



June 2010 Medicaid Bulletin

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

Attention: All Providers**Reporting Fraud, Waste, and Program Abuse**

DMA's Program Integrity (PI) Section is devoted to ensuring compliance, efficiency, and accountability within the N.C. Medicaid Program by detecting and preventing fraud, waste and program abuse, thus ensuring that Medicaid dollars are paid appropriately. You are encouraged to report matters involving Medicaid fraud and abuse. If you want to report fraud or abuse, you can remain anonymous; however, sometimes in order to conduct an effective investigation, staff may need to contact you. Your name will not be shared with anyone investigated. (In rare cases involving legal proceedings, we may have to reveal who you are.)

To report suspected Medicaid fraud, waste or program abuse by a medical provider

- contact DMA by calling the CARE-LINE Information and Referral Service at 1-800-662-7030 (English or Spanish) and ask for the DMA Program Integrity Section; or
- call DMA's Program Integrity Section directly at 1-877-DMA-TIP1 (1-877-362-8471); or
- call the State Auditor's Waste Line at 1-800-730-TIPS (1-800-730-8477); or
- call the Health Care Financing Administration Office of Inspector General's Fraud Line at 1-800-HHS-TIPS (1-800-447-8477); or
- complete and submit a Medicaid fraud and abuse confidential online complaint form on DMA's website at <http://www.ncdhhs.gov/dma/fraud/reportfraudform.htm>.

Examples of Medicaid Fraud and Abuse by Medical Providers (list is not all-inclusive)

- Medicaid recipient failed to report other insurance when applying for Medicaid
- non-recipient uses a recipient's Medicaid card with or without recipient's knowledge
- provider's credentials/qualifications are not accurate
- provider bills for services that were not rendered
- provider performs and bills for services not medically necessary
- provider alters claim forms and recipient records

Program Integrity
DMA, 919-647-8000

Attention: All Providers**NC Tracks Website Maintenance**

The NC Tracks Website (<http://www.nctracks.nc.gov/>) will be unavailable from 6:00 p.m. on June 4, 2010, through 8:00 a.m. on June 7, 2010, to allow for system maintenance.

CSC
1-866-844-1113

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

The list of standard national codes used on the Electronic Remittance Advice (ERA) has been cross-walked to EOB codes as an informational aid to adjudicated claims listed on the Remittance and Status Report (RA). Effective July 1, 2010, the format of the crosswalk will be changed to allow for codes to be filtered and sorted in a more efficient manner when multiple codes map to the same EOB. In addition, the crosswalk will be divided into separate crosswalks based on claims types – Institutional, Professional, Dental, and Pharmacy. This will eliminate some of the one-to-many mappings.

HP Enterprise Services**1-800-688-6696 or 919-851-8888****Attention: All Providers****Provider Information Regarding Changes in N.C. Health Choice Administration**

Effective July 1, 2010, the administration of the N.C. Health Choice (NCHC) program will move from the State Employees Health Plan to DMA. This change will not directly impact providers or recipients of NCHC. Blue Cross Blue Shield of North Carolina will continue to process claims for NCHC.

Effective July 1, 2010, the NCHC medical policies currently located on the State Employees Health Plan website will be moved to DMA's website at <http://www.ncdhhs.gov/dma/hcmp/>.

Medco will continue as the pharmacy benefit manager for NCHC. However, Medco will have a new customer service number for NCHC. That number is 1-800-466-4115. Until July 1, 2010, providers and recipients should continue using the existing customer service number, 1-800-336-5933. There will also be a new Rx group number that pharmacists should use beginning July 1. That number is NCDHHS1. It will be on the new NCHC ID cards issued on and after July 1, 2010.

Provider Information Regarding Changes in N.C. Health Choice Benefits

Effective July 1, 2010, NCHC will cover certain over-the-counter (OTC) medications if prescribed by a doctor. The covered OTC medications follow Medicaid's policy for OTC medications.

NCHC families are receiving notices informing them of these upcoming changes. New NCHC ID cards may not arrive to families until sometime in July so these notices also serve to remind families of their new copayments, the new Medco customer service number, and the Rx group number as well as the addition of the OTC medications benefit.

Cinnamon Narron**N.C. Health Choice, 919-855-4149**

Attention: All Providers**P**rovider Information Regarding Changes in N.C. Health Choice
Copayments

Effective with date of service July 1, 2010, copayment changes are being made to the benefits for N.C. Health Choice (NCHC). Based on a child's current NCHC ID card, the following copayment changes apply.

- If all copayment amounts on the NCHC ID card are \$0, they are still \$0; there are no changes.
- If the emergency room (ER) copayment on the NCHC ID card is \$0 but there are other copayment amounts, the following changes apply:
 - ◆ ER copayment is changing from \$0 to \$10
 - ◆ Generic drug copayment is changing from \$1 to \$2
 - ◆ Brand drug copayment with no generic available is changing from \$1 to \$2
 - ◆ Brand Drug copayment with a generic available is changing from \$3 to \$5
- If the ER copayment on the NCHC ID card is \$20, the following changes apply:
 - ◆ ER copayment is changing from \$20 to \$25
 - ◆ Generic drug copayment is changing from \$1 to \$2
 - ◆ Brand drug copayment with no generic available is changing from \$1 to \$2
 - ◆ Brand drug copayment with a generic available will stay the same at \$10

These changes in copayments are effective for all non-emergency ER visits and for prescriptions filled starting on July 1, 2010.

Cinnamon Narron
N.C. Health Choice, 919-855-4149

Attention: All Providers**C**linical Coverage Policies

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

- 1L-1, *Anesthesia Services*
- 10B, *Independent Practitioners*
- 10D, *Independent Practitioners Respiratory Therapy Services*

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

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers**Medicaid Integrity Contractors Audit**

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

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

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

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

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

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

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

MIC Audit Process

1. **Identification of potential audits through data analysis.** The MIG and the Review MICs examine all paid Medicaid claims using the Medicaid Statistical Information System. Using advanced data mining techniques, MIG identifies potential areas that are at risk for overpayments that require additional review by the Review MICs. The Review MICs, in turn, identify specific potential provider audits for the Audit MICs on which to focus their efforts. This data-driven approach to identifying potential overpayments helps ensure that efforts are focused on providers with truly aberrant billing practices.
2. **Vetting potential audits with the state and law enforcement.** Prior to providing an Audit MIC with an audit assignment, CMS vets the providers identified for audit with state Medicaid agencies, state and federal law enforcement agencies, and Medicare contractors. Vetting is the process whereby CMS provides a list of potential audits generated by the data analysis mentioned above. If any of these agencies are conducting audits or investigations of the same provider for similar billing issues, CMS may elect to cancel or postpone the MIC audit to avoid duplicating efforts.

