send it to the NC-MIPS Center using one of the following:

   Mail: C-MIPS CSC EVC Center
   PO Box 300020
   Raleigh, NC 27622-8020
   Fax: 866-844-1382
   Scan & Email: ncmips@csc.com

7. **Verification -** Once attestations are completed, they are verified by NC Medicaid. If any problems are found, providers are notified with instructions on how to address any issue. The verification process consists of multiple internal checks at NC Medicaid and can take as long as 4-10 weeks. This estimate is based on a fully implemented and operational system. **There may be delays as NC Medicaid continues to operationalize the system.**
8. **Notification -** Providers will be notified once the verification process has been completed along with when to expect an incentive payment. Payments are made according to the established Medicaid payment schedule.

9. **Future Payments -** EPs are eligible for 5 additional incentive payments based upon the Meaningful Use of their certified EHR technology (as defined by CMS). The first year of Meaningful Use will be based upon a 90-day reporting period. Additional years of Meaningful Use will have a reporting period of 365 days. The program runs through 2021 and program years do not have to be consecutive. Additional information about Meaningful Use and the measures associated with it can be found on the CMS website located at http://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp.

For technical issues or to inquire about the status of your attestation, please contact 1-866-844-1113 or ncmips@csc.com. For questions on the program or process, please contact NCMedicaid.HIT@dhhs.nc.gov.

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

## *Attention: All Providers and Vendors*

# *HIPAA 5010 Implementation*

The Division of Medical Assistance (DMA) started dual processing of ASC X12 5010 Transactions on November 4, 2011. DMA strongly encourages providers to take advantage of this dual processing time period to reduce potential impacts on the federally mandated ASC X12 5010 implementation date of January 1, 2012. Providers (or their vendors) must complete and submit Appendix A of the Trading Partner Agreement(TPA) to HP Enterprise Services (HPES) and successfully pass compliance testing or submit third party certification prior to submitting ASC X12 5010 Transactions into production. Appendix A is located at http://www.ncdhhs.gov/dma/hipaa/5010Appendix2.pdf.

Providers can choose to submit ASC X12 4010A1 or 5010 transactions (this includes any of the transactions noted in the table below and documented in your TPA) during the dual processing time period. Providers can move completely to the ASC X12 5010 transactions prior to January 1, 2012, use both ASC X12 4010A1 and 5010, or continue to use ASC X12 4010A1 transactions during the dual processing time period. DMA would recommend providers discuss testing and implementation plans with their vendors.

| ASC X12 5010 Transactions | Dual Processing Start Date | Dual Processing End Date |
|---|---|---|
| 837 Dental, Institutional, Professional | 11/4/2011 | 1/1/2012 |
| NCPDP D.0 | 11/18/2011 | 1/1/2012 |
| 835 | 11/8/2011 | 1/1/2012 |
| 270/271 | 11/29/2011 | 1/1/2012 |
| 276/277 | 11/23/2011 | 1/1/2012 |
| 820 (vendors only) | 12/2/2011 | 1/1/2012 |
| 834 (vendors only) | 12/2/2011 | 1/1/2012 |
| GHI Medicare Crossover Claims | 12/20/2011 | 1/1/2012 (with two week run out) |

**Note:** The ASC X12 5010 278 transaction is not included in this implementation.

There are currently no providers utilizing the ASC X12 278 4010A1 278 transaction. The NC Electronic Claims Submission/Recipient Eligibility Verification Web Tool will be updated to address changes associated with ASC X12 5010 implementation on December 29, 2011.

In addition, HPES is currently testing with vendors, trading partners, and providers. Providers can contact HPES, ECS unit, at 1-800-688-6696 or 919-851-8888; press option 1 for questions or assistance regarding this information about the ASC X12 5010 implementation. DMA will continue to post informational updates on the DMA website at http://www.ncdhhs.gov/dma/hipaa/index.htm, along with monthly Medicaid Provider bulletins and special Medicaid bulletins.

