December 2012 Medicaid Bulletin

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Attention: All Providers

Decommission of Modem Service

Notice to Providers: This article was originally published in November 2012.

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

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

HP Enterprise Services, 1-800-688-6696

Attention: All Providers

Medicare HMO UB-04 Claims

The N.C. Medicaid liability for UB-04 Medicare Health Maintenance Organization (HMO) charges is the Medicare HMO cost share amount.

The Medicare HMO cost share includes copayment, coinsurance, and/or deductible. The cost share should be submitted on the UB-04 claim in FL55. The amount indicated in FL55 should reflect the Medicare HMO cost share amount only and should not include other charges, such as non-covered charges, which may be included as patient responsibility on the Medicare EOB. **Claims submitted with an estimated amount due that does not match the actual Medicare HMO cost share amount will be denied.**

Third Party Recovery
DMA, 919-814-0240

Attention: All Providers

Termination of Inactive N.C. Medicaid and N.C. Health Choice Provider Numbers

Note to Providers: This article was originally published in September 2011.

The N.C. Division of Medical Assistance (DMA) wants to remind all providers of its policy for terminating inactive providers to reduce the risk of fraudulent and unscrupulous claims billing practices. DMA's updated policy was announced in the *July 2011 Medicaid Bulletin*.

N.C. Medicaid and N.C. Health Choice (NCHC) provider numbers that do not reflect any billing activity within the previous 12 months will be terminated. Unless providers **can** attest that they have provided services to N.C. Medicaid or NCHC recipients in the previous 12-month period, their provider numbers will be terminated. A new enrollment application and agreement to re-enroll must be submitted to CSC for any provider who is terminated. **As a result, a lapse in the provider's eligibility may occur.**

Termination activity occurs on a quarterly basis, with provider notices being mailed out on April 1, July 1, October 1, and January 1 of each year with termination dates of May 1, August 1, November 1, and February 1, respectively. These notices are sent to the current mailing address listed in the provider's file. **Providers are reminded to update their contact and ownership information in a timely manner.**

Terminated providers who wish to re-enroll can reach CSC by phone at 1-866-844-1113 or by e-mail at NCMedicaid@csc.com.

Provider Services
DMA, 919-855-4050

Attention: All Providers

Recredentialing Is Required for All N.C. Medicaid and N.C. Health Choice Providers a Minimum of Every Three Years

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

The N.C. Division of Medical Assistance (DMA) is federally mandated to ensure that all provider information is accurate and current in the Enrollment, Verification, and Credentialing (EVC) System. To that end, it is the State's policy to recredential providers and provider groups a minimum of every three years.

The EVC Operations Center electronically generates and distributes enrollment renewals for all enrolled providers 75 days prior to their three-year anniversary date or the date of their last renewal contract. Within 30 days of receiving the invitation letter, providers must verify their provider information and submit any additional information requested via the online recredentialing application.

Providers who do not take action within the specified time frame risk being terminated from the N.C. Medicaid and N.C. Health Choice programs. As a reminder, termination from the programs requires providers to re-enroll and pay any applicable fees. **Additionally, no claims will be paid during the time that providers are not enrolled in the programs.**

The explanation of benefits for **claims denial** will state:

- "1815 – Payments denied for failure to recredential billing provider enrollment. Please direct inquiries to CSC at 866-844-1113 for assistance in addressing this denial" or,
- "1813 – Payments denied for failure to recredential individual attending provider enrollment. Please direct inquiries to CSC at 866-844-1113 for assistance in addressing this denial."

The explanation of benefits for **provider termination** will state:

- "1814 – Payments denied – Billing Provider eligibility terminated for failure to recredential provider enrollment. Please direct inquiries to CSC at 866-844-1113 for assistance in addressing this denial" or,

- "1812 – Payments denied – Attending Provider eligibility terminated for failure to recredential provider enrollment. Please direct inquiries to CSC at 866-844-1113 for assistance in addressing this denial."

Providers are encouraged to be on the lookout for recredentialing invitations. The State will be targeting between 5,000 and 9,000 providers for recredentialing each month

between now and the end of 2012. Additional information regarding the recredentialing process can be found at: https://www.nctracks.nc.gov/provider/providerEnrollment/assets/onlineHelp/recredentialing_101_help.pdf.

Questions should be directed to the EVC Operations Center at 866-844-1113 or by e-mail at NCMedicaid@csc.com.

Provider Services
DMA, 919-855-4050

Attention: All Providers

Processing Changes for Duplicate Remittance and Status Reports (RAs)

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

The Remittance and Status Report (RA) is a computer-generated document showing the status of all claims submitted to HP Enterprise Services (HPES), along with a detailed breakdown of payment.

The RA is available through the North Carolina Claims Submission/Recipient Eligibility Verification Web (NCECSWeb) Tool. All providers who want to download their RA in PDF format from the NCECSWeb Tool are required to register for that service using this form: www.ncdhhs.gov/dma/forms/RARequest.pdf. Providers are encouraged to print the RAs or save an electronic copy to assist in keeping all claims and payment records current. Printed RAs should be kept in a notebook or filed in chronological order for easy reference.

RAs generated in the most recent 10 checkwrites are available free of charge via the NCECSWeb Tool. Duplicate copies of RAs older than 10 checkwrites are available for 35 cents per page.

Effective September 1, 2012, HP no longer mails duplicate RAs to providers. Duplicate RAs requested by providers will be posted on the NCECSWeb Tool. Providers may request duplicate RAs by contacting the HPES Provider Services Unit at 1-800-688-6696, menu option 3.Since the duplicate RAs will be posted electronically on the NCECSWeb Tool, you must be registered to receive PDF RAs in order to access the RAs you request. HP charges and collects a fee of 35 cents per page. After payment is received, your request should appear on the next checkwrite after it is processed and will remain posted for at least 9 checkwrites.

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

Attention: All Providers

Reporting Managing Relationship Changes

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

Providers are responsible for notifying the N.C. Division of Medical Assistance (DMA) of any changes to their managing relationships. This notification must be made within 30 calendar days of the change. The changes must be reported by submission of a new Provider Enrollment Packet, found on the NCTracks website at https://nctracks.nc.gov/provider/providerEnrollment/index.jsp

Providers are encouraged to use the online provider enrollment application. With each submission, the provider must disclose all managing relationships in the Managing Relationship section. The entire Provider Enrollment Packet must be complete and correct upon submission to avoid delays in processing.

Below are two examples of how changes in managing relationships should be reported on the Provider Enrollment Packet:

- **Scenario 1** (**Adding a managing relationship**): Upon enrollment, a provider disclosed that it had four managing relationships. A year later, the provider added one new managing relationship. The provider must complete a new Provider Enrollment Packet. In the Managing Relationship section, the provider must list all five managing relationships.

- **Scenario 2** (**Removing a managing relationship**): Upon enrollment, a provider disclosed that it had 20 managing relationships. Six months later, the provider removed one of its managing relationships. The provider must complete a new Provider Enrollment Packet. In the Managing Relationship section, the provider must list all 19 managing relationships.

Notifying DMA of managing relationship changes will ensure providers that their Medicaid provider files are always current.

Provider Services
DMA, 919-855-4050

Attention: All Providers

Enrollment and Application Fees

Affordable Care Act (ACA) Application Fee

As of October 1, 2012, the N.C. Division of Medical Assistance (DMA) began collecting the federal application fee required under Section 1866(j)(2)(C)(i)(l) of the Affordable Care Act (ACA) from certain providers.

The Centers for Medicare & Medicaid Services (CMS) sets the application fee, which may be adjusted annually. The application fee for enrollment in 2012 is set at $523. The purpose of the fee is to cover the cost of screening and other program integrity efforts. The application fee will be collected **per site location** prior to executing a provider agreement from a prospective or re-enrolling provider.

This requirement does not apply to the following:

(1) Individual physicians or non-physician practitioners.
(2) (i) Providers who are enrolled in either of the following:
    (A) Title XVIII of the Act.
    (B) Another State's Medicaid or CHIP plan.
  (ii) Providers who have paid the applicable application fee to:
    (A) A Medicare contractor; or
    (B) Another State.