3. **Audit MIC receives audit assignment.** CMS forwards the list of providers to be reviewed to the Audit MIC after the vetting process is completed. The Audit MIC immediately begins the audit process. CMS policy is that the audit period, also known as the “look back” period, should mirror that of the state that paid the provider’s claims.
4. **Audit MIC contacts provider and schedules entrance conference.** The Audit MIC mails a notification letter to the provider. The notification letter
 - identifies a point of contact within the Audit MIC;
 - gives at least two-weeks’ notice before the audit is to begin;
 - includes a records request outlining the specific records that the Audit MIC will be auditing; and
 - asks the provider to send the records to the Audit MIC for a desk audit. For a field audit, the provider must have the records available in time for the Audit MIC’s arrival at the provider’s office.

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

5. **Audit MIC performs audit.** Most of the audits conducted by the Audit MIC are desk audits; however, the Audit MIC also conducts field audits in which the auditors conduct the audit on-site at the provider’s location. Providers are given specific timelines in which to produce records. Because some audits will be larger in scope than others, provider requests for time extensions are seriously considered on a case-by-case basis. The audits are being conducted according to Generally Accepted Government Auditing Standards (<http://www.gao.gov/govaud/ybk01.htm>).
6. **Exit conference held and draft audit report is prepared.** At the conclusion of the audit, the Audit MIC will coordinate with the provider to schedule an exit conference. The preliminary audit findings are reviewed at this meeting. The provider has an opportunity to comment on the preliminary audit findings and to provide additional information if necessary. If the Audit MIC concludes, based on the evidence, that there is a potential overpayment, the Audit MIC prepares a draft report.
7. **Review of draft audit report.** The draft audit report is shared with CMS for approval and is provided to the state for review and comments. The report is then given to the provider for review and comment. The draft report may be subject to revision based on additional information and shared again with the state.
8. **Draft audit report is finalized.** Upon completion of this review process, the findings may be adjusted, either up or down, as appropriate based on the information provided by the provider and the state. The state’s comments and concerns will also be given full consideration. CMS has the final responsibility for determining the final amount of any identified overpayment in any audit. At this point, the audit report is finalized.
9. **CMS issues final audit report to the state, triggering the “60-day” rule.** CMS sends the final audit report to the state. Pursuant to 42 CFR 433.316 (a) and (e), this action serves as CMS’ official notice to the state of the discovery and identification of an overpayment. Under federal law, 42 CFR 433.12 (2), the state must repay the federal share of the overpayment to CMS within 60 calendar days, regardless of whether the state recovers or seeks to recover the overpayment from the provider.
10. **The state issues final audit report to provider and begins overpayment recovery process.** The state is responsible for issuing the final audit report to the provider. Each state must follow its respective administrative process in this endeavor. At this point, the provider may exercise whatever appeal or adjudication rights are available under state law when the state seeks to collect the overpayment amount identified in the final audit report.

Ten providers have completed MIC audits in North Carolina. To date, no errors have been reported.

Program Integrity
DMA, 919-647-8000

Attention: All Providers**Medicaid Credit Balance Reporting**

All providers participating in the Medicaid Program are required to submit a quarterly **Credit Balance Report** to the DMA Third-Party Recovery Section identifying balances due to Medicaid. Providers must report any **outstanding** credits owed to Medicaid that have not been reported previously on a Medicaid Credit Balance Report. However, hospital and nursing facility providers are required to submit a report every calendar quarter even if there are no credit balances. The report must be submitted no later than 30 days following the end of the calendar quarter (March 31, June 30, September 30, and December 31).

The Medicaid Credit Balance Report is used to monitor and recover “credit balances” owed to the Medicaid Program. A credit balance results from an improper or excess payment made to a provider. For example, refunds must be made to Medicaid if a provider is paid twice for the same service (e.g., by Medicaid and a medical insurance policy, by Medicare and Medicaid, by Medicaid and a liability insurance policy) or if the patient liability was not reported in the billing process or if computer or billing errors occur.

For the purpose of completing the report, a Medicaid Credit Balance is the amount determined to be refundable to the Medicaid Program. When a provider receives an improper or excess payment for a claim, it is reflected in the provider's accounting records (patient accounts receivable) as a “credit.” However, credit balances include money due to Medicaid regardless of its classification in a provider's accounting records. If a provider maintains a credit balance account for a stipulated period (e.g., 90 days) and then transfers the account or writes it off to a holding account, this does not relieve the provider of liability to the Medicaid Program. The provider is responsible for identifying and repaying all monies owed the Medicaid Program.

The Medicaid Credit Balance Report requires specific information for each credit balance on a claim-by-claim basis. The reporting form provides space for 15 claims but may be reproduced as many times as necessary to accommodate all the credit balances being reported. Specific instructions for completing the report are on the reverse side of the reporting form.

Submitting the Medicaid Credit Balance Report does not result in the credit balances automatically being reimbursed to the Medicaid Program. **Electronic adjustments are the preferred method of satisfying the credit balances and can be performed through the North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool. Refer to the February 2010 Medicaid Bulletin article, titled *Adjusting North Carolina Medicaid Claims Electronically*, on DMA’s website at <http://www.ncdhhs.gov/dma/bulletin/> for specific filing instructions.**

In the event, a billing error caused an individual provider to be paid for a service in which a provider group should have been paid, a refund check will need to be sent to HP Enterprise Services to correct the error as it is unlikely the individual provider will have future claims to adjust. In these circumstances only, a check must be made payable to HP Enterprise Services and sent to HP Enterprise Services using the **Medicaid Provider Refund Form** (<http://www.ncdhhs.gov/dma/provider/forms.htm>). The information on the form must be complete and accurate in order to process the provider refund check.

Submit the Medicaid Credit Balance Report Form to:	Electronic Adjustments using the North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool	Submit Refund Checks to:
Third Party Recovery Section Division of Medical Assistance 2508 Mail Service Center Raleigh NC 27699-2508	Refer to the February 2010 Medicaid Bulletin article titled, <i>Adjusting North Carolina Medicaid Claims Electronically</i>, (http://www.ncdhhs.gov/dma/bulletin/)	HP Enterprise Services Refunds P.O. Box 30968 Raleigh NC 27622 (Do not send these refund checks to DMA or to the Controller’s Office.)

Submit **only** the completed Medicaid Credit Balance Report to DMA. **Failure to submit a Medicaid Credit Balance Report to DMA will result in the withholding of Medicaid payment until the report is received.**

Send to DMA:

- The **original** completed Medicaid Credit Balance Report.
- Please circle “Adjustment” at bottom of original credit balance report to indicate an electronic adjustment has been performed. (**Note:** You may circle “Refund” in the event a check must be sent due to the reason stated above).