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

## *Attention: All Providers and Vendors*

# *Appendix A TPA - HIPAA 5010 Implementation*

HPES **must** receive updated Trading Partner Agreement (TPA) - Appendix A from providers, the provider's clearinghouses or billing agents who submit electronic transactions directly to HPES no later than **December 19, 2011** to ensure there is adequate time to process the appendix A prior to the federally mandated HIPAA ASC X12 5010 implementation date of January 1, 2012. Failure to provide HPES with the updated appendix A by December 19th may result in the inability to process your 5010 electronic transactions, including your claims, which could impact provider payment. DMA has been providing advance notifications regarding the necessity to update Appendix A since the July 2011 Medicaid bulletin and does not plan on issuing any cash advances as a result of a provider not being ready for 5010. In addition, DMA requires electronic billing paper claims received will be denied for not being filed electronically.

The CMS statement released on November 17, 2011 states "Today the Centers for Medicare & Medicaid Services' Office of E-Health Standards and Services (OESS) announced that it would not initiate enforcement action until March 31, 2012, with respect to any HIPAA covered entity that is not in compliance with the ASC X12 Version 5010 (Version 5010), NCPDP Telecom D.0 (NCPDP D.0) and NCPDP Medicaid Subrogation 3.0 (NCPDP 3.0) standards. Notwithstanding OESS' discretionary application of its enforcement authority, **the compliance date for use of these new standards remains January 1, 2012** (small health plans have until January 1, 2013 to comply with NCPDP 3.0). CMS' Office of E-Health Standards and Services is the U.S. Department of Health and Human Services' component that enforces compliance with HIPAA transaction and code set standards."

Providers can contact HPES, ECS unit at 1-800-688-6696 or 919-851-8888; press option 1 for questions or assistance regarding this information about the ASC X12 5010 implementation.

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

## *Attention: All Providers*

# *Gastric Bypass*

Effective with date of service January 1, 2012, the Division of Medical Assistance (DMA) will cover certain bariatric procedures under the Medicaid and NC Health Choice programs. Coverage criteria and other requirements are outlined in revised versions of DMA Clinical Coverage No. 1 A-15 and NCHC Clinical Coverage No. 2010.073, now entitled **Surgery for Clinically Severe or Morbid Obesity.** Providers should review both Clinical Policies in their entirety for **All** criteria requirements. These policies are located at http://www.ncdhhs.gov/dma/mp/1a15.pdf and http://www.ncdhhs.gov/dma/hcmp/NCHC-Surgery-for-Morbid-Obesity.pdf.

**Both Clinical Coverage policies** shall require, in part, the following:

1) The surgeon that conducts the pre-surgery regimen and performs the bariatric procedure and the facility where the procedure is performed (i.e. hospital, outpatient hospital, ambulatory surgical center) **must** be designated as a Bariatric Surgery Center of Excellence (BSCOE) as mandated by session law 2011-145 Section 10.31(d)(2)q. Providers interested in becoming a member of Centers of Excellence for Bariatric Surgery are encouraged to contact the Surgical Review Corporation at (919) 981-4460 for certification information.
2) Until notification in a future bulletin, when submitting a request for prior authorization, the surgeon must include documentation of their designation as a BSCOE as well as documentation of designation of BSCOE for the place of surgical service.
3) Prior Approval form, http://www.ncdhhs.gov/dma/forms/prior.pdf must be submitted with documentation of all required components.
4) Outpatient Hospital and Ambulatory Surgical Centers shall **only** perform Gastric Banding procedures.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**
**DMA, 252-208-1950**