Providers who are required to pay this fee will be sent an invoice via mail. States must collect the applicable fee for any newly enrolling, reenrolling or reactivating institutional provider.

North Carolina Enrollment Fee

Session Law 2011-145 Section 10.31(f)(3) mandates that DMA collects a $100 enrollment fee from providers upon initial enrollment with the N.C. Medicaid/Health Choice programs and at three-year intervals when the provider is re-credentialed.

Initial enrollment is defined as an in-state or border-area provider who has never enrolled to participate in the N.C. Medicaid/Health Choice programs. The provider's tax identification number is used to determine if the provider is currently enrolled or was previously enrolled.

Applicants should not submit payment with their application. Upon receipt of the enrollment application, an invoice will be mailed to the applicant if either 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 and N.C. Health Choice provider.

Provider Services
DMA, 919-855-4050

Attention: All Providers

Medicaid Providers Must Screen for Individual & Entity Exclusion

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

The Health and Human Services - Office of Inspector General (HHS-OIG) has authority to exclude individuals and entities from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and all Federal health care programs (as defined in Section 1128B(f) of the Social Security Act based on the authority contained in various sections of the Act, including Sections 1128, 1128A, and 1156).

When the HHS-OIG has excluded a provider, federal health care programs (including Medicaid and SCHIP programs) are generally prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities. (Section 1903(i)(2) of the Act; and 42 CFR Section 1001.1901(b)). This payment ban applies to any items or services reimbursable under a Medicaid program that are furnished by an excluded individual or entity, and extends to:

- all methods of reimbursement, whether payment results from itemized claims, cost reports, fee schedules, or a prospective payment system;
- payment for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to Medicaid recipients, when those payments are reported on a cost report or are otherwise payable by the Medicaid program; and
- payment to cover an excluded individual's salary, expenses, or fringe benefits, regardless of whether they provide direct patient care, when those payments are reported on a cost report or are otherwise payable by the Medicaid program.

In addition, no Medicaid payments can be made for any items or services directed or prescribed by an excluded physician/pharmacist or other authorized person when the individual or entity furnishing the services either knew, or should have known, of the exclusion. This prohibition applies even when the Medicaid payment itself is made to

another provider/pharmacist, practitioner or supplier that is not excluded in accordance with 42 CFR Section 1001.1901(b).

Providers can look for excluded individuals and entities on the HHS-OIG List of Excluded Individuals and Entities (LEIE) database, which is accessible to the general public and displays information about parties excluded from participation in Medicare, Medicaid, and all other Federal health care programs. The LEIE website is located at: https://oig.hhs.gov/exclusions/index.asp. Providers can also access the video podcast "How to Use the Exclusions Database" located on the HHS-OIG website at: www.youtube.com/watch?v=9jaaacHpwoc**.** This video explains how to effectively use the Exclusions Database.

To further protect against payments for items and services furnished, prescribed, or ordered by excluded individuals and/or entities, the Division of Medical Assistance (DMA) is advising all current providers and providers applying to participate in the Medicaid program to take the following steps:

- Provider has an **obligation** to screen all employees and contractors to determine whether any of them have been excluded.
- DMA requires this obligation as a condition of enrollment into the Medicaid program.
- The provider must immediately report to the appropriate Regional Office of the OIG Office of Investigations or DMA any exclusion information discovered.

DMA understands that providers share our commitment to combating fraud, waste, and abuse. Working together will strengthen efforts to identify excluded parties, improve the integrity and quality of the Medicaid program and benefit the Medicaid recipients and North Carolina taxpayers; therefore this form of defense in combating fraud, waste, and abuse must be conducted accurately, thoroughly, and routinely.

Program Integrity
DMA, 919-647-8000

Attention: All Providers

Implementation of Additional Correct Coding Edits: Facility Duplicates

Notice to Providers: This article was originally published in January 2012.

As announced in previous N.C. Medicaid bulletins, the N.C. Division of Medical Assistance (DMA) is implementing additional correct coding guidelines. These new correct coding guidelines and edits are nationally sourced by organizations such as the Centers for Medicare & Medicaid Services (CMS) and the American Medical Association (AMA). These edits identify any inconsistencies with CPT, AMA, CMS, and/or DMA policies and generate denials at the claim-detail level. Additional correct coding edits for Facility Duplicates will be implemented on January 1, 2013 for dates of service on or after January 1, 2013.

Duplicates – Outpatient Facility Claims

For Hospital Outpatient services, DMA will only edit claim details related to drug, radiology, and laboratory services. Edits will reject only the claim line when all criteria match at the line and header level. If all other criteria match, but the two lines have different CPT/HCPCS codes, or one line has a CPT/HCPCS code and the other line has no CPT/HCPCS code, the two lines do not meet the criteria for line level Duplicate Outpatient Facility editing. If both lines have **NO** CPT/HCPCS codes, the line will not be considered for duplicate matching. The criteria for line-level outpatient facility duplicate matching are as follows:

- Recipient/Patient
- Billing provider identification number
- Bill type
- Service date (line level)
- Charge amount (line level)
- HCPCS or CPT code

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

Attention: All Providers and N.C. Health Choice Providers

Subscribe & Receive E-mail Alerts on Important N.C. Medicaid and N.C. Health Choice Updates

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

N.C. Division of Medical Assistance (DMA) allows all providers the opportunity to sign up for N.C. Medicaid/N.C. Health Choice (NCHC) E-mail Alerts. Providers will receive E-mail Alerts on behalf of all Medicaid and NCHC programs. E-mail Alerts are sent to providers when there is important information to share outside of the general Medicaid Provider Bulletins. To receive E-mail Alerts subscribe at www.seeuthere.com/hp/medicaidalert.

Providers and their staff members may subscribe to the E-mail Alerts. Contact information including an e-mail address, provider type and specialty is essential for the subscription process. You may unsubscribe at any time. **E-mail addresses are never shared, sold or used for any purpose other than Medicaid E-mail Alerts.**

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

Attention: All Providers

At-Risk Case Management Services (ARCM) for Eligible N.C. Health Choice (NCHC) Beneficiaries - REVISED

Notice to Providers: This article is a revised version of one that was published in the September 2012 Medicaid Bulletin.

Providers were notified about updates for At-Risk Case Management (ARCM) services for eligible N.C. Health Choice (NCHC) beneficiaries on the following dates:

- August 2012 via e-mail through Local Business Liaisons
- June 2012 via SIS - Change Notice (Change No. 02-12)
- June 2012 via Recorded Webinar
- April 2012 via e-mail through Division of Aging and Adult Services

This article provides clarification of previously announced changes.

Effective March 12, 2012, the ARCM program provides coverage to children eligible under the N.C. Health Choice (NCHC) program. NCHC beneficiaries – ages 6 through 18 years of age – must be enrolled on the date of service to be eligible and must meet policy coverage criteria unless otherwise specified. All NCHC clinical coverage policies are

posted electronically with the N.C. Medicaid Program clinical coverage policies and provider manuals. For more information, visit www.ncdhhs.gov/dma/mp/.

When billing for ARCM for NCHC, providers should use procedure code T1017. The NCHC reimbursable rate is the same as the Medicaid reimbursable rate. Providers should bill their usual and customary charges. More information is located at: www.ncdhhs.gov/dma/fee/tcm/TCM_ARCM_fee120701.pdf.

Effective with the June 1, 2012 service month, a new SIS Code and a new Program Code were implemented to distinguish between N.C. Medicaid and NCHC services for day sheet coding purposes.

The new codes are:

- SIS Code 392 (At Risk Case Management Services – Child Welfare)
- Program Code HC2 (Health Choice CM)

The following chart gives examples of how the code would be used.

Code	Example
SIS Code 392 and Program Code HC2	Use when coding the day sheet for an ARCM-NCHC beneficiary.
SIS Code 392 and Program Code 2	Use when coding the day sheet for an ARCM-Medicaid beneficiary.

ARCM adults would continue to be coded using SIS Code 395 and Program Code 2.

