



August 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**Human Papilloma Virus (HPV) Vaccine, Types 16, 18, Bivalent, 3-Dose Schedule for Intramuscular Use (Cervarix, CPT Code 90650): Billing Guidelines**

The N.C. Medicaid Program covers vaccines in accordance with guidelines from the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP). The CDC recently announced the availability of an additional human papillomavirus vaccine (HPV) product, the bivalent vaccine, Cervarix. ACIP provisional recommendations on Cervarix vaccine can be found in the May 28, 2010, edition of the CDC's Morbidity and Mortality Weekly Report at http://www.cdc.gov/mmwr/mmwr_wk/wk_cvol.html.

North Carolina Immunization Program/Vaccines for Children (NCIP/VFC)

The N.C. Immunization Program (NCIP) distributes all recommended childhood vaccines to local health departments, hospitals, and private providers under NCIP guidelines. Effective May 1, 2010, NCIP began offering providers the bivalent Cervarix vaccine for female patients 9 through 18 years of age who are eligible for the Vaccines for Children (VFC) program. The NCIP continues to offer the quadrivalent HPV vaccine, Gardasil, for VFC-eligible males and females 9 through 18 years of age. For the NCIP coverage criteria for all NCIP-provided products, including HPV, go to <http://www.immunizenc.com/coveragecriteria.htm>.

For Medicaid Billing

For female recipients 9 through 18 years of age:

- Effective with date of service May 1, 2010, the N.C. Medicaid Program recognizes the NCIP/VFC vaccine Cervarix when billed with CPT code 90650, for female recipients 9 through 18 years of age.
- Medicaid covers the cost of the administration of the Cervarix vaccine for VFC-eligible female recipients 9 through 18 years of age.

For female recipients 19 through 20 years of age:

- Medicaid covers the cost of the Cervarix vaccine and the cost of administration for Medicaid-eligible female recipients 19 through 20 years of age.

For female recipients 9 through 20 years of age:

- When reporting or billing for Cervarix and it is appropriate to indicate a diagnosis code, Medicaid suggests using ICD-9-CM diagnosis code V04.89.

Note: Medicaid continues to cover the quadrivalent Gardasil vaccine (CPT code 90649) and its administration as previously published in the March 2010 Medicaid Bulletin. Refer to the Medicaid bulletin and the Health Check Billing Guide for detailed billing guidance. The fee schedule for the Physician's Drug Program is available on DMA's website at <http://www.ncdhhs.gov/dma/fee/>.

HP Enterprise Services

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

Attention: All Providers**Resolution of the Shortage of Haemophilus Influenzae Type B (Hib) Vaccine and Clarifications Regarding Hib Vaccines**

As documented in the April 2008 Medicaid Bulletin, the N.C. Medicaid Program covered the purchase of PedvaxHIB (CPT code 90647) or ActHIB (CPT code 90648), when administered to recipients through 18 years of age because of a Hib vaccine shortage. Medicaid billing instructions required the SC modifier to be appended to the CPT vaccine code to indicate that purchased vaccine was administered.

On March 31, 2010, the North Carolina Immunization Program (NCIP) announced the resolution of the shortage of the Hib-containing products. Effective with date of service September 1, 2010, as a result of the resolution of the shortage of Hib-containing vaccine products, Medicaid will no longer cover purchased PedvaxHIB and ActHIB for recipients through 18 years of age. Providers will no longer be able to append SC to the CPT vaccine codes and be reimbursed for the 0 through 18 years of age group. Medicaid does not cover the purchase of vaccines provided by the NCIP because State-supplied vaccines are available to all providers enrolled in NCIP for Vaccines for Children (VFC)-eligible recipients. Medicaid does cover the administration, if applicable.

Effective May 1, 2010, the NCIP began providing only two Hib-containing products, PedvaxHIB (CPT code 90647) and Pentacel (CPT code 90698, DTaP-Hib-IPV). These will continue to be recognized as VFC vaccines with no end date at this time. ActHIB and Hiberix (both reported under CPT code 90648) are no longer being provided by the NCIP; however, the ActHIB and Hiberix vaccines already provided by the NCIP through April 2010 have expiration dates through April 28, 2012. Therefore, Medicaid will continue to allow the reporting of these vaccines under CPT code 90648 for recipients through 18 years of age and will cover the administration codes through date of service April 28, 2012. **Effective with date of service April 29, 2012, Medicaid will no longer recognize CPT code 90648 as a VFC vaccine.** Refer to the Centers for Disease Control and Prevention (CDC) for guidance regarding administering Hib vaccines.

Clarifications Regarding Hib Vaccines

The haemophilus influenzae type b (Hib) vaccines available for reporting as a State-supplied vaccine or that may be billed to the N.C. Medicaid Program are listed in the following table. **No other CPT codes for a Hib conjugate vaccine, such as CPT codes 90645 (HibTITER) or 90646 (ProHIBIT), should be reported or billed. Providers are currently reporting CPT code 90645 as a VFC vaccine. There are no licensed vaccines currently available to be billed under CPT codes 90645 and 90646. CPT codes 90721 (TriHIBit) and 90748 (Comvax) for combination vaccines containing Hib are noncovered.**

Hib Vaccines that May be Reported or Billed

CPT Code and Brand Name	Description	Billing Guidelines	Coverage Dates
90647 PedvaxHIB	Hemophilus influenza b vaccine (Hib) PRP-OMP conjugate (3 dose schedule), for intramuscular use	May be reported as a VFC vaccine	No end date at this time
90648 ActHIB or Hiberix	Hemophilus influenza b vaccine (Hib) PRP-T conjugate (4 dose schedule), for intramuscular use Note: Hiberix is only licensed for a booster (final) dose of the Hib series	May be reported as a VFC vaccine through April 28, 2012	Coverage as a VFC vaccine ends April 28, 2012

CPT Code and Brand Name	Description	Billing Guidelines	Coverage Dates
90698 Pentacel	Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated (DTap-Hib-IPV), for intramuscular use	Licensed for children through 4 years of age. May be reported as a VFC vaccine	No end date at this time

For the complete NCIP coverage criteria document go to <http://www.immunizenc.com/coveragecriteria.htm>.