## *Attention: All Providers and North Carolina Health Choice 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/:

- *1E-5, Obstetrics*
- *1E-6, Pregnancy Medical Home*
- *1T-1, General Ophthalmological Services*
- *3A, Home Health Services*
- *2B-1, Nursing Facilities*
- *4A, Dental Services*
- *5A, Durable Medical Equipment*
- *6A, Routine Eye Exam and Visual Aids for Recipients Under Age 21*
- *11B-1, Lung Transplantation*
- *11B-2, Heart Transplantation*
- *11B-3, Islet Cell Transplantation*
- *11B-4, Kidney Transplantation*
- *11B-5, Liver Transplantation*
- *11B-6 Heart/Lung Transplantation*
- *11B-7, Pancreas Transplant*
- *11B-8, Small Bowel, Small Bowel/Liver, or Multivisceral Transplants*
- *11C, Ventricular Assist Devices*

The following new or amended NC Health Choice policies are now available on DMA's website at http://www.ncdhhs.gov/dma/hcmp/:

- *NCHC Lung Transplantation*
- *NCHC Heart Transplantation*
- *NCHC Islet Cell Transplantation*
- *NCHC Kidney Transplantation*
- *NCHC Liver Transplantation*
- *NCHC Heart/Lung Transplantation*
- *NCHC Pancreas Transplant*
- *NCHC Small Bowel, Small Bowel/Liver, or Multivisceral Transplants*
- *NCHC Ventricular Assist Devices*
- *NCHC Home Health Services*

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

## *Attention: North Carolina Health Choice Providers*

# *NC Health Choice Well Visits and Vaccines*

The Division of Medical Assistance (DMA) is currently working with our fiscal agent for claims adjudication, HP Enterprise Services, to correct a processing issue for N.C Health Choice wellness exams denying when billed in conjunction with vaccines for the same date of service. Claims affected are for dates of service on or after October 1, 2011. Providers will be notified by email alert and bulletin article when the system update is completed.

Providers who have received EOB 2066 (Immunization administration and Therapeutic injections not allowed same day as E/M) have several options until the system is updated. Claims that had the Evaluation and Management (E/M) code denied can be voided and a replacement claim can be filed for the E/M code only. Once providers receive notification of the system correction, the vaccines and vaccine administration can be billed on a separate claim. In addition, for NC Health Choice children, providers may bill the individual services that are part of the wellness package for Medicaid recipients. Providers may elect to hold all claims for preventative services for NC Health Choice until the system is corrected.

For further assistance, providers can contact HP Enterprise Services Provider Services Department at 1-800-688-6696, menu option 3, Monday through Friday from 8:00 a.m. to 4:30 p.m.

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

## *Attention: North Carolina Health Choice Providers*

## *Requesting a Health Choice Review When an Adverse Decision Has Been Issued*

Please note the following corrections to the Basic Medicaid Billing Guide:

1. To request a review for an adverse decision, it is not necessary to include the name of the representative in Customer Service who handled the inquiry.

2. A copy of the Health Choice Internal First Level Review Form is not included in the recipient mailing of an adverse notice. The Internal First Level and External Second Level Review Forms are available on the DMA website at http://www.ncdhhs.gov/dma/healthchoice/index.htm.

The information specified above will be revised in the next publication of the Basic Medicaid Billing Guide.

**Appeals and EPSDT**
**DMA, 919-855-4266**

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## *Attention: North Carolina Health Choice Providers*

## *NC Health Choice Claims Processing Transition Reminder*

All claims with effective dates of service on and after October 1, 2011, for NC Health Choice (NCHC) will be processed by the Division of Medical Assistance (DMA) fiscal agent, HP Enterprise Services (HPES). For dates of service prior to the transition date of October 1, 2011, providers will continue to submit claims to BCBSNC. **Providers must file all claims for dates of service through September 30, 2011 with BCBSNC by February 29, 2012.**

As of the transition date of October 1, 2011, active NC Medicaid providers who want to render service to NCHC recipients may do so without taking any action for NCHC enrollment. Providers who are not NC Medicaid-enrolled providers but who want to begin or continue serving NCHC recipients must complete the Medicaid provider enrollment application on www.nctracks.nc.gov. Computer Sciences Corporation, Inc. (CSC), DMA's agent for enrollment, verification, and credentialing (EVC), will process the applications. Any questions regarding provider enrollment for NCHC should be directed to the CSC EVC Center at 866-844-1113.