Send to HP Enterprise Services Refunds Department:

- Always send **live credit balance refund check(s)** to the HP Enterprise Services refunds address listed in this bulletin.
- Enclose a copy of the Medicaid Credit Balance Report associated with the refund.
- Please circle “Refund” at the bottom of the copy of the Medicaid Credit Balance Report.
- Include a completed **Medicaid Provider Refund Request Form** to ensure that HP Enterprise Services can appropriately document individual refund amounts.

A copy of the Medicaid Credit Balance Report form follows this article. The Medicaid Provider Refund Form and the Medicaid Credit Balance Report form are also available on DMA’s website at <http://www.ncdhhs.gov/dma/provider/forms.htm>.

**Debbie Odette, Third Party Recovery Section
DMA, 919-647-8100**

Instructions for Completing Medicaid Credit Balance Report

Complete the "Medicaid Credit Balance Report" as follows:

- Full name of facility as it appears on the Medicaid Records
- The facility's Medicaid provider number. If the facility has more than one provider number, use a separate sheet for each number. DO NOT MIX
- Circle the date quarter end
- Enter year
- The name and telephone number of the person completing the report. This is needed in the event DMA has any questions regarding some item in the report

Complete the date fields for each Medicaid balance by providing the following information:

Column 1 – The last name and first name of the Medicaid recipient (e.g., Doe, Jane)

Column 2 – The individual Medicaid identification (MID) number

Column 3 – The month, day, and year of beginning service (e.g., 12/05/03)

Column 4 – The month, day, and year of ending service (e.g., 12/10/03)

Column 5 – The R/A date of Medicaid payment (not your posting date)

Column 6 – The Medicaid ICN (claim) number

Column 7 – The amount of the credit balance (not the amount your facility billed or the amount Medicaid paid)

Column 8 – The reason for the credit balance by entering: "81" if it is a result of a Medicare payment; "83" if it is the result of a health insurance payment; "84" if it is the result of a casualty insurance/attorney payment or "00" if it is for another reason. Please explain "00" credit balances on the back of the form.

After this report is completed, total column 7 and mail to **Third Party Recovery, DMA, 2508 Mail Service Center, Raleigh, NC 27699-2508.**

MEDICAID CREDIT BALANCE REPORT

PROVIDER NAME: _____ CONTACT PERSON: _____
 PROVIDER NUMBER: _____ TELEPHONE NUMBER: _____
 QUARTER ENDING: (Circle one) 3/31 6/30 9/30 12/31 YEAR: _____

(1) RECIPIENT'S NAME	(2) MEDICAID NUMBER	(3) FROM DATE OF SERVICE	(4) TO DATE OF SERVICE	(5) DATE MEDICAID PAID	(6) MEDICAID ICN	(7) AMOUNT OF CREDIT BALANCE	(8) REASON FOR CREDIT BALANCE
----------------------------	---------------------------	-----------------------------------	------------------------------	---------------------------------	------------------------	---------------------------------------	--

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.
- 11.
- 12.
- 13.
- 14.
- 15.

Circle one: Refund Adjustment Third Party Recovery

Return form to: DMA
 2508 Mail Service Center
 Raleigh, NC 27699-2508

Revised 10/07

Attention: All Providers

PDF Format Remittance and Status Reports Changes

Effective with the June 8, 2010, checkwrite, the N. C. Medicaid Program will implement an expansion of the N.C. Electronic Claims Submission/Recipient Eligibility Verification (NCECS) Web Tool to allow providers to download a PDF version of their paper Remittance and Status Report (RA). There will be a transition period for the month of June where the paper RA will continue to be printed and mailed to providers. Beginning with the July 7, 2010, checkwrite, RAs will only be available through the NCECS Web Tool. As a part of this effort, minor changes were made to the layout of the RA as described below.

Duplicated or Unused Fields Removed From the Paid/Denied Claims Sections

- Original Paid Amount
- Original Detail Count
- Total Financial Payers
- Legislative Limits Percentage

New Fields Added to the Paid/Denied Claims Section

- Claim Adjustment Reason Code (CARC)
- Reason Remark Code (RRC)
- Adjustment Amount

The added fields will be reported at either the header or the detail of the claim depending on where the adjustment occurred. If reported at the header, these fields replace where the Original Paid Amount, Original Detail Count, and Total Financial Payers were previously reported. If reported at the detail, these new fields will be below the detail procedure information. Please refer to the following examples of the RA changes for the PDF format.



**NORTH CAROLINA MEDICAID
REMITTANCE AND STATUS REPORT**

Dr. Feelgood and Associates
P.O. Box 1234
Any City, NC 27123-4567

NPI: 1234567890
Provider Number: 9953XXX

DATE: 08/11/2009

PAGE: 2

NAME RECIPIENT ID	SERVICE DATES FROM TO	DAYS/ UNITS	PROCEDURE/ACCOMMODATION/ DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOW	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDCHG	PAID AMOUNT	EXP CODES
PAID CLAIMS											
MEDICAL											
<p>RECIPIENT JANE CD=92 RCC= CLAIM NUMBER= 102008042444666NCXIX EST AMT DUE = 123456789K PAT ACCT= XYZ123 MED REC = ATTN PROV= 8900000 CA-1 02072009 02072009 1 99213 OV ESTAB PT MODERATE PHY 65.00 9.06 55.94 .00 55.94 .00 55.94 98</p> <p>DED = .00 FT LIS = .00 CO PAY = .00 TPL = 0.00 DIFF = 65.00 9.06 55.94 .00 55.94 .00 55.94 ORIGINAL BILLED AMOUNT = 65.00 ORIGINAL DETAIL COUNT = 1 TOTAL FINANCIAL PAYERS = 1</p>											
1	CLAIMS		1 MEDICAL	*****	65.00	9.06	55.94	.00	55.94	.00	55.94

98 - FEE ADJUSTED TO MAXIMUM PAYABLE

Replaced these fields with CARC=xxx RRC=xxxxx Adjustment Amount=1234567.99



NORTH CAROLINA MEDICAID
REMITTANCE AND STATUS REPORT

Dr. Feelgood and Associates
P.O. Box 1234
Any City, NC 27123-4567

NPI 1234567890
Provider Number: 8953XXXX

DATE 08/11/2009

PAGE: 3

NAME RECIPIENT ID	SERVICE DATE FROM TO	DAYS/ UNITS	PROCEDURE/ACCOMMODATION/ DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOW	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCT	PAID AMOUNT	EXP CODES
DENIED CLAIMS											
MEDICAL											
<p>RECIPIENT JANE CO=92 RCC= CLAIM NUMBER= 102008042444666NCIX EST AMT DUE = 123456789K PAT ACCT= XYZ123 MED REC = ATTN PR01= 8900000 CA1 02072009 02072009 1 99213 OV ESTAB PT MODERATE PHY 65.00 65.00 00 00 00 00 00 00 00 11</p> <p>DEDUCT = .00 PT LI3 = 00 CO PAY = .00 TPL = .00 DIFF = 65.00 65.00 00 00 00 00 00 ORIGINAL BILLED AMOUNT = 65.00 ORIGINAL DETAIL COUNT = 1 TOTAL FINANCIAL PAYERS = 1</p>											
1	CLAIMS		1 MEDICAL	*****	65.00		00		00	00	0