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 August 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: All Providers**Medicaid Provider Administrative Participation Agreement: Update**

Following the publication of the July 2010 Medicaid Bulletin article, the revised N.C. Department of Health and Human Services Medicaid Provider Administrative Participation Agreement was updated to address minor changes and clarifications. Those providers who deferred the completion of the Agreement that was included in the verification packet mailed out as part of the 12-month verification project may now access the revised Agreement on the NC Tracks website at <http://www.nctracks.nc.gov/provider/forms/>. The initial goal is to reach those providers who deferred completing an Agreement with the N.C. Medicaid Program.

Providers who completed and submitted an Agreement with the verification packet or at the time of their initial enrollment or re-enrollment for participation with N.C. Medicaid do not need to resubmit an Agreement at this time. CSC, N.C. Medicaid's contractor for provider enrollment, verification, and credentialing, will contact providers when a new Agreement is required although any provider can opt to complete and submit the Agreement before the notification process begins. Any new Agreements received by CSC from providers who choose this option will be effective immediately and will supersede any previously submitted agreements.

The completed N.C. Department of Health and Human Services Medicaid Provider Administrative Participation Agreement should be submitted by mail, fax or by e-mail to CSC by September 1, 2010.

N.C. Medicaid Provider Enrollment
CSC
PO Box 300020
Raleigh NC 27622-8020

Fax: 1-866-844-1382
E-mail: NCMedicaid@csc.com

CSC, 1-866-844-1113

Attention: All Providers**Maternal Outreach Worker Program**

Effective with date of service September 1, 2010, the N.C. Medicaid Program no longer covers the Maternal Outreach Worker Program. Maternal Outreach Worker providers should submit all claims for services rendered as soon as possible.

The following policies are impacted by this elimination.

- 1M1, *Child Service Coordination*
- 1M4, *Home Visit for Newborn Care and Assessment*
- 1M5, *Home Visit for Postnatal Assessment and Follow-up Care*
- 1M7, *Baby Love Maternal Outreach Worker Program*
- 1M8, *Maternity Care Coordination*

HP Enterprise Services
1-800-688-6696 or 919-855-8888

Attention: All Providers**Update to the Annual Medicaid Identification Card**

In September 2009, the N.C. Medicaid Program began issuing an annual Medicaid identification (MID) card to all current Medicaid recipients. Since then, annual MID cards have been issued to newly eligible Medicaid recipients as well as to those recipients who changed their Primary Care Provider (PCP), had a legal name change or requested a replacement card. Starting in September 2010, new annual MID cards sent to those individuals who remain eligible for Medicaid and have not received a card in the past 12 months will include the date of birth of the recipient. (Please note that MID cards are not issued to recipients in the MQB-B and MQB-E benefit categories.) The new cards will continue to be printed on gray paper stock.

The MID card does not serve as proof of recipient eligibility or identity. A recipient's eligibility status may change from month to month if financial and household circumstances change. For this reason, providers should verify a Medicaid recipient's eligibility each time a service is rendered. Providers may verify a recipient's eligibility by various methods including

- Electronic Data Interchange
- Recipient Eligibility Verification Tool
- Automated Voice Response

Refer to Appendix F in the *Basic Medicaid Billing Guide* (<http://www.ncdhhs.gov/dma/basicmed/>) for detailed information on eligibility verification.

At each visit, providers must verify the cardholder's

- identity (if an adult)
- current eligibility
- Medicaid program (benefit category)
- CCNC/CA primary care provider information
- other insurance information

**John L. Benske, Medicaid Eligibility Unit
DMA, 919-855-4000**

Attention: All Providers**Basic Medicaid Seminars**

Basic Medicaid seminars are scheduled for the month of October 2010. Seminars are intended to educate providers on the basics of Medicaid billing as well as to provide an overview of Medicaid updates and resources. The seminar sites and dates will be announced in the September 2010 Medicaid Bulletin. The October 2010 *Basic Medicaid Billing Guide* will be used as the training document for the seminars and will be available prior to the seminars on DMA's website at <http://www.ncdhhs.gov/dma/basicmed/>.

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: 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**C**hanges to the N.C. Medicaid Preferred Drug List

N.C. Medicaid will implement changes to the N.C. Medicaid Preferred Drug List (PDL) beginning on **September 15, 2010**. Drugs will be indicated as “preferred” or “non-preferred” based on therapeutic effectiveness, safety, and clinical outcomes. Generally, “preferred” drugs will not require prior authorization unless there are other requirements such as step therapy or quantity limits. “Non-preferred” drugs will be available through prior authorization. The prior authorization process will be the same process as it is today. If a prescriber deems that the patient’s clinical status necessitates therapy with a “non-preferred” drug, the prescriber will be responsible for initiating a prior authorization request. For therapeutic drug classes that do not appear on the PDL, nothing has changed. Prescribers can prescribe drugs in these classes as in the past, unless existing prior authorization criteria exists.