Rate Setting
DMA, 919-814-0062

Attention: All Providers

NC Medicaid Recovery Audit Contractors (RAC)

Under the Medicaid RAC program, states must contract with at least one Recovery Audit Contractor (RAC) to perform post-payment audits in order to identify Medicaid payments that may have been underpaid or overpaid. Effective January 1, 2012, the N.C. Division of Medical Assistance (DMA) partnered with Public Consulting Group (PCG) to be one of the N.C. Medicaid RACs; Effective October 1, 2012, DMA partnered with Health Management Systems (HMS) to be another RAC vendor.

Beginning in December 2012, PCG will be initiating RAC reviews of hospice providers, specifically evaluating billing activity concurrent with the all-inclusive hospice rate. The DMA and PCG will be working with provider associations to supply further information, including contact information, education materials and a webinar.

Below is a brief explanation of the RAC initiative.

On September 16, 2011, the Centers for Medicare &Medicaid Services (CMS) published the Final Rule for RAC. Mandated by the Affordable Care Act (ACA), the Medicaid RAC Final Rule required states to implement their Medicaid RAC programs by January 1, 2012 or lose federal funding. RACs must follow federal and state guidelines to recover overpayments or to inform the DMA of underpayments.

On February 17, 2011, DMA received approval of Medicaid State Plan Amendment NC 10-037 to establish one or more RACs. PCG and HMS were contracted under the terms of this amendment. Additional information regarding RAC activities by both HMS and PCG will be published in future articles.

Federal Regulations for the Medicaid RAC program can be obtained at www.gpo.gov/fdsys/pkg/FR-2011-09-16/pdf/2011-23695.pdf.

Program Integrity
DMA, 919-814-0000

Attention: All Providers

Clinical Coverage Policies

The following new or amended combined N.C. Medicaid and N.C. Health Choice (NCHC) clinical coverage policies are available on the N.C. Division of Medical Assistance (DMA) website at www.ncdhhs.gov/dma/mp/:

- *A3, Prior Authorization for Outpatient Pharmacy Point-of-Sale Medications (Date of Termination 9/30/12)*
- *1E-1, Hysterectomy (10/1/12)*
- *1-O-3, Keloid Excision and Scar Revision (10/1/12)*
- *8M, Community Alternatives Program for Persons with Intellectual/Developmental Disabilities (CAP-I/DD) (10/1/12)*
- *1D-4, Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics (10/15/12)*
- *1-O-1, Reconstructive and Cosmetic Surgery (11/1/12)*
- *3D, Hospice Services (11/1/12)*
- *5B, Orthotics & Prosthetics (11/1/12)*
- *8B, Inpatient Behavioral Health Services (11/1/12)*
- *NCHC Hospice Care (Date of Termination 10/31/2012)*

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

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

Appeals for Outpatient Specialized Therapies Policy Tiered Limits

Medicaid Beneficiary Service Appeals

Medicaid beneficiaries (or their *authorized* personal representatives) have the right to appeal adverse decisions of the State Medicaid agency and receive a fair hearing as specified in the Social Security Act, 42 C.F.R. 431.200 *et seq.*, and the N.C.G.S. §108A-70.9A. Further, Medicaid beneficiaries have a constitutional right to due process because Medicaid is an entitlement program.

When an adverse decision is rendered, the beneficiary will be issued a written notice with an opportunity to request a hearing. If the beneficiary has identified a representative – or if there is a guardian and Medicaid has been notified of the representative's/guardian's name and mailing address – that person will receive a copy of the notice.

For the beneficiary **21 years of age and older**, the table below summarizes the amount of service covered by Medicaid under medical coverage policy 10A, Outpatient Specialized Therapies*****. See the medical coverage policy located at www.ncdhhs.gov/dma/mp/index.htm for complete details of service provision.

Number of Visits Covered	Diagnoses
3 combined treatment visits and 1 evaluation visit of all therapies combined (PT, OT, SLP) per calendar year, from all therapy providers, in any outpatient setting.	Diagnoses that are medically necessary and are ordered by physicians that are not indicated below.
1 physical therapy evaluation and/or 1 occupational therapy evaluation visit and 10 therapy treatment combined visits (PT, OT, SLP) per calendar year, from all therapy providers, in any outpatient setting	amputation, joint replacement or post-op hip fracture within 3 months post surgery or discharge from inpatient services
1 physical therapy evaluation and/or 1 occupational therapy evaluation and/or 1 speech therapy evaluation and 30 therapy treatment combined visits (PT, OT, SLP) per calendar year, from all therapy providers, in any outpatient setting	stroke, traumatic brain injury or spinal cord injury within 6 months post discharge from inpatient services
***NOTE:** For beneficiaries **under 21 years of age** and as required by Early and Periodic Screening, Diagnostics, and Treatment (EPSDT) under Federal Medicaid law at 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act], the beneficiary is entitled to receive as much of the requested service as needed (if all EPSDT criteria are met) which are medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition identified by screening". Visit the EPSDT provider page at www.ncdhhs.gov/dma/provider/epsdthealthcheck.htm for additional information about EPSDT and its application to Medicaid services.	

The beneficiary can appeal a decision for outpatient specialized therapies treatment visit limits and evaluation limits when the service request is denied, reduced, or terminated by the utilization review contractor. Providers are encouraged to resubmit the request with

the correct diagnosis or contact the utilization review contractor if inaccurate diagnosis information was submitted with the initial request which placed the recipient in the wrong tier. As a reminder, providers may not file appeals on behalf of beneficiaries unless the beneficiary lists the provider as the representative on the appeals request form.

Provider Claims Denial Reconsideration Review

Under 10A NCAC 22J .0102, providers have the right to request a reconsideration review within 30 calendar days from receipt of final notification of payment, payment denial, disallowances, payment adjustment, notice of program reimbursement and adjustments and within 60 calendar days from receipt of notice of an institutional reimbursement rate. If no request is received within the respective 30 or 60 day periods, the state agency's action shall become final.

1. Prior to requesting a reconsideration review, the provider is encouraged to exhaust all remedies to have the claim pay correctly.

2. A request for reconsideration review must be in writing and signed by the provider and contain the provider's name, address, provider number or other identifying information, and telephone number. It must state the specific dissatisfaction with DMA's action, actions the provider attempted for correction, and be mailed to: Provider Appeals, Division of Medical Assistance at the Division's current address (2501 Mail Service Center, Raleigh NC 27699-2501).

3. If the provider disagrees with the reviewer’s decision, a contested case hearing may be filed with the Office of Administrative Hearings as specified by the Administrative Procedures Act found at www.ncoah.com/150b.pdf.

Ancillary Services, DMA, 919-855-4310
Provider Appeals, DMA, 919-855-4350

Attention: Physicians

Affordable Care Act Enhanced Payments to Primary Care Physicians – UPDATE

According to Section 1202 of the Affordable Care Act (ACA) – which amends section 1902(a)(13) of the Social Security Act – Medicaid is federally required to pay up to the Medicare rate for **certain primary care services** and to reimburse 100% of the Medicare Cost Share for services rendered and paid in calendar years 2013 and 2014.

Section 1902(a)(13)(C) now specifies that physicians with a primary specialty designation of family medicine, general internal medicine or pediatric medicine are primary care providers. Those who render evaluation and management (E&M) codes and services related to immunization administration for vaccines and toxoids for specified codes would be eligible for reimbursement.

The Final Rule for this section was released by Centers for Medicare & Medicaid Services in November 2012. It can be found at: www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/Downloads/CMS%E2%80%9310422.pdf.

Providers can attest to having board certification in a specialty (family medicine, general internal medicine or pediatric medicine) or subspecialty designated in the statute and attest to billing at least 60% for Evaluation & Management (E&M) and vaccine/toxoid codes through a N.C. Division of Medical Assistance (DMA) website portal using their N.C. Medicaid provider numbers.

This rule provides for the higher payment for services provided under the personal supervision of eligible physicians by all advanced practice clinicians - *Final rule: CMS-2370-F; RIN 0938-AQ63; Section b. Services Furnished by a Specified Physician*. Advanced clinical practitioners are required to attest to being under the supervision of a board certified physician.

N.C. Medicaid will reimburse providers retroactively if they attested prior to implementation.

The codes included in this provision include E&M services and immunization administration for vaccines and toxoids. The MMIS+ claims processing system will reference both the Medicaid fee schedule, as well as the Medicare fee schedule to determine the enhanced payment amount.