11 - RECIPIENT NOT ELIGIBLE ON SERVICE DATE

Added fields below the detail CARC=xxx RRC=xxxx Adjustment Amount=1234567.99

As a reminder, all providers who want to access and download a PDF version of their RA are required to register for this service regardless of whether they already have an NCECSWeb logon ID. The RA can only be associated with one logon ID. The Remittance and Status Reports in PDF Format Request form and instructions can be found on DMA's Provider Forms web page at <http://www.ncdhhs.gov/dma/provider/forms.htm>. Providers are encouraged to complete the form immediately and return it to the HP Enterprise Services Electronic Commerce Services Unit to ensure adequate time for set up.

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

Attention: All Providers

N.C. Mental Health, Developmental Disabilities, and Substance Abuse Services Health Plan Waiver (Formerly, Piedmont Cardinal Health Plan)

Effective July 1, 2010, additional services will be added to the N.C. Mental Health, Developmental Disabilities and Substance Abuse Services (MH/DD/SAS) Health Plan Waiver. The MH/DD/SAS Health Plan currently operates in Cabarrus, Davidson, Rowan, Stanly, and Union counties and is administered by the area Local Management Entity, Piedmont Behavioral Healthcare (PBH). Except for emergency services, all MH/DD/SAS providers must obtain prior authorization from PBH to qualify for reimbursement of services provided to Medicaid recipients who, for Medicaid purposes, are residents of the PBH five-county catchment area.

The services listed in the table below will be included in the MH/DD/SAS Health Plan beginning with dates of service July 1, 2010, when

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

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

Narcosynthesis for Psychiatric Diagnostic and Therapeutic Purposes

90865

Evaluation of Implanted Neurostimulator

95970	95971	95972	95973
95974	95975	95978	95979

Standardized Cognitive Performance Testing

96125

Biopsychosocial Assessment/Intervention

96150	96151	96152
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Outpatient and Other Visits

99201	99202	99203	99204	99205
99211	99212	99213	99214	99215

Facility Observation Visits: Initial and Discharge

99217	99218	99219	99220
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Inpatient Hospital Visits: Initial and Subsequent

99223	99231	99232	99233
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Observation/Inpatient Visits: Admitted/Discharged

99234	99235	99236
-------	-------	-------

Inpatient Hospital Discharge Services

99238	99239
-------	-------

Consultations

99241	99242	99243	99244	99245
99251	99252	99253	99254	99255

Emergency Department Visits

99281	99282	99283	99284	99285
-------	-------	-------	-------	-------

Nursing Facility Visits

99304	99305	99306	99307	99308
99309	99310	99315	99316	99318

Domiciliary Care, Rest Home, Assisted Living Visits

99321	99325	99326	99327	99328
99334	99335	99336	99337	

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

99339	99340
-------	-------

Home Visits

99341	99342	99343	99344	99345
99347	99348	99349	99350	

Prolonged Services Outside Customary Services

99354	99355	99356	99357	99358	99359
-------	-------	-------	-------	-------	-------

Alcohol and/or Substance Abuse Structured Screening

99408

Injections: Diagnostic/Preventive/Therapeutic

96372	96373	96374	96375	96379
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Telehealth Originating Site Facility Fee

Q3014

All services provided in emergency rooms to Medicaid recipients residing in the PBH catchment area with a primary diagnosis in the 290 through 319 range will be included in the MH/DD/SAS Health Plan beginning with dates of service July 1, 2010. Providers of emergency room services must contact PBH for reimbursement. These services are currently billed under the following revenue codes:

Emergency Room

RC450	RC451	RC452	RC456	RC459
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**Behavioral Health and Waiver Development
DMA, 919-855-4260**

Attention: All Providers**Critical Access Behavioral Health Agencies**

Several organizations have now been certified as meeting Critical Access Behavioral Health Agency (CABHA) status. As a reminder, CABHA status will be certified once for the entire state through a review by a certification team comprised of staff from: local management entities (LMEs), the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) and DMA. The provider is still required to enter into standardized Memoranda of Agreements (MOAs) with LMEs in the catchment areas where they deliver services and a standardized contract with those same LMEs for State-funded services. Continued certification as a CABHA will be based upon the agency's meeting or exceeding the required performance standards established by DHHS.

Additional information about CABHAs can be found at <http://www.ncdhhs.gov/mhddsas/cabha/>.

CPT and HCPCS Billing Information

Each CABHA is required to offer, at a minimum, the following "Core" services:

1. Clinical Assessment

CABHA attending providers may bill the following CPT and HCPCS codes for clinical assessments:

- **90801, 90802, H0001, and H0031**

For provider types and service limitations, please refer to DMA Clinical Coverage Policy 8C (<http://www.ncdhhs.gov/dma/mp/>). Physicians may also bill any of the CPT codes in this policy.

- **T1023 – Diagnostic Assessment**

For provider types and service limitations, please refer to DMA Clinical Coverage Policy 8A (<http://www.ncdhhs.gov/dma/mp/>).

- **99201, 99202, 99203, 99204, and 99205**

Physicians and advanced practice nurses may also bill these evaluation and management (E/M) CPT codes. E/M codes are not specific to mental health and are not subject to prior approval. E/M codes are subject to published benefit limits, including the 24-visit-per-year limit for adults. These assessment codes are limited to one per attending provider, per recipient, in a 3-year period.

2. Medication Management

Physicians and advanced practice nurses may bill the following E/M CPT codes: **90862, 99211, 99212, 99213, 99214, and 99215**. E/M codes are not specific to mental health and are not subject to prior approval. E/M codes are subject to published benefit limits, including the 24-visit-per-year limit for adults. For recipients under the age of 21, there is no limit to E/M codes allowed per year.

3. Outpatient Therapy

For provider types, billable codes, and service limitations, please refer to DMA Clinical Coverage Policy 8C on DMA's website at <http://www.ncdhhs.gov/dma/mp/>. Physicians may also bill any of the CPT codes in this policy.