Please refer to DMA’s Outpatient Pharmacy Program’s website for PDL updates (<http://www.ncdhhs.gov/dma/pharmacy>).

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

Attention: All Providers**C**overage of Prescription Vitamin and Mineral Products

Due to future changes to Medicaid outpatient pharmacy policy, Medicaid will no longer cover certain prescription vitamin and mineral products. Prescription prenatal vitamin and fluoride products will continue to be covered for Medicaid patients only. Medicaid will not cover any vitamin or mineral products for dually eligible recipients. Additional information on the implementation date for these changes will be provided once it becomes available.

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

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/>:

- 8M, *Community Alternatives Program for Persons with Mental Retardation and Developmental Disabilities (CAP/MR-DD)*

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**Implementation of a Recipient Management Lock-In Program**

N.C. Medicaid will implement a recipient management lock-in program. The N.C. Administrative Code, 10A NCAC 22F.0704 and 10A NCAC 22F.0104, along with 42 CFR 431.54 and the Medicaid State Plan supports the State's development of procedures for the control of recipient overutilization of Medicaid benefits, which includes implementing a recipient management lock-in program. Recipients identified for the lock-in program will be restricted to a single prescriber and pharmacy in order to obtain opioid analgesics, benzodiazepines, and certain anxiolytics covered through the Medicaid Outpatient Pharmacy Program.

N.C. Medicaid recipients who meet one or more of the following criteria will be locked into one prescriber and one pharmacy for controlled substances categorized as opiates or benzodiazepines and certain anxiolytics for a period of one year:

1. Recipients who have at least **ONE** of the following
 - a. Benzodiazepines and certain anxiolytics: more than six claims in two consecutive months
 - b. Opiates: more than six claims in two consecutive months
2. Receiving prescriptions for opiates and/or benzodiazepines and certain anxiolytics from more than three prescribers in two consecutive months
3. Referral from a provider, DMA or CCNC.

The process of identifying recipients for the program began in July. Recipients who meet the criteria will be notified by letter and asked to choose a prescriber and a pharmacy. The recipient must obtain all prescriptions for these medications from their lock-in prescriber and lock-in pharmacy in order for the claim to pay. Additionally, the **prescriber's NPI will be required on the pharmacy claim**. Submitting the prescriber's DEA will cause the claim to be denied. Claims submitted by a prescriber or filled at a pharmacy other than the one listed on the lock-in file will be denied. The recipient may not change their lock-in prescriber or pharmacy without authorization from DMA.

Recipients who qualify for the program will be notified and locked in for one year after which time they will be removed from the program if they no longer meet the criteria. Recipients who continue to meet the criteria will be locked in for a subsequent year. Once released from the lock-in program, prescription claims will continue to be monitored. If it is determined that a recipient again meets the criteria, the recipient will be re-identified for the lock-in program.

The N.C. Medicaid Program will reimburse an enrolled Medicaid pharmacy for a four-day supply of a prescription dispensed to a recipient locked into a different pharmacy and prescriber in response to an emergent situation. The recipient will be responsible for the appropriate copayment. Only one emergency occurrence will be reimbursed per lock-in period. Records of dispensing of emergency supply medications are subject to review by Program Integrity. Paid quantities for more than a four-day supply are subject to recoupment.

Please refer to the DMA website at <http://www.ncdhhs.gov/dma/pharmacy/> for updates.

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

Attention: All Providers**P**olicy Changes for Coverage of Breast Surgeries

DMA has implemented a number of changes in response to legislated budget reductions. As a result of these budget reductions, Clinical Coverage Policy 1A-12, *Breast Surgeries*, has been revised. Effective with date of service October 1, 2010, Medicaid will no longer covers reduction mammoplasty except when performed on a contralateral breast as part of a reconstruction surgery as described in Section 3.6 of the policy. Medicaid will no longer cover CPT procedure code 19316 (mastopexy) except on the affected breast. Please refer to sections 1.5, 3.5, 3.6, 4.2, and 5.4 and Attachment A of the policy (<http://www.ncdhhs.gov/dma/mp/>) for a copy of the revised criteria.

HP Enterprise Services

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

Attention: All Providers**R**eductions to Covered Podiatry Services

Due to legislated budget reductions, the N.C. Medicaid Program will implement reductions and limitations for podiatry services. Podiatry services will be limited to certain diagnoses. Clinical Coverage Policy 1C-1, *Podiatry Services*, and Clinical Coverage Policy 1C-2, *Medically Necessary Routine Foot Care*, will be revised to list the covered diagnosis codes that will be required on claims from podiatrists and podiatry practices effective with date of service October 1, 2010.

HP Enterprise Services

1-800-688-6696 or 919-855-8888

Attention: All Providers**E**nd-Dated Coverage of Panniculectomy

Due to legislated budget reductions, effective with date of service October 1, 2010, the N.C. Medicaid Program no longer covers panniculectomy procedure. Clinical Coverage Policy 1A-10, *Panniculectomy*, will be end-dated effective October 1, 2010.