**NC Health Choice**
**DMA, 919-855-4100**

## *Attention: CAP-MR/DD Providers, I/DD TCM Case Managers, and LMEs*

## *Extension of Current CAP-MR/DD Waiver and Process for Submitting Authorization Requests*

The Division of Medical Assistance (DMA) has asked the Centers for Medicare and Medicaid Services (CMS) for an extension for the current 2008 CAP MR/DD waiver. The CAP MR Waiver renewal date has been modified from November 1, 2011 to January 1, 2012. This CMS approved extension date allows for coordination with 1915 bc waiver roll-out, more effective transition activities for families and recipients.

DMA drafted the following guidelines in an attempt to minimize further disruption for recipients and their families. Providers should review the following bullets to determine if the case manager and recipient/family need to submit an updated revision (authorization request), including the PCP revision form with appropriate signatures, CTCM form, and updated cost summary.

- If services were authorized to fit the new waiver requirements and the recipient/legally responsible person accepted the plan/services, a revision (authorization request) does not need to be submitted. Specifically, if a request to change Home Supports services to Home and Community Supports and Personal Care has been approved, those services may be provided effective November 1, 2011.
- If services currently authorized under the 2008 CAP MR/DD waiver are not in compliance with the new proposed waiver requirements, a revision (authorization request) does not need to be submitted at this time. A revision for authorization of new services must be submitted by January 1, 2012 to have services meet the requirements under the new waiver.
- If an authorization request was approved to change services to meet the new waiver requirements, and the recipient/legally responsible person would rather continue with their current services under the 2008 CAP waiver, the case manager needs to document this information into a case management note and update the PCP and cost summary for the recipient record. This updated PCP will serve as the authorization in the interim until January 1, 2012. The case manager does not submit this information to the UR Vendor. The plan that was to go into effect on November 1, 2011 will now go into effect on January 1, 2012.
- If a revision request was sent to the UR vendor to change services to meet the new waiver requirements, the UR vendors will process the request with an effective date of January 1, 2012. The case manager will need to contact the UR Vendor if they would like the request that was submitted to be effective November 1, 2011 instead of January 1, 2012.
- If a CNR (yearly renewal) with an effective date of November 1, 2011 has been approved or is currently being reviewed by a UR Vendor, and the recipient/legally responsible person would rather continue with their current services, the case manager needs to update the PCP and cost summary to show 2 months of services under the current waiver and 10 months of services in compliance with the requirements of the new waiver. This updated CNR must be submitted to the UR Vendor by January 1, 2012.

**Clinical Policy**
**DMA, 919-855-4290**

## *Attention: Durable Medical Equipment and Community Alternatives Program Providers*

# *Rate Revisions for Metabolic Formulas*

Effective December 1, 2011, rates for Procedure Codes B4157 and B4162 will be revised as follows:

| HCPCS Code | Code Description | NC Medicaid Reimbursement Rate effective December 1, 2011 |
|---|---|---|
| B4157 | Enteral formula, nutritionally complete for special metabolic needs for inherited disease of metabolism , includes proteins, fats, carbohydrates, vitamins & minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit, each. | 1.97 |
| B4162 | Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit, each | 1.97 |

Refer to individual NC Medicaid clinical policies for details on product coverage and limitations. Providers are reminded to bill their usual and customary rates.