4. Mental Health/Substance Abuse Targeted Case Management (upon approval by CMS)

5. At least **two** additional services (from the list below). Refer to DMA Clinical Coverage Policy 8A for Enhanced Behavioral Health Services and DMA Clinical Coverage Policy 8D-2 for Residential Child Care Services on DMA's website at <http://www.ncdhhs.gov/dma/mp/>.

- H2022 Intensive In-Home (IIH)
- H2015 HT Community Support Team (CST)
- H0015 Substance Abuse Intensive Outpatient Program (SAIOP)

- H2035 Substance Abuse Comprehensive Outpatient Treatment (SACOT)
- H2012 HA Child and Adolescent Day Treatment
- H2017 Psychosocial Rehabilitation (PSR)
- H0040 Assertive Community Treatment Team (ACTT)
- H2033 Multi-Systemic Therapy (MST)
- H0035 Partial Hospitalization (PH)
- H0013 Substance Abuse Medically Monitored Community Residential Treatment
- H0012 HB Substance Abuse Non-Medical Community Residential Treatment
- H0020 Outpatient Opioid Treatment
- S5145 (Therapeutic Foster Care) Child Residential Level II – Family Type
- H2020 Child Residential Level II – Program Type
- H0019 Child Residential Level III and IV
- Therapeutic Family Services (upon approval by CMS)

CABHA Enrollment

Per Implementation Update #70 (<http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/>), providers who have achieved certification as a CABHA will need to complete a Medicaid Provider Enrollment Application (<http://www.nctracks.nc.gov/provider/providerEnrollment/>) to obtain a Medicaid provider billing number (MPN).

CABHA applicants must complete and submit either the downloadable paper version of the In-State/Border Organization Provider Enrollment Application or the online version of the Provider Enrollment Application to enroll as a CABHA. When completing the Affiliated Provider Information section of the Application, the CABHA **must** list the name, MPN, and NPI associated with that number for each independently enrolled behavioral health practitioner and the name, attending MPN (identified by the alpha suffix appended to the core number), and the NPI associated with that number for each community intervention service that will be billed through the CABHA.

CABHA and National Provider Identifiers

At enrollment, CABHAs will need to identify an NPI associated with the CABHA billing MPN. Providers with current NPIs may choose to subpart or request multiple NPIs for specific entities within the organization. **All CABHAs are encouraged to obtain a separate NPI for the CABHA for ease of claims reimbursement.**

This CABHA NPI must be used by the CABHA in order to bill for services rendered by the direct-enrolled individuals (for example, MD, LCSW) and for Enhanced Services (for example, Community Support Team) provided by the CABHA. This CABHA NPI will be used as the "billing number." **Please see special instructions below for Therapeutic Foster Care (Level II – Family Type) and Residential Levels II – Program Type, III, and IV Residential Child Care (RCC) services.**

For dates of service July 1, 2010, forward, **if a provider has multiple MPNs but does not elect to subpart their CABHA, the claim will adjudicate through the NPI mapping solution and adjudicate to the CABHA MPN only.** For example, if a single NPI is linked to a CABHA, a physician group, and a psychology group or a CABHA and a Community Intervention Services Agency (CISA), the NPI mapping solution will assign the CABHA MPN as the billing provider for services that are rendered by a CABHA. **Please see special instructions below for Therapeutic Foster Care (Level II – Family Type) and Residential Levels II – Program Type, III, and IV Residential Child Care (RCC) services.**

Please refer to the NPI section on the DMA website at <http://www.ncdhhs.gov/dma/NPI/> for additional information regarding NPI.

Authorization Requests

CABHAs should submit requests for all enhanced services with the attending MPN. All authorizations will be made to the attending MPN. In other words, providers should continue to request authorizations in the same way as they do today.

For outpatient services, independently enrolled providers operating under a CABHA are required to submit a new request for prior approval to ValueOptions for service dates effective July 1, 2010, and forward for any recipient that will now be seen under a CABHA. Again, these new authorizations will be required only for "CABHA" clients. Providers must submit one authorization request per recipient for **each attending provider**. For dates of service, effective July 1, 2010, and forward, all authorizations for outpatient services will be made to the attending MPN (the "Attending Provider Name/Medicaid #" on the ORF2 form). This is a change from prior authorization guidance published in the June 2009 and July 2009 Medicaid Bulletins. Prior authorizations for outpatient services will now cover **only** the attending provider who requested and received the authorization.

In these situations, providers must submit a new request on the ORF2 with their "Attending Provider Name/Medicaid #" and the (CABHA) "Billing Provider Name/Medicaid #." A new prior authorization will be created for the "Attending Provider Name/Medicaid #."

Special Instructions: Therapeutic Foster Care (Level II – Family Type) and Levels II – Program Type, III, and IV Residential Child Care (RCC)

Even in instances when these services are part of the CABHA continuum, CABHAs should submit requests for Therapeutic Foster Care (Level II—Family Type) with the LME's MPN. In other words, providers should continue to request authorizations in the same way as they do today.

In instances when these services are part of the CABHA continuum, CABHAs should submit requests for all Level II – Program Type, III, and IV Residential Child Care Services (RCC) with the Level II – Program Type, III, or IV provider's MPN. In other words, providers should continue to request authorizations in the same way as they do today.

Claims Submission

Claims for all CABHA services (with the exception of Levels II – Program Type, III, and IV) will be billed using the professional claim (CMS-1500/837P) format. The CABHA NPI should be listed as the "billing provider." The "attending provider number" should be the NPI associated with the provider/service for which prior authorization was obtained. **Claims for Therapeutic Foster Care (Level II – Family Type) must continue to be submitted through the LME for processing.** In other words, providers should continue to submit Therapeutic Foster Care claims in the same way as they do today.

Claims for Residential Levels II – Program Type, III, and IV (provided by CABHAs) should continue to be billed using the institutional claim (UB-04/837I) format. In these instances, providers must continue to submit claims with the current billing NPI associated with the Level II – Program Type, III, or IV. In other words, providers should continue to submit claims for Levels II – Program Type, III, and IV services in the same way as they do today. If providers submit RCC claims under the CABHA's NPI, the claim will be denied.

Additional information about CABHA can be found at <http://www.ncdhhs.gov/mhddsas/cabha/>.