DMA will notify providers through upcoming Medicaid bulletins, e-mail blasts, remittance advices or banner messages as the ACA Enhanced Payments to Primary Care Physicians implementation efforts progress.

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

Attention: All Providers

NC Medicaid Provider Direct Enrollment and Screening - UPDATE

Beginning October 1, 2012, the N.C. Division of Medical Assistance (DMA) implemented Federal regulations 42 CFR 455.410 and 455.450 – requiring all participating providers to be screened according to their categorical risk level. These screenings will take place both upon initial enrollment and re-enrollment.

42 CFR 455.450 establishes the following three categorical risk levels for N.C. Medicaid and N.C. Health Choice (NCHC) providers to assess the risk of fraud, waste, and abuse:

- Low
- Moderate
- High

Provider types and specialties that fall into the moderate- and high-risk categories are subject to a pre-enrollment site visit, unless a screening and site visit has been successfully completed by Medicare or another state agency within the previous 12 months. Senate Bill 496 §108C-3 further defines provider types that fall into each category.

The Centers for Medicare & Medicaid Services (CMS) sets the application fee, which may be adjusted annually. The application fee amount for enrollment in 2012 is set at $523. The purpose of the fee is to cover the cost of screening and other program integrity efforts. The application fee will be collected per site location prior to executing a provider agreement from a prospective or re-enrolling provider.

This requirement does **not** apply to the following:

(1) Individual physicians or non physician practitioners.

(2) (i) Providers who are enrolled in either of the following:
(A) Title XVIII of the Act.
(B) Another State's Medicaid or CHIP plan.

(ii) Providers that have paid the applicable application fee to—
(A) A Medicare contractor; or
(B) Another State.

Providers who are required to pay this fee will be sent an invoice via mail. States must collect the applicable fee for any newly enrolling, reenrolling or reactivating institutional provider.

North Carolina Senate Bill 496 108C-9.c, also requires that – prior to initial enrollment in the N.C. Medicaid or NCHC programs – an applicant's representative shall attend trainings as designated by DMA, including, but not limited to, the following:

- The *N.C. Basic Medicaid and N.C. Health Choice Billing Guide*, common billing errors, and how to avoid them.
- Audit procedures, including explanation of the process by which the DMA extrapolates audit results.
- Identifying Medicaid recipient fraud.
- Reporting suspected fraud or abuse.
- Medicaid recipient due process and appeal rights.

This training is completely web-based and will be made available to online.

It is imperative for providers to submit their application with a valid e-mail address that is frequently checked. Providers will be notified via e-mail when it is time to complete the training and the steps necessary to complete the training.

Provider Services
DMA, 919-855-4050

Attention: All Providers

CMS' Stage 2 Final Rule for EHR Incentive Program Affects Eligible Professionals

As previously announced in the *October 2012 Medicaid Bulletin*, the Centers for Medicare & Medicaid Services (CMS) recently released the Stage 2 Final Rule (September 4, 2012) for the Electronic Health Record (EHR) Incentive Program. As a result of the new rule, there have been changes to the patient volume requirements for the N.C. Medicaid EHR Incentive Program. **These changes will take effect January 1, 2013 for Eligible Professionals (EPs).**

The new definition of patient volume allows the patient volume reporting period to be any consecutive 90 days within the prior calendar year or preceding 12-month period from the date of the attestation.

In addition, **effective January 1, 2013**, EPs who use the criteria of "practicing predominantly" when calculating patient volume may choose a consecutive six-month period in the most recent calendar year or preceding 12-month period from the date of the attestation.

Also **effective January 1, 2013,** when calculating needy individuals, the EP's patient volume reporting period can be any consecutive 90 days within the prior calendar year or preceding 12-month period from the date of the attestation.

The new patient volume definition also allows the numerator in the patient volume calculation to include a billable service rendered on any one day to a Medicaid-enrolled individual, regardless of payment liability. This includes zero-pay claims. For more information on patient volume, visit the EHR website at www.ncdhhs.gov/dma/provider/ehr.htm.

Examples of billable services include:

1. encounters denied for payment by Medicaid or that would be denied if billed due to exceeding the allowable limitation for the service/procedure;
2. encounters denied for payment by Medicaid or that would be denied if billed because of lack of following correct procedures as set forth in the state's Medicaid clinical coverage policy, such as not obtaining prior approval before performing the procedure;
3. encounters denied for payment due to not billing in a timely manner;
4. encounters paid by another payer which exceed the potential Medicaid payment;
5. encounters that are not covered by Medicaid such as some behavioral health services, HIV/AIDS treatment, or other services not billed to Medicaid for privacy reasons, oral health services, immunizations, but where the provider has a mechanism to verify Medicaid eligibility.

Further, the Final Rule defines billable as follows:

1. concurrent care or transfer of care visits;
2. consultant visits; or,
3. prolonged physician service without direct, face-to-face patient contact (for example, tele-health).

A consultant visit occurs when a provider is asked to render an expert opinion/service for a specific condition or problem by a referring provider. The visit does not have to be individually billable in instances where multiple visits occur under one global fee. Billable services do not include:

1. encounters denied for payment by Medicaid or that would be denied if billed because of absence of medical necessity under the state's Medicaid clinical coverage policy;
2. encounters denied for payment by Medicaid because the patient was not enrolled in Medicaid at the time the service was rendered.

Finally, under the new Stage 2 Final Rule, providers will now be able to count Medicaid Children's Health Insurance Program (MCHIP) encounters toward their patient volume requirements. MCHIP recipients are children covered under a Medicaid expansion program. This requires no action on the part of the provider, since these patients have historically been reported by the provider as a part of their numerator in the patient volume calculation. The State will no longer subtract them from the reported numerator.

The Stage 2 Final Rule also altered the meaning of the term "hospital-based." EPs are now eligible for incentive payments if they can demonstrate:

- they funded the acquisition, implementation and maintenance of the Certified EHR Technology (CEHRT), including supporting hardware and any interfaces necessary to meet meaningful use;
- were not reimbursed by an eligible hospital (EH) or critical access hospitals (CAH);
- use such CEHRT in the inpatient or emergency department of a hospital (instead of the hospital's CEHRT).

The 120-day tail period for program year 2012 allows EPs until **April 30, 2013** to attest for an incentive payment. The new definitions explained above do not apply to providers attesting for a program year 2012 payment during the 120-day tail period.

EPs attesting for program year 2013 (January 1, 2013 – December 31, 2013) will be able to use the new definitions.

EHR Certification Number Required When Attesting with North Carolina

The N.C. Medicaid EHR Incentive Program reminds providers that even though CMS **does not** require providers to enter their EHR certification numbers during registration in the CMS Registration & Attestation System, such information **will** be required when attesting for an incentive payment with North Carolina.

Therefore, the N.C. Division of Medical Assistance (DMA) requires providers who did not provide an EHR certification number during initial program registration with CMS to update the CMS Registration & Attestation System with this information. This number will be transmitted to the State and will pre-populate in the N.C. Medicaid Incentive Payment System (NC-MIPS) portal. Those who do not see their certification number when logging onto the NC-MIPS portal will be asked to go back to the CMS Registration & Attestation System to provide this information. The changes should be seen in the NC-MIPS portal after 24 hours.

N.C. Medicaid Health Information Technology (HIT)
DMA, 919-855-4200

Attention: All Hospitals

CMS' Stage 2 Final Rule for EHR Incentive Program Affects Eligible Hospitals

As announced in the *October 2012 Medicaid Bulletin*, the Centers for Medicare & Medicaid Services (CMS) recently released the Stage 2 Final Rule (September 4, 2012) for the Electronic Health Record (EHR) Incentive Program. As a result of the new rule, there have been changes to the patient volume requirements for the N.C. Medicaid EHR Incentive Program. These changes took effect October 1, 2012 for eligible hospitals (EHs).

Definitions

The new definition of patient volume allows the patient volume reporting period to be any consecutive 90 days within the prior fiscal year or preceding 12-month period from the date of the attestation.