Procedure Code	Description
15831	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy

HP Enterprise Services

1-800-688-6696 or 919-855-8888

Attention: Adult Care Home Providers, Nurse Practitioners, and Physicians**Adult Care Home Prior Approval and Admissions**

Medicaid will accept the signature of a physician, nurse practitioner or physician assistant on an FL2 for use in an adult care home prior approval and/or admission, in order to comply with G.S. §90-18.3. of the Physician Practice Act, which states:

- (a) Whenever a statute or State agency rule requires that a physical examination shall be conducted by a physician, the examination may be conducted and the form signed by a nurse practitioner or a physician's assistant, and a physician need not be present. Nothing in this section shall otherwise change the scope of practice of a nurse practitioner or a physician's assistant, as defined by G.S. §90-18.1 and G.S. §90-18.2, respectively.

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

Attention: Ambulatory Surgery Centers**CPT Procedure Codes 64490, 64491, 64492, 64493, 64494, and 64495**

DMA is aware of denials received by Ambulatory Surgery Centers (ASCs) when billing the following new 2010 CPT procedure codes 64490, 64491, 64492, 64493, 64494, and 64495.

Procedure Code	Description
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level
64491	second level (List separately in addition to code for primary procedure)
64492	third and any additional level(s) (List separately in addition to code for primary procedure)
64493	Injection(s), , diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
64494	second level (List separately in addition to code for primary procedure)
64495	Third and any additional level(s) (List separately in addition to code for primary procedure)

System changes have now been completed to allow for reimbursement of these services for ASCs for dates of service January 1, 2010, and after. ASC providers who have received claim denials for these procedure codes with EOB 24 (This procedure code not allowed for your provider type) may resubmit new claims for processing. One of the following modifiers, as applicable, must be appended to the procedures code: SG, 73 or 74. Claims submitted without applicable modifiers will be denied.

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

Attention: HIV Case Management Providers**Announcement of New Vendor for HIV Case Management Program**

The Carolinas Center for Medical Excellence (CCME) has been awarded the contract for the management of the day-to-day operations for the HIV Case Management Program. Additional information regarding the program will be published in future Medicaid Bulletin articles. During the transition, please continue to direct any questions to Victoria Landes, HIV Program Consultant, DMA, 919-855-4389.

**Victoria Landes, HIV Program Consultant
DMA, 919-855-4389**

Attention: HIV Case Management Providers**Procedure Code Change for HIV Case Management**

Effective August 31, 2010, HCPCS code T1017 will be end-dated for HIV case management services. The new HCPCS code, G9012, will be effective with date of service September 1, 2010.

The limitation on the number for billable units of HIV case management services provided to a recipient (16 units per calendar month) remains in effect. The only exception is that the limit may not be applied to recipients under the age of 21 years if all criteria for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Medicaid for Children, are met. For further information about EPSDT, visit DMA's website at <http://www.ncdhhs.gov/dma/epsdt/>.

Until contact information is provided for the new vendor, please continue to direct any questions to Victoria Landes, HIV Program Consultant, DMA, 919-855-4389.

**Victoria Landes, HIV Program Consultant
DMA, 919-855-4389**

Attention: CAP/C Case Managers**CAP/C Waiver Renewal Training**

CMS has granted approval for N.C. Medicaid's Community Alternatives Program for Children (CAP/C) waiver program for an additional five-year period beginning July 1, 2010. An article will be published in the September 2010 Medicaid Bulletin to provide details for the implementation of the new and amended waiver services on October 1, 2010.

Case Manager Training for the CAP/C waiver is scheduled via videoconference on August 16 and 17, 2010, from 9:00 a.m. until 3:30 p.m. with a 30-minute lunch break. There will be six sites across the State from which providers may participate in the videoconference. Case managers will be notified by e-mail with registration information.

**Teresa Piezzo, Home and Community Care
DMA, 919-855-4380**

Attention: Pharmacists**Lost Prescriptions Limited to One Occurrence During a 365-Day Time Period**

Effective **August 15, 2010**, the use of the submission clarification code (04) to override a Drug Utilization Review (DUR) alert for lost prescriptions will be limited to one occurrence on the same date of service over a 365-day time period. This will apply to non-controlled medications only. The use of the submission clarification code (03) for vacation supplies will be monitored for overuse following this change. Vacation supply and lost prescriptions are not allowed for controlled substances.

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

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

Refer to the **Independent Assessment website** (<http://www.qireport.net>) for the following:

- PCS forms and instructions for new referrals, change of status reassessments, and change of provider requests
- Audio content from May and June 2010 webinars on independent assessment and plan of care development
- **New** electronic plan of care tool for providers
- **New** educational content on PCS referrals for physicians and other referring practitioners
- Claims processing requirements, common EOB codes and explanations, and corrective steps to resolve billing issues
- Discharge update and provider number update forms
- **New** information on change of provider procedures to expedite transfers of recipients whose providers terminate services during a current authorization period
- Announcements about upcoming regional trainings on the **new** provider web interface
- **New** announcements and updates to frequently asked questions

Please continue to submit weekly discharge updates to CCME using Part 2 of the Weekly Summary Form (see the **Independent Assessment website**, <http://www.qireport.net>).

Questions may be directed to the CCME Independent Assessment Help Line at 1-800-228-3365 and by e-mail to PCSAssessment@thecarolinascenter.org.

CCME, 1-800-228-3365

Attention: Critical Access Behavioral Health Agencies**A**pplication Clarifications

Effective May 10, 2010, providers who have achieved certification as a Critical Access Behavioral Health Agency (CABHA) must complete and submit the In-State Organization Provider Enrollment Application to obtain a Medicaid Provider Number (MPN). On the application, providers will select CABHA and indicate each of the services that will make up the CABHA agency. There is help available on each screen to assist in completion of the application. To access provider enrollment applications and features, download forms, or to report a change to your provider information visit the NC Tracks website at <http://www.nctracks.nc.gov>.