Enrollment Questions CSC, 1-866-844-1113

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

Policy Questions Behavioral Health Section DMA, 919-855-4290

Attention: All Providers**Maintaining the Security and Accessibility of Records after a Provider Agency Closes**

All Medicaid providers are responsible for maintaining custody of the records and documentation to support service provision and reimbursement of services by N.C. Medicaid for at least six years. See 10A NCAC 22F.0107 and section seven of the N.C. Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement. The Agreement is part of the enrollment application and may be accessed at <http://www.nctracks.nc.gov/provider/providerEnrollment/DownloadAction?SessionIndex=begin&title=Download%20Provider%20Enrollment%20Applications>. Documentation that is required to be maintained includes clinical service records, billing and reimbursement records, and records to support staff qualifications and credentials (personnel records). Clinical service records include, but are not limited to

- Diagnostic testing results (X-rays, lab tests, EKGs, psychological assessments, etc.)
- Records from other providers used in the development of care plans
- Nurses' notes or progress notes
- Service orders that authorize treatment and treatment
- Service or treatment plans

Billing and reimbursement records should include recipient demographic information.

Providers are **required** to arrange for continued safeguarding of the above-described records in accordance with the record retention guidelines. Failure to protect consumer or staff privacy by safeguarding records and ensuring the confidentiality of protected health information is a violation of the Health Insurance Portability and Accountability Act (HIPAA) and NCGS § 108A-80 and may be a violation of the North Carolina Identity Theft Protection Act. Violations will be reported to the Consumer Protection Section of the N.C. Attorney General's Office, the Medicaid Investigations Unit of the N.C. Attorney General's Office and/or the U.S. DHHS Office of Civil Rights, as applicable. The following sanctions, penalties, and fees may be imposed for HIPAA violations:

- Mandatory investigation and penalties for noncompliance due to willful neglect
- Willful neglect: \$50,000 up to \$1.5 million (\$10,000 up to \$250,000 if corrected within 30 days)
- Enforcement by the State Attorney General along with provisions to obtain further damages on behalf of the residents of the State in monetary penalties plus attorney fees and costs as provided for by the Health Information Technology for Economic and Clinical Health (HITECH) Act.

A provider's obligation to maintain the above-described records is independent from ongoing participation in the N.C. Medicaid Program and extends beyond the expiration or termination of the Agreement or contract. See 10A NCAC 22F.0107 and section eight of the DHHS Provider Administrative Participation Agreement. Provider records may be subject to post-payment audits or investigations after an agency closes. Failure to retain adequate and accessible documentation of services provided may result in recoupment of payments made for those services, termination or suspension of the provider from participation with the N.C. Medicaid Program and/or referral to the US DHHS Office of Inspector General for exclusion or suspension from federal and state health care programs, at the discretion of the Department.

If another provider takes over the functions of a closing entity, maintenance of the closing entity's records for the applicable recipients may be transferred to the new provider, if the new provider agrees to accept custody of such records in writing and a copy of this agreement is provided to DMA upon request. When custody of records is not transferred, the closing providers should send copies of transitional documentation to the providers who will be serving the recipient for continuity of care. Consumer authorization should be obtained as necessary. Copies of records may be provided to the recipient directly for coordination of care.

N.C. Medicaid must be notified of changes in provider enrollment status, including changes in ownership and voluntary withdrawal from participation in the N.C. Medicaid program, as indicated on the N.C. Tracks website at <http://www.nctracks.nc.gov/provider/cis.html>. Providers who anticipate closure are required to develop and implement a records retention and disposition plan. The plan must indicate how the records will be stored, the name of the designated records custodian, where the records will be located, and the process to fulfill requests for records. Information must be included on how recipients will be informed of the contact information and the process to request their records. The plan should also designate retention periods and a records destruction process to take place when the retention period has been fulfilled and there is no outstanding litigation, claim, audit or other official action. The plan should be on file with the records custodian.

Mental health, developmental disabilities, and substance abuse (MH/DD/SA) services records are subject to additional retention and management requirements, including those mandated by S.L. 2009-451 (Section 10.68A(a)(5)(j) and (k) for Community Support and Other MH/DD/SA Services and Section 10.68A(a)(7)(h) and (i) for MH Residential Services). MH/DD/SA providers should refer to guidance from Implementation Updates #72, #62, #60, and #58 for more information. Implementation Updates may be accessed at <http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/>.

HIPAA Privacy
DMA, 919-855-4230

Program Integrity
DMA, 919-647-8000

Attention: All Providers

CPT Code 99420

The January 2009 Medicaid Bulletin article titled *CPT Code Update 2009* stated that procedure code 99420 was limited to two units per date of service. However, claims billed for procedure code 99420 with two units per date of service have been denied. Changes have now been applied to the system to allow providers to bill for two units per date of service. Providers who have received claim denials for this procedure code for dates of service on January 1, 2009, and after may resubmit the denied charges as a new claim.

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

Attention: All Providers**P**ayment Error Rate Measurement in North Carolina

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

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

It is anticipated that A+ Government Solutions will begin requesting medical records for North Carolina's sampled claims in June 2010. Providers are urged to respond to these requests promptly with timely submission of the requested documentation.

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

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

Attention: Anesthesia Providers**A**nesthesia Policy Clarification

Effective with date of service June 1, 2010 changes have been made to Clinical Coverage Policy 1L-1, *Anesthesia Services*, to clarify information related to modifiers, billing without medical direction, and reimbursement rates.

Refer to the following sections in Attachment A of the policy (<http://www.ncdhhs.gov/dma/mp/>) for additional information.

- Section D. Modifiers
- Section F. Billing for Services Provided without Medical Direction
- Section N. Reimbursement Rate

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

Attention: Nurse Practitioners and Physicians**Immune Globulin Subcutaneous (Human) Injectable (Hizentra, HCPCS Code J3590): Billing Guidelines**

Effective with date of service April 1, 2010, the N.C. Medicaid Program covers immune globulin subcutaneous (human) injectable, 20% liquid (Hizentra) for use in the Physician's Drug Program when billed with HCPCS code J3590 (unclassified biologics). Hizentra is available in 1-gm/5-ml, 2-gm/10-ml, and 4-gm/20-ml vials.

Hizentra is indicated for the treatment of primary immunodeficiency (PI). This includes, but is not limited to, the humoral immune defect in congenital agammaglobulinemia, common variable immunodeficiency, X-linked agammaglobulinemia, Wiskott-Aldrich syndrome, and severe combined immunodeficiencies.

Hizentra dosing should be individualized based on the patient's clinical response to therapy and serum IgG trough levels. Prior to switching treatment from IGIV to immune globulin subcutaneous, obtain the patient's serum IgG trough level to guide subsequent dose adjustments. Establish the initial weekly dose of immune globulin subcutaneous by converting the monthly IGIV dose into a weekly equivalent and increasing it using a dose adjustment factor. To calculate the initial weekly dose of Hizentra, multiply the previous IGIV dose in grams by the dose adjustment factor of 1.53; then, divide this by the number of weeks between doses during the patient's IGIV treatment (i.e., 3 or 4).