The new patient volume definition also allows the numerator in the patient volume calculation to include a billable service rendered on any one day to a Medicaid-enrolled individual, regardless of payment liability. This includes zero-pay claims. For more information, visit the EHR website at www.ncdhhs.gov/dma/provider/ehr.htm.

Examples of billable services include:

1. encounters denied for payment by Medicaid or that would be denied if billed due to exceeding the allowable limitation for the service/procedure;
2. encounters denied for payment by Medicaid or that would be denied if billed because of lack of following correct procedures as set forth in the state's Medicaid clinical coverage policy, such as not obtaining prior approval prior to performing the procedure;
3. encounters denied for payment due to not billing in a timely manner;
4. encounters paid by another payer that exceed the potential Medicaid payment.

Billable services do not include:

1. encounters denied for payment by Medicaid or that would be denied if billed because of absence of medical necessity under the state's Medicaid clinical coverage policy;
2. encounters denied for payment by Medicaid because the patient was not enrolled in Medicaid at the time the service was rendered.

Finally, under the new Stage 2 Final Rule, EHs will now be able to count Medicaid Children's Health Insurance Program (MCHIP) encounters toward their patient volume requirements. MCHIP recipients are children covered under a Medicaid expansion program. This requires no action on the part of the provider, since these patients have historically been reported by the provider as a part of their numerator in the patient volume calculation. The State will no longer subtract them from the reported numerator.

The 120-day tail period for program year 2012 allows EHs until January 28, 2013 to attest for an incentive payment. The new definitions explained below do not apply to providers attesting for a program year 2012 payment during the 120-day tail period.

EHs attesting for program year 2013 (October 1, 2012 – September 30, 2013) will be able to use the new definition of patient volume.

NC Medicaid Health Information Technology (HIT)
DMA, 919-814-0030

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

Transition and Implementation Update, Personal Care Services

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

Consolidated Personal Care Services Policy and State Plan Amendment

Effective January 1, 2013, Medicaid PCS for recipients in all settings – including private residences and licensed adult care homes (ACH), family care homes, 5600a and 5600c supervised living homes, and combination homes with ACH beds – will be provided under a consolidated PCS benefit. Clinical Coverage Policy 3L, Personal Care Services, was posted for a second, 15-day public comment period from November 9 to November 24, 2012. Policy 3L will be posted in final version in December 2012, with a January 1, 2013 effective date.

For more information, refer to the N.C. Division of Medical Assistance (DMA) Medicaid Clinical Coverage Policy webpage. DMA anticipates that approval of the N.C. Medicaid State Plan Amendment (SPA) 12-013 by the Centers for Medicare & Medicaid Services (CMS) is forthcoming. Additional information will be posted on the DMA Consolidated PCS webpage as it becomes available.

Independent Assessments of Licensed Facility Residents

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

Providers may continue to report new Medicaid admissions who require independent assessments to determine eligibility for PCS effective January 1, 2013. Complete the Independent Assessment Request for New Admissions (Form DMA-3066) and submit it by fax to The Carolinas Center for Medical Excellence (CCME) at 877-272-1942. Note that the valid dates for submitting Form DMA-3066 have been revised. Use Form DMA-3066 to request independent assessments for newly admitted beneficiaries who receive PCS in licensed facilities **on or before dates of service through December 31, 2012.**

After receipt of a completed Independent Assessment Request for New Admissions (Form DMA-3066), CCME will contact the facility to schedule a return visit to assess beneficiaries who have not previously been assessed for PCS eligibility. Independent assessments of beneficiaries admitted through December 31, 2012 will be scheduled through December 2012 and into January 2013 to determine PCS eligibility with an effective date of January 1, 2013.

To ensure beneficiary prior authorization for PCS is assigned to the correct licensed home provider, use the Independent Assessment Request for New Admissions (Form DMA-3066) to report all new Medicaid admissions to your facility, including beneficiaries who transfer from other licensed homes and who may have previously received independent assessments. PCS eligibility for beneficiaries previously assessed while residing in a different licensed home will be determined by the previous assessment.

Submission of Medical Attestation Forms

A completed PCS Medical Attestation (Form DMA-3065) is also required to determine PCS eligibility for all licensed facility residents, including those admitted to provider facilities after an assessor's initial assessment visit. Initiate completion of the PCS Medical Attestation *immediately* for all new admissions to ensure that a completed form is available for presentation to the assessor at the time of the resident's scheduled assessment. **Failure to complete and submit the medical attestation will result in a denial of services effective January 1, 2013, whether or not a beneficiary has received an independent assessment.** Decision notices for assessed beneficiaries whose medical attestation forms have not been received will be held until mid-December to allow additional time for submission.

Beneficiary Decision Notices

DMA's release of beneficiary decision notices is contingent upon approval by CMS of the N.C. Medicaid State Plan Amendment 12-013. Licensed home providers will receive copies of beneficiary decision notices. Adverse decision notices will include an appeal request form and instructions and deadlines for filing an appeal. In accordance with federal regulations, maintenance of service will be available for recipients whose request for continuation of PCS has been denied or reduced, and who have filed a timely appeal.

Adverse decisions include service reductions and denials of Medicaid ACH/PCS beneficiaries' current service levels, and denials of new requests for PCS by Medicaid beneficiaries who have received an independent assessment but are not currently receiving ACH/PCS. Providers may assist beneficiaries who wish to appeal an adverse decision to complete and submit the appeal request. As a reminder, providers may not file appeals on behalf of beneficiaries unless the beneficiary lists the provider as the representative on the appeal request form.

The determination that a beneficiary's request is a request for new services will be based on calendar year 2012 paid claims. Independent assessments for residents with no calendar year 2012 ACH/PCS claims will be treated as new requests for services. Maintenance of service will not be available in the event of an appeal of an adverse decision on a new request for services. If, due to claims lag, a current ACH/PCS beneficiary's assessment is processed as a new request, providers may contact the CCME Independent Assessment Help Line at 1-800-228-336. Upon Medicaid payment of ACH/PCS claims for dates of service December 31, 2012 or earlier, a new notice of

decision on a continuing request will be issued. In the event of a timely appeal of an adverse decision, maintenance of service at the previous service level will be authorized with an effective date of January 1, 2013.

The determination that a continuing beneficiary's service approval is a service reduction will be based on comparison of the authorized service level effective January 1, 2013 to the beneficiary's service level through December 2012.

Service levels for beneficiaries receiving Enhanced and Special Care Unit-A (SCU-A) ACH/PCS services through December 2012 will be determined by summing the time equivalents for all paid or prior approved codes and the Basic ACH/PCS code. Table 1 provides the daily time equivalents for current ACH/PCS Basic, Enhanced, and Special Care Unit (SCU) billing codes. Table 2 provides the equivalent service hours for a 31-day month for beneficiaries receiving Basic, Enhanced, and Special Care Unit ACH/PCS.

Table 1: Daily Time Equivalents for Current ACH/PCS Billing Codes

ACH/PCS Billing Code	**Billing Code Description**	**Daily Time Equivalent**	**Source of Current Service Level**
W8251, W8258	**Basic ACH/PCS**	1.10 hours	Paid claims
W8256	**Enhanced ACH/PCS** Eating	.98 hours	Paid claims
W8257	**Enhanced ACH/PCS** Toileting	.35 hours	Paid claims
W8259	**Enhanced ACH/PCS** Eating & Toileting	1.33 hours	Paid claims
W8255	**Enhanced ACH/PCS** Ambulation/Locomotion	.20 hours	Paid claims
W8291, W8292	**SCU-A ACH/PCS**	4.07 hours	DMA prior approval

Table 2: ACH/PCS Billing Code Service Hour* Equivalents for 31-Day Month

Billing Code or Billing Code Combination	**Service Level**
W8251 or W8258 (Basic)	35 hours
Basic and W8255	41 hours
Basic and W8257	45 hours
Basic, W8255, and W8257	52 hours
Basic and W8256	65 hours
Basic, W8255, and W8256	71 hours
Basic and W8259	76 hours
Basic, W8255, and W8259	82 hours
Basic and W8291 or W8292	161 hours

*Rounded up to next full hour.