Previous Enrollment

The application includes a question about previous enrollment and prompts the applicant to indicate their MPN. Providers are requested **not** to indicate an MPN when completing the application for CABHA enrollment. Since this is the provider's first request for enrollment as a CABHA agency, the answer should indicate "No" or be left blank. This question is designed for re-enrollment of a terminated MPN.

National Provider Identifier

When enrolling, CABHAs will need to identify a National Provider Identifier (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 to ensure correct claims adjudication. If your CABHA NPI is the same NPI that you are using to bill for other services, the claims will adjudicate and pay to the CABHA first according to the NPI mapping solution. This CABHA NPI must be used by the CABHA in order to bill for services rendered by the direct-enrolled individuals affiliated with the CABHA. The CABHA NPI is used as the "billing number" on the claim. The professional claim (CMS-1500/837P) format is used for billing CABHA services.

Physical Site Address

Providers may have several physical site locations in which services are provided. The physical site address indicated on the application should match the address on the Certification Letter of Approval for the CABHA.

Provider Affiliation

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 who will be providing services under the CABHA. The CABHA must list 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 (enhanced) service that will be provided by the CABHA. The CABHA must list the name, MPN, and the NPI associated with that number for each residential service that will be provided by the CABHA.

Providers have the ability to add (affiliate) a service or a direct-enrolled outpatient therapy practitioner, physician or nurse practitioner to the CABHA. The Medicaid Provider Change Form and Electronic Claim Submission (ECS) Agreement for Organizations should be used to report the addition or deletion of a service or a direct-enrolled outpatient therapy practitioner, physician, or nurse practitioner to the CABHA. The CABHA Addendum to Add Services should be used to add a new service to the CABHA or a new service site.

Contact

CSC, the enrollment, verification and credentialing vendor for the NC Medicaid Program, has a dedicated credentialing staff who will process the CABHA enrollment applications as high priority. Providers will be notified if any information is required to complete the application. For additional assistance, questions or further information, please feel free to contact the CSC EVC Call Center. Customer service agents are available Monday through Friday, 8:00 a.m. through 5:00 p.m., at 1-866-844-1113. Select menu option 2 for CABHA.

CSC, 1-800-866-844-1113

Attention: Critical Access Behavioral Health Agencies and Enhanced Behavioral Health (Community Intervention) Services Providers**Extension of Case Management Functions of Community Support Services**

The end date for the provision of the case management functions of Community Support Services has been extended to allow recipients to access these case management functions until the Mental Health and Substance Abuse Case Management State Plan Amendment has been approved and recipients, who meet medical necessity criteria, have been transitioned into the service. Community Support case management functions may be provided for only up to four hours per month for adults and children, though services for individuals under 21 are subject to Early and Periodic Screening, Diagnosis, and Treatment (EPDST) provisions. (Please see DHHS Implementation Updates #65 and #68 for information on providing the case management functions of Community Support.) Community Support providers should continue to request authorizations and bill under their current Community Intervention Service Agency (CIS) Medicaid Provider Number (MPN). Providers should not attempt to request authorization or bill under a Critical Access Behavioral Health Agency (CABHA) MPN.

Revised Authorization Limit and Effective Date for Community Support Team

Effective August 1, 2010, all new authorizations for Community Support Team (CST) shall be based upon medical necessity as defined by DMA Clinical Coverage Policy 8A and shall not exceed 32 hours (128 units) per 60-day period. Effective August 1, 2010, requests received by ValueOptions for more than 32 hours per 60-day period shall be authorized at the maximum allowable limit of 32 hours per 60-day period. Existing authorizations for CST will remain effective until the end of the current authorization period.

Community Support Team Provider Numbers

Providers were informed in DHHS Implementation Updates #63 and #65 and the November 2009 and December 2009 Medicaid Bulletins that DMA is engaged in the re-verification of Notifications of Endorsement Actions (NEA) for CIS Agencies and specifically for providers of CST. CST providers were required to submit the verification packet with appropriate credentials including all current NEAs to qualify for continued enrollment as a provider of CST services. Further verification has also occurred through the endorsing Local Management Entities (LMEs).

This process is now complete and new MPNs have been issued for CST using the provider's core number with a V suffix to provide a unique MPN for CST (H2015 HT) separate from other Community Support services (H0036 HA, HB, and HQ) to be used effective with dates of service July 1, 2010. With this separation, all new service authorization requests submitted to ValueOptions on July 1 and after must include the V suffix.

Note: Providers who have already submitted authorization requests for CST on or after July 1 using their MPN with the B suffix do not need to resubmit the authorization request; ValueOptions has been instructed to automatically transfer any approved requests received from July 1 through July 31 to the provider's MPN with the V suffix. This provided a limited 30-day time period to ensure that providers were informed of these changes. After July 31, 2010, service requests for CST services will be returned as "Unable to Process" if the provider's MPN retains the B suffix rather than the V suffix. Service authorizations approved prior to July 1, 2010, under the B suffix will be honored until the authorizations expire.

Please be attentive to how you bill your claim. Providers must use the NPI associated with the MPN that matches the CST authorization for proper adjudication of claims.