**Rate Setting**
**DMA, 919-647-8182**

## *Attention: Durable Medical Equipment and Pharmacy Providers*

## *Roche ACCU-CHEK Diabetic Supplies Under the DME and Pharmacy Programs*

Effective November 15, 2011, Roche Diagnostics Corporation Diabetes Care is N.C. Medicaid's designated preferred manufacturer for blood glucose monitors, diabetic test strips, control solutions, lancets, and lancing devices. These products are covered under the Durable Medical Equipment and Outpatient Pharmacy Programs and will be reimbursed under the pharmacy point-of-sale system with a prescription. There will be an initial transition period from November 15, 2011 through December 14, 2011 when both Roche and Prodigy diabetic supplies will be covered. Beginning on December 15, 2011, a second transition period will be available where both Prodigy and Roche diabetic supplies will be covered; however, a one time override will be required for continued use of Prodigy products until January 15, 2012. As of **January 15, 2012**, only Roche diabetic supplies will be covered. Prior authorization will be allowed for insulin-pump dependent recipients who cannot use Roche products. Pharmacy and DME providers need to ensure that invoices are easily retrievable in case documentation is needed to support the billing of these products. This could be requested to support the quantities being invoiced to Roche for the rebates due back to N.C. Medicaid and N.C. Health Choice.

Effective November 15, 2011, there are no designated preferred manufacturers of insulin syringes. The following are the list of NDC's that will be covered:

| Covered Products | Package Size | Unit Type | NDC-11 |
|---|---|---|---|
| ACCU-CHEK Aviva Care Kit | 1 Meter Kit | 1 Meter | 65702-0101-10 |
| ACCU-CHEK Compact Plus Care Kit | 1 Meter Kit | 1 Meter | 50924-0019-01 |
| ACCU-CHEK Aviva Test Strips | 50 count | 1 bottle | 65702-0103-10 |
| ACCU-CHEK Compact Test Strips | 51 count | 1 bottle | 50924-0988-50 |
| ACCU-CHEK Aviva Plus Test Strips | 50 count | 1 bottle | 65702-0407-10 |
| ACCU-CHEK Aviva Control Solution (2 levels) | 1 bottle | 1 bottle | 65702-0107-10 |
| ACCU-CHEK Compact Control Solution (2 levels) | 1 bottle | 1 bottle | 65702-0369-10 |
| ACCU-CHEK Multiclix Lancets | 102 count | 1 box | 50924-0450-01 |
| ACCU-CHEK Softclix Lancets | 100 count | 1 box | 50924-0971-10 |
| ACCU-CHEK Softclix Lancing Device (Blue) | 1 count | 1 | 50924-0957-01 |
| ACCU-CHEK Softclix Lancing Device (Black) | 1 count | 1 | 65702-0400-10 |
| ACCU-CHEK Multiclix Lancing Device Kit | 1 count | 1 | 50924-0446-01 |

**Billing Instructions for Submitting Diabetic Supplies under DME**
Claims for diabetic test strips, control solution, lancets and lancing devices submitted under the DME program must be billed using the NDC in addition to the HCPCS code. The NDC will be entered in the shaded area of block 24A of the CMS-1500 claim form. During the time period December 15, 2011 through January 15, 2012 when the one time override is available for Prodigy products, DME providers will need to place the SC modifier in block 24D of the CMS-1500 claim form to bypass the requirement to bill for Roche NDCs listed in the chart above. Following January 15, 2012, this modifier will no longer be accepted. These requirements will not apply to private duty nursing and home health providers until February 15, 2012.

HCPCS codes and supply limits for diabetic supplies are the same as outlined in Clinical Coverage Policy 5A, Durable Medical Equipment, as indicated below:

| HCPCS Code | Product Description | Quantity Limit |
|---|---|---|
| A4253 | Blood glucose test or reagent strips (1 unit = 50 strips) | 4/month – age ≥21 |
| A4253 | Blood glucose test or reagent strips (1 unit = 50 strips) | 6/month – age ‹ 21 |
| A4259 | Lancets (1 unit = 100 lancets) | 2/month |
| A4258 | Lancing device | 2/year |
| A4256 | Normal, high, low calibrator solution | 4/year |