Change of Status Request Process

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

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

Provider Interface

Licensed facility provider registration for the PCS Provider Interface began on November 29, 2012. To register to use the Provider Interface, complete the Provider Registration For PCS Agency Use of QiRePort form and send to The Carolinas Center for Medical Excellence (CCME) via fax at 877-272-1942 or mail: CCME, ATTN: PCS Independent Assessment, 100 Regency Forest Drive, Suite 200, Cary, NC 27518-8598.

When the Provider Interface is available, registered users will receive an e-mail notification from *support@QiRePort.net* that includes the QiRePort website link and your login i.d. and temporary password. To ensure that the registration e-mail is properly delivered to your account inbox, add *support@QiRePort.net* to your e-mail account contacts list.

Beginning in mid-December 2012, licensed facility PCS providers will be able to log into QiRePort and view and download beneficiary assessments for beneficiaries assessed during the transition assessment period – including those authorized for services effective January 1, 2013, those denied transition effective January 1, 2013, and beneficiaries who appeal adverse decisions and are authorized for maintenance of service. Providers not registered to use the Provider Interface may request faxed copies of independent assessments beginning January 2, 2013. Refer to the DMA Consolidated PCS webpage beginning January 2, 2013 for the independent assessment copy request form and instructions.

Policy 3L Plan of Care Requirements for Transitioning Beneficiaries

Pursuant to Clinical Coverage Policy 3L, for each beneficiary transitioning to the new PCS program with an effective date of January 1, 2013, a person-centered plan of care

that addresses all unmet needs identified in the independent assessment must be implemented within 30 days of the effective date of Clinical Coverage Policy 3L.

Enhanced ACH/PCS and Special Care Unit Prior Approval Requests

Effective for date of service beginning January 1, 2013, PCS claims for beneficiaries in all settings must be submitted using the billing code and modifiers indicated in Clinical Coverage Policy 3L. Reimbursement for current ACH/PCS billing codes will no longer be available for dates of service after December 31, 2012. Prior approval requests for Special Care Unit ACH/PCS must be postmarked by no later than December 31, 2012 in order to be processed under current program rules. SCU prior approval requests postmarked after December 31, 2012 will not be processed.

PCS New Referrals Beginning January 1, 2013

Beneficiaries who seek admission, are admitted, or first receive services in licensed homes on January 1, 2013 and after may request new referral assessments through their primary care or attending physicians, nurse practitioners, or physician assistants. A new referral form and additional information about the new referral process will be available on the DMA Consolidated PCS webpage prior to program implementation. **PCS reimbursement will not be available for a beneficiary admitted to a licensed facility on or after January 1, 2013, unless and until the beneficiary has received an independent assessment and Policy 3L qualifying criteria are met.**

Upcoming Provider Trainings

Plans for December 2012 provider trainings will be announced on the DMA Consolidated PCS webpage. For additional information about the new PCS program, refer to the DMA Consolidated PCS webpage and to previous and future Medicaid Bulletins for licensed ACH providers.

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

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

Attention: In-Home Care Providers

Consolidated Personal Care Services Implementation Update

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

Consolidated PCS Policy

Effective January 1, 2013, Medicaid PCS for recipients in all settings – including private residences and licensed adult care homes (ACH), family care homes, 5600a and 5600c supervised living homes, and combination homes with ACH beds – will be provided under a consolidated PCS benefit. Clinical Coverage Policy 3L, Personal Care Services, was posted for a second, 15-day public comment period from November 9 to November 24, 2012. Policy 3L will be posted in final version in December 2012, with a January 1, 2013 effective date. Refer to the Division of Medical Assistance (DMA) Medicaid Clinical Coverage Policy webpage. Additional information will be posted on the DMA Consolidated PCS webpage as it becomes available.

Change in Covered Services

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

Beneficiary Transition Notices

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

Discharge Reporting

To ensure that beneficiaries no longer receiving In-Home Care services from your agency do not receive PCS transition notices authorizing services with your agency, **please report all discharges immediately**. Discharges may be reported via the QiRePort Provider Interface or by calling the CCME Call Center at (800) 228-3365 (option 2). Please refer to the discharge reporting instructions on the CCME website.

PCS New Referrals Beginning January 1, 2013

Beneficiaries seeking PCS services to begin January 1, 2013 and after may request new referral assessments through their primary care or attending physicians, nurse practitioners, or physician assistants. A revised new referral form and other program forms will be posted on the DMA Consolidated PCS webpage and the CCME Independent Assessment website. Current In-Home Care program forms may be used until the revised forms are available.

Upcoming Provider Trainings

Plans for December provider trainings will be announced on the DMA Consolidated PCS webpage. For additional information about the new PCS program, refer to the DMA Consolidated PCS webpage and to previous and future Medicaid Bulletins for licensed Adult Care Home providers.

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

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

Attention: Community Alternative Program for Disabled Adults (CAP/DA) Providers and Lead Agencies (e.g., Departments of Social Services, Departments of Public Health, Area Aging Programs, and Hospitals)

Renewal of the Community Alternative Program for Disabled Adults 1915 (c) HCBS Waiver

In 2008, an application was submitted to the Centers for Medicare & Medicaid Services (CMS) to renew the Community Alternative Program for Disabled Adults (CAP/DA) 1915 (c) Home and Community-Based Services Waiver. The renewal application submitted for approval included updated service procedure names and definitions as well as several new CAP/DA services available to beneficiaries participating in this 1915 (c) HCBS wavier.

In October 2008, CMS granted approval of these expanded CAP/DA benefits (services) and the assurances of the wavier application for five years. Due to IT system incapability of these new CAP/DA services, when claims against these services were submitted by CAP/DA Lead Agencies a denial Explanation of Benefits (EOB) – "service not covered under this benefit package" – was referenced. Systems changes performed by Hewlett-Packard (HP) of the Medicaid Management Information System (MMIS) will now allow reimbursement of these new CAP/DA services.

By February 2013, all Medicaid claims made against these new CAP/DA services will reimburse according to the service definition. For all Medicaid claims that were denied with an EOB – "service not covered under this benefit package" – prior to the date of this bulletin, the CAP/DA Lead Agency can resubmit that denied claim for reimbursement according to the service definition.

The updated service names and definitions consisted of:

1. **Personal Care Services (S5125)** – (*Formerly in-home aide services*): Personal Care Aide is assistance with personal care and basic home management tasks for participants who are unable to perform these tasks independently due to physical or mental disabilities. Personal care is assistance with activities such as eating, bathing, dressing and grooming (Activities of Daily Living). Home management is assistance with tasks such as light housekeeping, laundry, and meal preparation (Instrumental Activities of Daily Living). Personal Care Aide Services can be provided in the community, including the home, workplace, and educational settings. However, provision of a Personal Care Aide in these settings is at the discretion of the Home Care Provider.

2. **Personal Emergency Response Services (PERS) (S5161)** – (*Formerly Telephone Alert*): This service pays for the monthly service charges or monthly rental charges for a system used to alert a central monitoring facility of medical

emergencies that threaten the beneficiary's health, safety, and well-being. This service may also alert the central facility of other situations that threaten the beneficiary's safety.

3. **Home Delivered Meals and Preparation (S5170)** – (*Formerly Preparation and Delivery of Meals*): This service is often referred to as "Meals on Wheels" and provides for the preparation and delivery to the participant's home of one nutritious meal per day.

4. **Adult Day Health (S5102)** – This service provides care for the beneficiary in a certified Adult Day Health Care facility. The program supports the adult's independence and promotes social, physical, and emotional well-being. Services include health services and a variety of program activities designed to meet the individual needs and interests of the beneficiary.

5. **Institutional Respite (H0045)** – Services are provided in a Medicaid-certified nursing facility or a hospital with swing beds. This service may be used to meet a wide variety of needs, including family or caregiver emergencies and planned special occasions when the caregiver needs to be away from town for some extended period of time.

6. **Non-Institutional Respite (S5150)** (*Formerly in-home respite*) – This service is the provision of temporary support to the primary unpaid caregiver(s) of the beneficiary by taking over that person's tasks for a limited period of time. This service may be used to meet a wide variety of needs, such as family emergencies, planned special circumstances (such as vacations, hospitalizations, or business trips), relief from the daily responsibility and stress of caring for an individual with a disability, or the provision of time for the caregiver(s) to complete essential personal tasks.