Behavioral Health Unit
DMA, 919-855-4290

Attention: Critical Access Behavioral Health Agencies***T*ransition Timeframe for Full Critical Access Behavioral Health Agency Implementation**

To assure continued access to services and a smooth transition for recipients, the timeframe for full implementation of Critical Access Behavioral Health Agencies (CABHAs) has been extended to occur between July 1, 2010, and December 31, 2010. This transition period will enable CABHAs who have been certified, enrolled, and endorsed for these specific services to begin or to continue providing Intensive In-Home Services (IIH), Community Support Team (CST), and Child and Adolescent Day Treatment effective July 1, 2010. This will also allow current endorsed and enrolled providers of these services to continue to provide services between July 1, 2010, and December 31, 2010, if necessary to either complete the certification process to become a CABHA or to transition consumers to a CABHA.

Over the next several months, as CABHAs complete the certification and enrollment process, DHHS will work with Local Management Entities (LMEs) and providers to transition consumers to certified CABHAs. A workgroup with representation from the LME and the provider community is currently working with DHHS to outline the specifics of the consumer transition process. Additional details will be forthcoming from that workgroup.

Update on Subcontracting between a CABHA and Another Provider Agency

CMS has clarified that a CABHA may not subcontract with another agency for the provision of services to meet CABHA requirements for required services. CABHAs may, however, secure the services of individual practitioners either through employment of the individual or as an independent contractor.

CABHA Medicaid Provider Numbers

Several CABHAs have completed the Medicaid enrollment process and may begin billing for dates of service beginning July 1, 2010, with the NPI associated with the CABHA. CABHAs can continue to bill with current NPI numbers for outpatient therapy and enhanced services until they receive their Medicaid Provider Number (MPN). MPNs for outpatient therapy and enhanced services will not be end-dated at this time.

Authorization Requests for Enhanced Services under a CABHA

Providers do not need to request a new authorization for an enhanced service that will now be delivered under a CABHA. All current authorizations for enhanced services will remain valid. When it is time for a new authorization for an enhanced service, the CABHA should submit requests using the current MPN associated with the enhanced service. The MPN for an enhanced service is identified by the alpha suffix appended to the core MPN (for example "8300005B"). All authorizations will be made to that current MPN. This is the MPN that providers currently list on the ITR as the "Facility ID." In other words, providers should continue to request authorizations in the same way as they do today.

Authorizations will not be made to the CABHA MPN. Providers should not request authorization with the CABHA MPN. Requests submitted only with the CABHA MPN and not the MPN associated with the enhanced service will be returned as "Unable to Process."

CABHA Claims Submission

As a reminder, claims for all CABHA enhanced and outpatient therapy services will be billed using the professional claim (CMS-1500/837P) format. This is the same claim type that is used today for billing enhanced and outpatient therapy services. The CABHA NPI should be listed as the "billing provider." The "attending provider number" should be the NPI associated with the directly enrolled "attending" provider/physician or the enhanced service for which prior authorization was obtained.

Medicaid claims questions may be directed to HP Enterprise Services at 1-800-688-6696 or 919-851-8888.

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

Attention: Behavioral Health Providers in Durham, Duplin, Lenoir, Sampson, and Wayne Counties**Prior Authorization of Medicaid-Funded Mental Health, Developmental Disabilities, and Substance Abuse Services for Recipients with Eligibility in Durham, Duplin, Lenoir, Sampson, and Wayne Counties**

As of September 20, 2010, Medicaid services for mental health, substance abuse, and developmental disabilities (MH/SA/DD) will be reviewed for prior authorization by The Durham Center and Eastpointe Local Management Entities (LMEs) **for their respective catchment areas only**. All LMEs will continue to authorize State-funded services as is their current practice.

As of September 20, 2010, all providers for recipients with eligibility within The Durham Center's catchment area (Durham County) will be required to submit requests for initial and concurrent authorization for MH/DD/SA services to The Durham Center for prior authorization. All providers for recipients with eligibility within Eastpointe's catchment area (Duplin, Lenoir, Sampson, and Wayne counties) will be required to submit requests for initial and concurrent authorization for mental health, developmental disabilities, and substance abuse services to Eastpointe for prior authorization. This change will only apply to providers delivering services to **recipients with eligibility** in those catchment areas.

Eastpointe and The Durham Center each have an electronic web-based system that will allow for a seamless and very efficient means of requesting authorizations. This system is called "ProviderConnect." It should not be confused with ValueOptions web-based system, which has the same name.

Submission of prior authorization requests to The Durham Center can be done through The Durham Center's LME Provider Connect web-based system or to their dedicated fax number at 919-560-7377. The Durham ProviderConnect system can be accessed via the LME website at <http://www.durhamcenter.org>.

Submission of prior authorization requests to Eastpointe can be done through Eastpointe's LME ProviderConnect web-based system or dedicated fax number at 910-298-7189. The Eastpointe ProviderConnect system can be accessed via the LME website at <http://www.eastpointe.net>.

Trainings on how to use the LME ProviderConnect systems as well as other related prior authorization topics will be conducted during the month of August. If you serve a consumer in one of the counties listed above, please make sure to sign up for the trainings via the LME websites.