For Medicaid Billing

- Providers must bill Hizentra with HCPCS code J3590 (unclassified biologics).
- Providers must indicate the number of HCPCS units.
- One Medicaid unit of coverage is 100 mg. Providers may bill for an entire 1-gram/5-ml, 2-gram/10-ml or 4-gram/20-ml vial. The maximum reimbursement rate, per 100 mg, is \$13.12.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Hizentra should be reported in "MLs." To bill for the entire 1-gram/5-ml vial of Hizentra, bill 10 HCPCS units. Report the NDC units as "ML5." To bill for the entire 2-gram/10-ml vial of Hizentra, report the NDC units as "ML10." To bill for the entire 4-gram/20-ml vial of Hizentra, report the NDC units as "ML20." 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 new 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 919-851-8888**

Attention: Nurse Practitioners and Physicians**Velaglucerase Alfa Injectable (VPRIV, HCPCS Code J3590): Billing Guidelines**

Effective with date of service February 26, 2010, the N.C. Medicaid Program covers velaglucerase alfa (VPRIV) for use in the Physician's Drug Program when billed with HCPCS code J3590 (unclassified biologics). VPRIV is available in 400-unit single-dose vials.

VPRIV is indicated for long-term enzyme replacement therapy (ERT) for pediatric and adult patients with type 1 Gaucher disease. VPRIV should be administered intravenously at a recommended dose of 60 units/kg every other week. The dose should be adjusted based upon disease activity. A dosing range of 15 to 60 units/kg was evaluated in clinical trials.

VPRIV should be administered intravenously at a recommended dose of 60 units/kg every other week. The dose should be adjusted based upon disease activity. A dosing range of 15 to 60 units/kg was evaluated in clinical trials.

For Medicaid Billing

- The ICD-9-CM diagnosis code required for billing VPRIV is 272.7 (disorders of lipoid metabolism – Lipidoses).
- Providers must bill VPRIV with HCPCS code J3590 (unclassified biologics).
- Providers must indicate the number of HCPCS units.
- One Medicaid unit of coverage is one unit. Providers may bill for an entire 400-unit single-dose vial. The maximum reimbursement rate, per 400-unit vial, is \$1,405.37.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for VPRIV should be reported in "UNs." If billing for the entire 400-unit vial of VPRIV, bill 400 HCPCS units. Report the NDC units for the whole vial 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 new 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 919-851-8888**

Attention: Community Alternatives Program Case Managers, Durable Medical Equipment Providers, and Orthotics and Prosthetics Provider**V**ideo Conference Seminars for Providers of Durable Medical Equipment and Orthotics and Prosthetics

Video conference seminars for providers of durable medical equipment (DME) and orthotics and prosthetics (O&P) are scheduled for the month of August 2010. Information presented at these seminars will include a review of policy, and billing and prior approval guidelines for DME and O&P. This will be an interactive video conference seminar providing virtual training with live video and audio communication. The video conference seminar sites and dates will be announced in the July 2010 Medicaid Bulletin.

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

HP Enterprise Services**1-800-688-6696 or 919-851-8888****Attention: Pharmacists and Prescribers****N.C. Medicaid Preferred Drug List Changes**

The N.C. Medicaid Preferred Drug List (PDL) will be changed to include additional drugs that will require prior authorization. The changes are targeted for the end of June 2010. Drugs listed as “non-preferred” will require prior authorizations. Drugs listed as “preferred” will not require prior authorizations unless noted on the PDL. The prior authorization process will not change.

No additional prior authorization requirements will be added for

- Recipients who are currently stable on **second generation anticonvulsants**
- Recipients under 2 years of age using **Accuneb and its generic version**
- Recipients less than 21 years of age using **insulin pens and cartridges**
- **Mental health drugs**

For additional information, refer to DMA’s Outpatient Pharmacy Program web page at <http://www.ncdhhs.gov/dma/pharmacy.htm> for a list of the drugs on the PDL and for updates.

HP Enterprise Services**1-800-688-6696 or 919-851-8888****ACS****1-866-246-8505**

Attention: Pharmacists and Prescribers**End-Dated Coverage for Exocrine Pancreatic Insufficiency Drugs**

Effective with date of service July 1, 2010, the exocrine pancreatic insufficiency drugs with the National Drug Codes (NDCs) listed below will no longer be covered by N.C. Medicaid. A notice regarding this change was mailed in May to all Medicaid recipients.

In a memo dated April 29, 2010, CMS stated “According to the FDA, these drugs do not have approved applications; therefore, CMS has determined that the NDCs do not meet the definition of a covered outpatient drug as defined in Section 1927(k) of the Social Security Act and are subsequently no longer eligible for inclusion in the rebate program.”

The following table lists the drugs that will be affected by this change.

National Drug Code	Product Name
00032-1205	Creon 5 Capsules
00032-1210	Creon 10 Capsules
00032-1220	Creon 20 Capsules
00091-4175	Kutrase Capsules Rx
10267-2737	Pancrelipase 8,000 Tablets
39822-9045	Pancrelipase 4,500
39822-9100	Pancrelipase 10,000
39822-9160	Pancrelipase 16,000
39822-9200	Pancrelipase 20,000
58177-0028	Pangestyme MT 16 Capsules
58177-0029	Pangestyme CN 10 (Pancrelipase) Delayed Release Cap
58177-0030	Pangestyme CN 20 (Pancrelipase) Delayed Release Cap
58177-0031	Pangestyme EC Capsules
58177-0048	Pangestyme UL 12 Capsules
58177-0049	Pangestyme UL 18 Capsules
58177-0050	Pangestyme UL 20 Capsules
58177-0416	Plaretase
58914-0002	Ultrase MT 12
58914-0004	Ultrase MT 20
58914-0018	Ultrase MT 18
58914-0045	Ultrase MS 4
58914-0111	Viokase
58914-0115	Viokase 8oz Powder
58914-0116	Viokase 16000
59767-0001	Pancrecarb MS-8
59767-0002	Pancrecarb MS-4
59767-0003	Pancrecarb MS-16

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

Attention: Pharmacists**Synagis Pharmacy Claims for 2009/2010 Season**

The last accepted date of service for Synagis pharmacy claims for the 2009/2010 policy coverage period was March 31, 2010. Synagis claims processing began on October 27, 2009, for this season. All Synagis requests must be completed on criterion-specific forms, which can be found at DMA's website at <http://www.ncdhhs.gov/dma/pharmacy/synagis.htm>.

No more than five monthly doses of Synagis can be obtained by using these forms. Copies of the submitted North Carolina Medicaid Synagis for RSV Prophylaxis forms should be mailed by pharmacy distributors to DMA. Please mail forms to:

N.C. Division of Medical Assistance
Pharmacy Program
1985 Umstead Drive
2501 Mail Service Center
Raleigh, N.C. 27699-2501

Pharmacy distributors with a large volume of Synagis claims should submit scanned copies of the North Carolina Medicaid Synagis for RSV Prophylaxis forms on a diskette. Please call Charlene Sampson at 919-855-4306 to coordinate this process if you need further assistance or have questions. All diskettes must be sent to DMA by June 1, 2010.