**Billing Instructions for Submitting Diabetic Supplies under Pharmacy Point-of-Sale System**
Claims for diabetic test strips, control solution, lancets and lancing devices submitted at point-of-sale must be billed using the NDC. Test strips must be billed in multiples of 50 and lancets must be billed in multiples of 100 except for the ACCU-CHEK Compact Test Strips, 51 count package size and the ACCU-CHEK Multiclix Lancets, 102 count package size. In order to accommodate the unbreakable package sizes under the pharmacy point-of-sale system, the ACCU-CHEK Compact Test Strips (NDC 50924-0988-50) can be billed up to 204 test strips per month for recipients 21 years of age and older and up to 306 test strips per month for recipients under 21 years of age will be allowed. **At this time, test strip quantities over 204 per month must be requested through the DME program; however, point-of-sale system changes are underway to accommodate the higher quantity limits for pediatric recipients. Additional information will be provided when this system change has been completed**. The same rules apply for the ACCU-CHEK Multiclix Lancets (NDC 50924-0450-01). For Medicaid billing, 1 lancing device = 1 unit. Rates apply to these diabetic supplies; therefore, no copayments and no dispensing fees apply.

During the time period December 15, 2011 through January 15, 2012 when the one time override is available for Prodigy products, pharmacy providers can place a "1" in the prior authorization type code field (461-EU) or a "2" in the submission clarification field (420-DK) to override the requirement to bill for Roche NDCs. Following January 15, 2012, this override will no longer be available and only the Roche NDCs referenced above will be covered. Diabetic supply limits will be the same as under the DME program. Prior authorization requests for additional quantities or for non-Roche diabetic supplies must go through the DME program.

**Blood Glucose Monitors**
ACCU-CHEK Aviva and Compact Plus blood glucose monitors are free to N.C. Medicaid and N.C. Health Choice recipients through the DME and Outpatient Pharmacy Programs. DME providers will have access to free blood glucose monitors to supply to recipients. Pharmacy providers can dispense free blood glucose monitors to recipients by submitting the following information to Roche Diagnostics:

*Rx GRP (Carrier Group): MAX26266*
*ID#: 1ACCUCHEK*
*Suffix (Dependent) Code: 01*
*Rx BIN#: 610415*
*PCN: PCS*
*COB: Primary*
*Other Coverage Code: Blank*

For additional information, providers may call ACCU-CHEK Customer Care, 1-877-906-8969 or DMA Clinical Policies and Programs at 919-855-4310 (DME) or 919-855-4300 (Pharmacy).

**Clinical Policies and Programs**
**DMA, 919-855-4310**

## *Attention: HIV Case Management Providers*

## *Application Deadline*

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

In addition, all providers seeking to become certified under Clinical Coverage Policy 12 B are required to attend a mandatory training session in order to obtain an application. It is CCME and DMA's intention to make this training available the first week in December 2011. The exact venue is still to be determined. Providers are advised to monitor CCME's website http://www.thecarolinascenter.org/HIVCM for details and updates on this issue.

**HIV Case Management Program**
**DMA, 919-855-4389**

## *Attention: Outpatient Behavioral Health Providers, CABHAs and LMEs*

## *Changes in Clinical Coverage Policy 8C*

Beginning January 1, 2012, an updated version of the Division of Medical Assistance (DMA) Clinical Coverage Policy 8C will be implemented. The proposed changes were approved by the Physician's Advisory Group (PAG) in June 2011. They were posted for public comment in August 2011. A joint group from (DMA) and the Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMHDDSAS) reviewed each of the internal and external comments and made changes accordingly. DMA hosted a series of statewide outpatient seminars in the month of November to inform providers of the changes to be implemented in January 2012.

The proposed policy was updated based on stakeholder feedback. It will be posted for an additional 15 days on the DMA website http://www.ncdhhs.gov/dma/mpproposed/index.htm . The final version of the policy with a January 1, 2012 effective date will be posted on the on the DMA website http://www.ncdhhs.gov/dma/mp/index.htm prior to January 1, 2012. Providers will need to be in compliance with the new policy on January 1, 2012.