- Eastpointe: <http://www.eastpointe.net/providers/trainingcalendar/trainingcalendar.aspx>
- The Durham Center: <http://www.durhamcenter.org/index.php/provider/pcalendar>

During the transition of service authorizations from ValueOptions to the appropriate LME, the goal is to ensure that recipients have no interruption in service. In order for a seamless transition, these guidelines must be followed:

- All active authorizations for all mental health, substance abuse, targeted case management for developmental disabilities (TCM/DD), and Community Alternatives Program (CAP) services as of September 19, 2010, will remain in effect.
- ValueOptions will keep and process all prior authorization requests with an effective date prior to September 19, 2010, and submitted prior to September 19, 2010.
- Effective September 20, 2010, providers for recipients with eligibility in the LME catchment areas should begin sending initial and concurrent requests to the appropriate LME for processing. LMEs can only begin accepting authorization requests received on or after September 20, 2010.

- For any prior authorization request already received by ValueOptions that has an effective service date of service September 20, 2010, or later, that ValueOptions has already received but cannot process by close of business September 19, 2010, ValueOptions will forward the request and all provider-submitted supporting documentation to the appropriate LME (The Durham Center or Eastpointe) and notify the requesting provider.
- The respective LME will determine the date ValueOptions received the prior authorization request (by the ValueOptions date stamp, and this original date of receipt will be honored).
- After September 20, 2010, any request that is received by ValueOptions that should be processed by one of the LMEs will be forwarded to the LME and the provider will be notified.
- Effective September 20, 2010, any retroactive review request for recipients with eligibility in the LME catchment areas must be sent to the appropriate LME. **This includes requests for services provided prior to September 20, 2010.**
- Effective September 20, 2010, all CAP and TCM/DD requests must be sent to the appropriate LME for processing.
- **Special Note for Inpatient Hospitals and Psychiatric Residential Treatment Facilities (PRTFs):** All concurrent inpatient and PRTF requests should continue to be sent to ValueOptions for recipients currently in care as of September 20, 2010, until the patient is discharged.
- Providers should submit requests for “additional units” to ValueOptions for processing if ValueOptions originally approved the initial or concurrent request. In other words, if a recipient with eligibility in the Durham Center or Eastpointe catchment areas needs the authorization of additional units for a request that was authorized by ValueOptions prior to September 20, 2010, that request for additional units should be sent to ValueOptions for processing. It is important that the request be clearly labeled as a request for “additional units” to ensure that it is processed appropriately by ValueOptions in a timely fashion.

All current DMA Clinical Coverage Policy guidelines and prior approval submission requirements will continue to apply. All providers, regardless of catchment area, must continue to use the same forms that are currently being used for prior authorization requests to ValueOptions, including the ITR, PCP, ORF2, and CTCM.

Information about Mediation and Appeals

ValueOptions and the LMEs will be responsible for mediation and appeals of cases that each has reduced or denied. ValueOptions will still be responsible for all mediation and appeals of requests that ValueOptions has reduced or denied, even if the date of the mediation or appeal is after September 20, 2010.

Questions about maintenance of service (MOS) can be directed to the utilization review vendor (ValueOptions, Durham or Eastpointe) who made the reduction or denial decision.

Behavioral Health Unit
DMA, 919-855-4290

ValueOptions
1-888-510-1150

The Durham Center
919-560-7100

Eastpointe LME
1-800-913-6109

Attention: Critical Access Behavioral Health Agencies' Direct-Enrolled Licensed Professionals and Provisionally Licensed Professionals, Outpatient Behavioral Health Service Providers, and Provisionally Licensed Providers Billing "Incident to" a Physician or through a Local Management Entity

Update on New Prior Authorization Guidelines for Behavioral Health Services

As stated in the June 2010 Medicaid Bulletin and DHHS Implementation Updates #73 and #76, effective July 1, 2010, prior authorizations for all outpatient services, with dates of services July 1, 2010, and forward, 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 National Provider Identifier (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. This applies to all direct-enrolled licensed professionals.

Current authorizations for outpatient services remain in effect. This new guidance applies only when a recipient needs new or additional authorization for dates of service July 1, 2010, and forward. As a reminder, prior authorization is only required after the 26 unmanaged visits for children and 8 unmanaged visits for adults.

To ease the transition to the new authorization process, providers will only need to list the "Attending Provider Name/Medicaid #" on the ORF2 form. The "Billing Provider Name/Medicaid #" field is not required through December 31, 2010. ORF2s submitted without the "Attending Provider Name/Medicaid #" will be returned by ValueOptions as "Unable to Process."

If clinically appropriate, providers may submit up to three MPNs on the "Attending Provider" line on the ORF2. This will allow for "reserve" attending therapists for a recipient in addition to the primary attending therapist. Each provider MPN must be separated by a comma. All attending MPNs/providers listed will be authorized for identical service codes, frequencies, and durations if the service request is deemed medically necessary. An ORF2 could have up to three "attending providers" indicated and those MPNs may be for a direct-enrolled professional, a Local Management Entity (LME) (for provisionally licensed), a physician (for "incident to"), and for any combination of these three provider types. No provider names need to be listed on the ORF2 when multiple MPNs are listed.

Provisionally Licensed Professionals Billing through a Local Management Entity

Provisionally licensed professionals who bill through the LME will continue to request prior authorization with the LME's MPN as the "attending provider" and should continue to bill through the LME.

To ease the transition to the new authorization process, providers will only need to list the "Attending Provider Name/Medicaid #" on the ORF2 form. The "Billing Provider Name/Medicaid #" field is not required through December 31, 2010. ORF2s submitted without the "Attending Provider Name/Medicaid #" will be returned by ValueOptions as "Unable to Process."