A Notice of Approval was provided by ACS (DMA's prior authorization vendor) for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requests for Synagis coverage outside of the policy limits. These include requests for an April dose of Synagis. A copy of the Notice of Approval from ACS should be maintained on file at the pharmacy.

The N.C. Medicaid Program should not be billed for Synagis unless one of the following is on file at the pharmacy:

- An accurate and complete Synagis for RSV Prophylaxis form
- An ACS Notice of Approval from an EPSDT request for Synagis

Payment of Synagis claims will be reviewed and may be subject to recoupment by Program Integrity if the appropriate forms or approval notifications are not on file.

Charlene Sampson, Pharmacy Program
DMA, 919-855-4306

Attention: Personal Care Services Providers**Independent Assessment Reminders**

Independent assessment of personal care services (PCS) recipients was implemented on April 1, 2010. The Carolinas Center for Medical Excellence (CCME) is conducting all Medicaid PCS independent assessments. Please review the following:

1. Referrals for Independent Assessment

Referral forms are available on the DMA website (<http://www.ncdhhs.gov/dma/services/pcs.htm>) and the Independent Assessment website (<http://www.qireport.net>). Individuals referred for independent assessment must have been seen by the referring practitioner within the preceding 90 days and must be medically stable. Referral forms must be completed in their entirety before assessments may be scheduled.

2. Weekly Summaries of Provider Agency Assessments

If you have not submitted updates to CCME for new recipients that you assessed and admitted through April 16, 2010, and updates of continuing recipients that you reassessed through April 30, 2010, do so immediately. Refer to the April 2010 and May 2010 Medicaid Bulletins (<http://www.ncdhhs.gov/dma/bulletin/>) for instructions. Do not submit new admission or reassessment updates for recipients assessed by CCME.

3. Weekly Discharge Updates

Until further notice, continue to submit weekly discharge updates to CCME. Use and follow the instructions in Part 2 of the Weekly Summary Form (see the **Independent Assessment website**).

4. Claims Processing

New claims processing requirements went into effect in May 2010. In order for claims to process correctly, CCME must have a record of the provider agency's correct Medicaid provider number for each recipient. Refer to the April 2010 and May 2010 Medicaid Bulletins (<http://www.ncdhhs.gov/dma/bulletin/>) for the new claims processing requirements. Refer to the **Independent Assessment website** (<http://www.qireport.net>) for corrective steps if you experienced problems with claims processing beginning in May.

5. PCS and PCS-Plus Annual Reassessments

Not all PCS and PCS-Plus recipients will receive independent assessments before the annual reassessment dates indicated on client PACT assessments. For recipients with PACTs expiring May 1, 2010, and after, continue to provide and bill for services in keeping with recipient Plans of Care until you are notified of assessment results by CCME.

CCME will notify providers before recipient annual reassessments only when scheduled to occur more than a month before recipients' annual reassessment dates. Providers who wish to contact CCME with information pertinent to a recipient's reassessment should do so a month or more before the recipient's annual reassessment date.

6. Provider Training

On June 15 and 17, 2010, CCME will conduct webinar trainings for PCS provider agencies and for physicians and other practitioners who refer patients for PCS. Regional trainings are planned for July 2010. Refer to the **Independent Assessment website** (<http://www.qireport.net>) and the DMA website (<http://www.ncdhhs.gov/dma/provider/seminars.htm>) for additional information and announcements and to register for trainings.

Refer to the new clinical coverage policy for PCS and PCS-Plus (<http://www.ncdhhs.gov/dma/mp/>), the **Independent Assessment website**, and future Medicaid Bulletin articles for additional information and updates. Questions may be directed to the CCME Independent Assessment Help Line at 1-800-228-3365 and by e-mail to PCSAssessment@thecarolinascener.org.

CCME, 1-800-228-3365

Attention: Outpatient Behavioral Health Services Providers and Provisionally Licensed Providers Billing “Incident to” a Physician or through the Local Management Entity**New Prior Authorization Guidelines**

Effective July 1, 2010, prior authorizations for all outpatient services will be created for the "Attending Provider Name/Medicaid #" on the ORF2 form. Providers must enter the Attending Medicaid Provider Number (MPN) associated with the Attending NPI with which they will submit their claims (do not submit NPI on the ORF2). Prior authorization requests will no longer be made for group providers.

For CABHA only: For outpatient services, independently enrolled providers operating under a CABHA are required to submit a new request for prior approval to ValueOptions for service dates effective July 1, 2010, and forward for any recipient that will be now seen under a CABHA. Again, these new authorizations will only be required for “CABHA” clients. In these situations, providers must submit a new request on the ORF2 with their "Attending Provider Name/Medicaid #" and the (CABHA) "Billing Provider Name/Medicaid #." A new prior authorization will be created for the "Attending Provider Name/Medicaid #."

For all providers: Both the "Attending Provider Name/Medicaid #" and "Billing Provider Name/Medicaid #" fields on the ORF2 must be completed or the request will be returned by ValueOptions as "Unable to Process."

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

Attention: Critical Access Behavioral Health Agencies, Enhanced Behavioral Health (Community Intervention) Services Providers, and Local Management Entities**Community Support Case Management Component**

Current Community Intervention Services providers and Critical Access Behavioral Health Agencies will be able to provide the case management component of Community Support service by qualified and licensed professionals during the interim period until the new case management service definition is approved. As a result, consumers currently receiving Community Support and new consumers entering the system on or after July 1, 2010, will be able to receive the case management component of Community Support in order to ease the transition to the new case management service. Further information will be published here as it becomes available.

For additional information, please see Implementation Updates #65 and #68 (<http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/>). (Note: Local management entities [LMEs] may also authorize the case management component of Community Support services for non-Medicaid-eligible consumers under these same criteria, subject to availability of funds and the provisions of the LME's benefit plan.)

Requests for Community Support services for children must follow the established Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) procedures and requirements, which are available at <http://www.ncdhhs.gov/dma/epsdt/>.

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

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

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

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

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

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

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

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

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

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

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

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

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

Proposed Clinical Coverage Policies

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

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

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

2010 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
June	6/3/10	6/8/10
	6/10/10	6/15/10
	6/17/10	6/24/10
July	7/1/10	7/7/10
	7/8/10	7/13/10
	7/15/10	7/22/10
	7/29/10	8/3/10

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.

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

Melissa Robinson
 Executive Director
 HP Enterprise Services