The majority of the changes made to the policy were an effort to bring together information that had been previously published in Medicaid Bulletins and Implementation Updates (IUs) into one central location, the policy itself. Changes include: service limitations in line with the National Correct Coding Initiative (NCCI) that went into effect in April, an updated Prior Approval section, the addition of new places of service, criteria for billing 'incident to' a physician (as previously published in the March 2009 Medicaid Bulletin), further clarification of coordination of care activities, updated documentation section clarifying expectations, updated comprehensive clinical assessment section (with elements that were previously published in IU #36), and the addition of expected clinical outcomes. Along with the changes listed above, beginning in January 2012, H codes (H0001, H0004, H0004HR, H0004HS, H0004HQ, H0005, and H0031) will no longer be billable codes for fully licensed behavioral health providers. See the November Bulletin for information on limits to H codes for provisionally licensed professionals billing through the LME.

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

## *Attention: Nurse Practitioners and Physicians*

# *Brentuximab Vedotin (Adcetris, HCPCS code J9999): Billing Guidelines*

Effective with date of service September 26, 2011, the North Carolina Medicaid covers brentuximab vedotin injection (Adcetris) for use in the Physician's Drug Program when billed with HCPCS code J9999 (not otherwise classified, antineoplastic drugs). Adcetris is available in 50 mg single-use vials.

Adcetris is a CD30-directed antibody-drug conjugate indicated for the treatment of Hodgkin's lymphoma after failure of autologous stem cell transplant (ASCT) or after failure of at least two prior multi-agent chemotherapy regimens in patients who are not ASCT candidates, and systemic anaplastic large cell lymphoma after failure of at least one prior multi-agent chemotherapy regimen. The recommended dose of brentuximab is 1.8 mg/kg delivered by intravenous infusion over 1 hour. Treatment is to be repeated every three weeks for a maximum of 16 cycles, or until there is disease progression or unacceptable toxicity.

**For Medicaid Billing**

- An ICD-9-CM diagnosis code from one of the ranges below must be billed with Adcetris:
  - 201.00 201.98 Hodgkin disease, or
  - 200.60–200.68 Anaplastic large cell lymphoma
- Providers must bill Adcetris with HCPCS code J9999 (not otherwise classified, antineoplastic drugs).
- Providers must indicate the number of HCPCS units.
- One Medicaid unit of coverage is 50 mg. The maximum reimbursement rate per unit is $4,684.55.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Adcetris should be reported as "UN." To bill for the entire 50 mg vial of Adcetris, report the NDC units as "UN1."
- If the drug was purchased under the 340-B drug pricing program, place a "UD" modifier in the modifier field for that drug detail.
- Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III,* on DMA's website (http://www.ncdhhs.gov/dma/bulletin/) for additional instructions.
- Providers must bill their usual and customary charge.
- The fee schedule for the Physician's Drug Program is available on DMA's website at: http://www.ncdhhs.gov/dma/fee/.

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

## *Attention: Nurse Practitioners and Physicians*

## *Centruroides (Scorpion) Immune F(ab')² (Equine) (Anascorp, HCPCS code J3590): Billing Guidelines*

Effective with date of service August 3, 2011, the North Carolina Medicaid Program covers centruroides (scorpion) immune F(ab')² (equine) injections. Anascorp is for use in the Physician's Drug Program when billed with HCPCS code J3590 (unclassified biologicals). It is made from equine plasma, and each vial of Anascorp contains a sterile, lyophilized preparation of not more than 120 milligrams of total protein.