7. **Waiver Services** – Supplies provided to the waiver beneficiary to promote the health and well-being of the individual. The service is necessary to avoid institutionalization. Such supplies include nutritional supplements taken by mouth when ordered by a physician (B4150BO. B4152BO- B4155 BO, B4157BO-B4162BO; reusable incontinence undergarments **(T4539),** disposable liners **(T4535)** for reusable incontinence undergarments, and incontinence pads for personal undergarments; and medication dispensing boxes **(T2028).**

8. **Personal Assistant Services (Choice Option Only) (S5135)** – Personal Assistant Services are available only for those participants who have elected the Choice Option under the CAP/DA Waiver. The Personal Assistant provides help with personal and home maintenance tasks for beneficiary unable to meet these needs independently due to physical or mental impairments.

9. **Care Advisor (T2041)** – The Care Advisor is available only to participants who elect the Choice Option. Care Advice focuses on empowering consumers to

define and direct their own personal assistance needs and services. Care Advisor guides and supports the participant, rather than directing and managing the participant throughout the service planning and delivery process. The Care Advisor assesses the beneficiary's strengths, needs and ability to direct his/her own care. The Care Advisor assists the participant to develop a plan of care that contains paid services, unpaid services, and supports needed by the participant to live successfully in the home and community.

The new services consisted of:

1. **Home Modification and Mobility Aides (S5165)** – A definition and cost limitation expansion of Home Modification Services. This expansion changed the benefit name to Home Modification and Mobility Aides (S5165). The cost limitation increased from $1,500 to $2,000 per state fiscal year or cannot exceed $10,000 over the lifetime of the waiver years.

2. **Transition Services (T2038)** – This service assists beneficiaries who are not eligible under Money Follows the Person to transition out of an institution. The Transition Services is a one-time procedural process per beneficiary per lifetime of the waiver. The maximum allotment for this service is $2,500. These expenditures are for initial set-up expenses for individuals who make the transition from an institution to their own home or apartment in the community.

3. **Training and Education Services (S5111)** – The purpose of this training is to enhance the decision-making ability of the participant, enhance the ability of the individual to independently care for themselves, or enhance the ability of the family member or personal assistant in caring for the participant. Training and education may also include information and techniques for the use of specialized equipment and supplies. This service is for the individual, a family member who is the primary caregiver, or under the Choice Option, the personal assistant. The maximum state fiscal limitation per beneficiary is $500.

4. **Assistive Technology Services (T2029)** – This service allows beneficiaries access to items, product systems, supplies, and equipment necessary to the proper functioning of items and systems (whether acquired commercially, modified, or customized) that are used for the purposes of improving or maximizing the functional capabilities of the participant, improve the accessibility and use of the participant's environment, or address the 24/7 participant coverage. This service may be used for (but is not limited to) adaptive or therapeutic equipment designed to enable participants to increase, maintain, or improve functional capacity in performing daily life tasks that would not be possible otherwise; specialized monitoring systems; and specialized accessibility/safety adaptations or additions. This service includes technical assistance in device selection and training in device use by a qualified assistive technology professional, assessment and evaluation, purchases, shipping costs, and as necessary, the repair of such devices. The maximum limitation is $3,000 over the lifetime of the waiver (5 years). The

procedural code for Assistive Technology can be billed by the CAP/DA Lead Agency, a Home Health Provider, a Rehabilitation Facility or North Carolina Assistive Technology Program.

5. **Participant Goods and Services (T2025)** – Formerly Consumer-Directed Goods and Services. This service allows the planning of services, equipment or supplies not otherwise provided through the waiver or through Medicaid State Plan that will allow beneficiaries more functional independence in their homes. The cost limitation increased from $600 to $800 per state fiscal year. A service, equipment or supply that exceeds $200 must be approved by the Division of Medical Assistance.

For questions or guidance in providing or filing a claim for these CAP/DA waiver services, contact your assigned CAP/DA consultant directly.

Clinical Coverage Policy - Home and Community Care
DMA, 919-855-4371

Attention: All Dental Providers and Health Department Dental Centers

Dental Providers Must Be Enrolled in N.C. Medicaid Program in Order to Participate

In accordance with federal and state rules, regulations, and policies, all dental providers must be enrolled with Medicaid and must sign a Provider Administrative Participation Agreement to be allowed to participate in the N.C. Medicaid Program. This includes providers working in a group practice, local health department, federally qualified health center, or rural health center.

Dental providers shall not submit a claim for reimbursement if they are not enrolled in the program. Dental providers shall not use another provider's National Provider Identifier (NPI) to bill for dental services. The claim must accurately reflect the NPI of the rendering dentist. No substitutions are allowed.

Any dental provider not currently enrolled in the N.C. Medicaid program who wants to provide care to Medicaid or North Carolina Health Choice (NCHC) recipients must complete the online enrollment application which is available on the NCTracks website located at www.nctracks.nc.gov/provider/providerEnrollment/index.jsp.

CSC, the N.C. Division of Medical Assistance's Enrollment, Verification, and Credentialing vendor, is available to assist providers who want to enroll in N.C. Medicaid. CSC contact information is provided below.

Enrollment, Verification, and Credentialing (EVC) Call Center Contact Information

Contact Name	Contact Information
EVC Call Center Toll-Free Number	**866-844-1113**
EVC Call Center Fax Number	**866-844-1382**
EVC Call Center E-Mail Address	NCMedicaid@csc.com
CSC Website Address	www.nctracks.nc.gov

For billing or claims questions, contact the HP Enterprise Services (HPES) Help Desk. Representatives are available Monday through Friday, 8 a.m. – 4:30 p.m., at 919-851-8888 or 1-800-688-6696.

Dental Program
DMA, 919-855-4280

Attention: Durable Medical Equipment Providers

NC Health Choice (NCHC) Durable Medical Equipment Requests Through Provider Link

Effective December 1, 2012, providers may use Provider Link to submit Durable Medical Equipment requests for N.C. Health Choice (NCHC) beneficiaries.

Providers with questions will need to contact Covisint at 1-866-373-0878.

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

Attention: Durable Medical Equipment Providers

Place of Service for Durable Medical Equipment

As previously outlined in the January 2004 and December 2005 N.C. Medicaid Bulletins, Durable Medical Equipment (DME) providers are reminded that they may only bill for DME and related supplies when the recipient resides in a:

- Private Residence
- Adult Care Home
- Family Care Home
- Level I-IV Behavioral Health Group Home
- Homeless Shelter
- Custodial Care Facility
- Hospice

Procedure codes are billed in the appropriate place of service as defined by American Medical Association (AMA) and/or the Centers for Medicare & Medicaid Services (CMS). Refer to Clinical Coverage Policies #5A, Durable Medical Equipment for detailed coverage and billing information.

Program Integrity (PI) has identified instances of DME providers designating the place of service in block 24B on the CMS-1500 claim form outside of a private residence, an Adult Care Home, Family Care Home or Level I-IV Behavioral Health Group home, Homeless Shelter, Custodial Care Facility, or Hospice. Any payments to DME providers for supplies and equipment with place of service other than those listed above may be considered improper and subject to recoupment. This may include Medicare cross-over claims that were automatically submitted to DMA by the Medicare claim processor.

Additionally, PI has identified instances where other types of facilities are paid a per diem for a recipient stay that overlaps the dates of service on a DME provider claim. A per diem payment to a facility is inclusive of DME supplies and equipment. Refer to Adult Medicaid Manual MA-2905- Medicaid Covered Services for detailed coverage information. Any payments to DME providers for supplies and equipment with dates of service that overlap with the per diem payments may be considered duplicate payments and are subject to recoupment. This recoupment action would not preclude the DME provider from billing a facility – other than an adult care home – directly for those equipment and supplies.

Program Integrity
DMA, 919-814-0000

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

Implanon/Nexplanon and Other Family Planning Denials

Since the transition of claims processing to HPES on October 1, 2011, N.C. Health Choice (NCHC) providers have experienced difficulty getting paid for services which in Medicaid claim details are billed with the FP modifier. Claims for NCHC beneficiaries cannot be processed for payment with this modifier.