Anascorp is an antivenom that is indicated for the treatment of clinical signs of scorpion envenomation. The recommended initial dose of Anascorp is 3 vials. Each vial is to be reconstituted with 5 ml of sterile normal saline, combined and diluted to a total volume of 50 ml which is infused intravenously over 10 minutes. Additional vials may be used as needed and should be administered at 30–60 minute intervals. Each additional vial should be reconstituted with 5 ml of normal saline and diluted to a total volume of 50 ml and infused over 10 minutes.

**For Medicaid Billing**

- The ICD-9-CM diagnosis code required for billing Anascorp is:
  - E905.2 – Scorpion sting as the cause of poisoning and toxic reactions.
- Providers must bill Anascorp with HCPCS code J3590 (unclassified drugs).
- Providers must indicate the number of HCPCS units.
- One Medicaid unit of coverage is 120 mg. The maximum reimbursement rate per unit is $3,795.36.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Anascorp should be reported as "UN." To bill for the entire 120 mg vial of Anascorp, report the NDC units as "UN1."
- If the drug was purchased under the 340-B drug pricing program, place a "UD" modifier in the modifier field for that drug detail.
- Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III,* on DMA's website (http://www.ncdhhs.gov/dma/bulletin/) for additional instructions.
- Providers must bill their usual and customary charge.
- The fee schedule for the Physician's Drug Program is available on DMA's website at: http://www.ncdhhs.gov/dma/fee/.

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

## *Attention: Nurse Practitioners and Physicians*

## *Injection, Icatibant Acetate (Firazyr, HCPCS code J3590): Billing Guidelines*

Effective with date of service August 25, 2011, the North Carolina Medicaid Program covers icatibant acetate injections (Firazyr) for use in the Physician's Drug Program when billed with HCPCS code J3590 (unclassified biologicals). Firazyr is available in 30 mg/3 ml prefilled syringes.

Firazyr is a bradykinin B2 receptor antagonist indicated for the treatment of acute attacks of hereditary angioedema (HAE) in adults 18 years of age and older. Following an acute HAE attack, 30 mg of icatibant should be administered subcutaneously in the abdomen. Additional 30 mg doses may be repeated every 6 hours up to a maximum of three doses per 24 hours.

**For Medicaid Billing**

- The ICD-9-CM diagnosis code required for billing Firazyr is:
  - 277.6 – Other deficiencies of circulating enzymes. Hereditary Angioedema (HAE).
- Providers must bill Firazyr with HCPCS code J3590 (unclassified biologicals).
- Providers must indicate the number of HCPCS units.
- One Medicaid unit of coverage is 10 mg. The maximum reimbursement rate per unit is $2,359.63.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Firazyr should be reported as "ML." To bill for the entire 30 mg/3 ml syringe of Firazyr, report the NDC units as "ML3."
- If the drug was purchased under the 340-B drug pricing program, place a "UD" modifier in the modifier field for that drug detail.
- Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III,* on DMA's website (http://www.ncdhhs.gov/dma/bulletin/) for additional instructions.
- Providers must bill their usual and customary charge.
- The fee schedule for the Physician's Drug Program is available on DMA's website at: http://www.ncdhhs.gov/dma/fee/.

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

### *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/gnrlinfo.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 htt://www.ncdhhs.gov/dma/mpproposed/. To submit a comment related to a policy, refer to the instructions on the website. Providers without Internet access can submit written comments to the address listed below.

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

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

### *2011 - 2012 Checkwrite Schedule*

| Month | Checkwrite Cycle Cutoff Date | Checkwrite Date | EFT Effective Date |
|---|---|---|---|
| **December** | 12/1/11 | 12/6/11 | 12/7/11 |
| | 12/8/11 | 12/13/11 | 12/14/11 |
| | 12/15/11 | 12/22/11 | 12/23/11 |
| **January** | 1/5/12 | 1/10/12 | 1/11/12 |
| | 1/12/12 | 1/18/12 | 1/19/12 |
| | 1/19/12 | 1/26/12 | 1/27/12 |

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

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

**Melissa Robinson**
**Executive Director**
**HP Enterprise Services**