DMA has resolved all of these issues except for claims billed for Implanon or Nexplanon (J7307 – Etonogestrel (contraceptive) implant system, including implant and supplies.) Nexplanon is a newer product and is comparable to Implanon.

Providers who received a denial with EOB 1609 – "Claim includes family planning diagnosis (es) and no family planning procedure. Please resubmit with a family planning procedure/modifier or correct the diagnosis" – should resubmit the claim electronically (not as an adjustment) to HPES.

Claims for Implanon/Nexplanon that have denied with EOB 9143 – "Procedure must be filed with FP modifier" – will be processed manually by DMA staff.

NCHC providers should complete an adjustment request form and include the paper claim and Remittance Advice (RA) for each denied claim and send it to:

Division of Medical Assistance
Attention: Implanon Claims
2501 Mail Service Center
Raleigh, N.C. 27699

Providers needing further assistance may contact HPES Provider Services Call Center at 1-800-688-6696, Monday – Friday, from 8:00 a.m. to 4:30 p.m.

N.C. Health Choice (NCHC)
DMA, 1-800-688-6696

Attention: Pharmacists and Prescribers

Benzodiazepines and Barbiturates are No Longer Covered for Dual Eligible Beneficiaries

The Medicare Improvement for Patients and Providers Act (MIPPA) Section 175 requires Medicare Part D prescription drug plans to cover **benzodiazepines** for any condition and **barbiturates** used for seizures, cancer, or chronic mental health conditions. Because Medicare will begin coverage for these drugs effective January 1, 2013, N.C. Medicaid will no longer provide coverage for these medications for dual eligibles except for barbiturates when used for conditions not listed above.

Pharmacies should submit these claims to the beneficiary's Medicare Part D prescription drug plan beginning on January 1, 2013. Providers must follow the manual claims submission process to submit barbiturate drug claims to Medicaid for diagnoses not listed.

Outpatient Pharmacy
DMA, 919-855-4300

Attention: Pharmacists and Prescribers

Prescribers not Enrolled in Medicaid

The Affordable Care Act established a new rule that prohibits Medicaid programs from paying for prescriptions written by prescribers who are not enrolled in the Medicaid program. On January 1, 2013, pharmacy providers will begin to receive a message at point-of-sale for prescriptions written by prescribers not enrolled in the Medicaid program. This message will notify pharmacy providers that pharmacy claims written by non-enrolled prescribers will begin denying on April 1, 2013.

Outpatient Pharmacy
DMA, 919-855-4300

Attention: Private Duty Nursing Providers

Clinical Coverage Policy 3G, Private Duty Nursing – Update

Medicaid Clinical Coverage Policy 3G, Private Duty Nursing, has been posted and is effective as of December 1, 2012. Significant changes to the program include the following:

Eligibility for Private Duty Nursing (PDN) Services

Clinical eligibility for the program has changed as per Section 3.3 of the policy. To be eligible for PDN services, the beneficiary must:

a. be dependent on a ventilator for at least eight hours per day, or
b. meet at least four of the following criteria:

1. be unable to wean from a tracheostomy
2. require nebulizer treatments at least two scheduled times per day and one as needed time per day
3. require pulse oximetry readings every nursing shift
4. require skilled nursing or respiratory assessments every shift due to respiratory insufficiency
5. need oxygen pro re nata (PRN) or rate adjustments PRN at least two times per week
6. require tracheostomy care at least daily
7. require tracheostomy suctioning PRN. Suctioning is defined as endotracheal suctioning requiring a suction machine and a flexible catheter
8. be at risk for requiring ventilator support

Eligibility for Expanded PDN Services

Beneficiaries who meet the criteria for standard nursing services plus at least one of the criteria below may be eligible for expanded PDN services:

a. uses a respiratory pacer
b. has dementia or other cognitive deficits but needs increased support and safety assistance due to physical functional status
c. requires infusions, such as through an intravenous, PICC, or central line
d. has seizure activity requiring PRN use of Diastat, oxygen, or other interventions that require assessment and intervention by a licensed nurse
e. has a primary caregiver who is 80 or more years of age or who has disability confirmed by the Social Security Administration that interferes with caregiving ability
f. Received a determination by Child Protective Services or Adult Protective Services that additional hours of PDN would help ensure the recipient's health, safety, and welfare

Determining the Amount of PDN Services Allowed

Expanded PDN services in most cases allow an additional 14 hours per week – as long as that new total does not exceed the program maximum limit of 112 hours per week.

a. Approval will be granted as hours/units per week, rather than as hours/units per day.
b. The number of hours/units approved is based upon care needs and caregiver availability as per Subsection 5.3.7 of the policy:

Informal Caregiver Availability	Standard PDN Services (Refer to Subsection 3.3.1)	Expanded PDN Services (Refer to Subsection 3.3.2)
Two or more fully available caregivers	56 hours per week	70 hours per week
One fully available caregiver, with or without the presence of any other caregivers	76 hours per week	90 hours per week
Two or more partially available caregivers	56 hours per week plus time absent for work, up to maximum of 96 hours per week	70 hours per week plus time absent for work, up to maximum of 110 hours per week
One partially available caregiver	76 hours per week plus time absent for work, up to maximum of 112 hours per week	90 hours per week plus time absent for work, up to maximum of 112 hours per week

Notes:

A fully available caregiver is one who lives with the beneficiary, is not employed, and who is physically and cognitively able to provide care.

A partially available caregiver is one who lives with the beneficiary and has verified employment or who has been determined by the Social Security Administration to be unable to work due to disability that interferes with the ability of that person to provide care to the PDN beneficiary.

Approved hours for other formal support programs (including Community Alternatives Program for Individuals with Intellectual/Developmental Disabilities) apply toward the maximum limit.

Hours are approved on a per-week basis beginning 12:01 a.m. Sunday and ending at 11:59 p.m. Saturday. Beneficiaries may use the hours as they choose. For example, a beneficiary approved for 70 hours per week may use ten hours per day

seven days per week, or may use 14 hours per day five days per week. It is the responsibility of the beneficiary and caregiver to schedule time to ensure the health and safety of the beneficiary. Additional hours cannot be approved because the family planned poorly and "ran out" before the end of the week.

The maximum number of hours per week any beneficiary can be approved for is 112.

Unused hours of services **cannot** be "banked" for future use or "rolled over" to another week.

Beneficiaries Previously Approved for Expanded Services

a. Individuals who are PDN beneficiaries on December 1, 2012, and who are receiving **greater than 112 hours per week**, may continue to receive those hours until such time as either their need for nursing interventions decreases, the availability of informal supports increases, or they are disenrolled from the program including for a hospitalization exceeding 30 days.

b. Individuals who are PDN beneficiaries on the date this policy takes effect and who are receiving 1**12 hours per week or less** but whose current hours exceed the above parameters or who do not meet the clinical coverage criteria, have until December 1, 2013 to decrease their hours to meet the new limits or find other resources.

Provider Qualifications

a. All beneficiaries must have at least one trained informal support person to provide direct care during the planned and unplanned absences of the PDN nurse.

b. PDN provider agencies must be accredited by Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), Community Health Accreditation Program (CHAP), or Accreditation Commission for Health Care (ACHC), within 18 months of the effective date of this policy.

c. An RN or LPN providing direct care to a PDN beneficiary must have at least one year of experience within the last five years in caring for medically fragile patients in an acute care or home care setting. A supervising RN must have at least two years of the same experience.

The entire policy is available at www.ncdhhs.gov/dma/mp/index.htm. Review it carefully.

Clinical Policy, Home Care Initiatives Unit
DMA, 919-855-4380

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

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

Proposed Clinical Coverage Policies

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

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

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

2012-2013 Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
December	11/29/12	12/04/12	12/05/12
	12/06/12	12/11/12	12/12/12
	12/13/12	12/20/12	12/21/12
Jan. 2013	01/03/13	01/08/13	01/09/13
	01/10/13	01/15/13	01/16/13
	01/17/13	01/23/13	01/24/13
	01/24/13	01/31/13	02/01/13

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

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

Melissa Robinson
Executive Director
HP Enterprise Services