In this scenario, provisionally licensed providers do not need to list separate MPNs on the ORF2 for "reserve" therapists if all authorization requests are for provisionally licensed professionals billing under the same LME. In this scenario, the LME MPN only needs to be listed once on the "Attending Provider" line of the ORF2. However, if the "reserve" therapist is a direct-enrolled provider or a provisionally licensed therapist is the "reserve" therapist to a direct-enrolled provider, the direct-enrolled provider's MPN **AND** the LME MPN are both included and separated by a comma. An ORF2 could have up to three "attending providers" indicated and those MPNs may be for a direct-enrolled professional, an LME (for provisionally licensed), a physician (for "incident to"), and for any combination of these three provider types. All attending MPNs/providers listed will be authorized for identical service codes, frequencies, and durations if the service request is deemed medically necessary. No provider names need to be listed on the ORF2 when multiple MPNs are listed.

Current authorizations for outpatient services remain in effect. This new guidance applies only when a recipient needs new or additional authorization for dates of service July 1, 2010, and forward. As a reminder, prior authorization is only required after the 26 unmanaged visits for children and 8 unmanaged visits for adults.

Provisionally Licensed Professionals Billing “Incident to” a Physician

Provisionally licensed professionals who bill "incident to" a physician should request prior authorization with the MPN of the individual physician as the "attending provider." This individual physician MPN is the individual physician that the provisionally licensed professional practices "incident to."

To ease the transition to the new authorization process, providers will only need to list the "Attending Provider Name/Medicaid #" on the ORF2 form. The "Billing Provider Name/Medicaid #" field is not required through December 31, 2010. ORF2s submitted without the “Attending Provider Name/Medicaid #” will be returned by ValueOptions as “Unable to Process.”

Current authorizations for outpatient services remain in effect. This new guidance applies only when a recipient needs new or additional authorization for dates of service July 1, 2010, and forward. As a reminder, prior authorization is only required after the 26 unmanaged visits for children and 8 unmanaged visits for adults.

In this scenario, provisionally licensed providers do not need to list separate MPNs on the ORF2 for “reserve” therapists if all authorization requests are for provisionally licensed professionals billing “incident to” the same physician. In this scenario, the physician’s MPN only needs to be listed once on the “Attending Provider” line of the ORF2. However, if the “reserve” therapist is a direct-enrolled provider or a provisionally licensed therapist is the “reserve” therapist to a direct-enrolled provider, the direct-enrolled provider’s MPN **AND** the MPN of the individual physician are both included and separated by a comma. An ORF2 may have up to three “attending providers” indicated and those MPNs may be for a direct-enrolled professional, an LME (for provisionally licensed), a physician (for “incident to”), and for any combination of these three provider types. All attending MPNs/providers listed will be authorized for identical service codes, frequencies, and durations if the service request is deemed medically necessary. No provider names need to be listed on the ORF2 when multiple MPNs are listed.

Please see all "incident to" guidelines in the March 2009 Medicaid Bulletin.

Outpatient Services Provided in a Critical Access Behavioral Health Agency by Direct-Enrolled Providers

Prior authorizations for all outpatient services, with dates of services July 1, 2010, and forward, will be created for the "Attending Provider Name/Medicaid #" on the ORF2 form. Providers must enter the attending 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. This applies to all direct-enrolled licensed professionals.

If clinically appropriate, providers may submit up to three MPNs on the “Attending Provider” line on the ORF2 for “reserve” attending therapists for a recipient in addition to the primary attending therapist. Each provider MPN must be separated by a comma. All MPNs/providers will be authorized identical service codes, frequencies, and durations if the service request is deemed medically necessary. An ORF2 could have up to three “attending providers” indicated and those MPNs may be for a direct-enrolled professional, an LME (for provisionally licensed), a physician (for “incident to”), and for any combination of these three provider types. No provider names need to be listed on the ORF2 when multiple MPNs are listed.

All current authorizations for outpatient services provided under a CABHA will remain in effect. This new guidance applies only when a recipient needs new or additional authorization for dates of service July 1, 2010, and forward.

To ease the transition to the new authorization process, providers will only need to list the "Attending Provider Name/Medicaid #" on the ORF2 form. The "Billing Provider Name/Medicaid #" field is not required through December 31, 2010. ORF2s submitted without the "Attending Provider Name/Medicaid #" will be returned by ValueOptions as "Unable to Process." Authorizations will not be made to the CABHA MPN.

As a reminder, prior authorization is only required after the 26 unmanaged visits for children and 8 unmanaged visits for adults.

Provisionally Licensed Providers under a CABHA

Provisionally licensed providers providing services under a CABHA may bill "incident to" a physician in the CABHA or through the LME. All current authorizations for outpatient services provided by provisionally licensed providers under a CABHA will remain in effect.

Provisionally licensed professionals who bill through the LME will continue to request prior authorization with the LME's MPN as the "attending provider" and should continue to bill through the LME. In this scenario, provisionally licensed providers do not need to list separate MPNs on the ORF2 for "reserve" therapists if all authorization requests are for provisionally licensed professionals billing under the same LME. In this scenario, the LME MPN only needs to be listed once on the "Attending Provider" line of the ORF2. However, if the "reserve" therapist is a direct-enrolled provider or a provisionally licensed therapist is the "reserve" therapist to a direct-enrolled provider, the direct-enrolled provider's MPN **AND** the LME's MPN are both included and separated by a comma. An ORF2 could have up to three "attending providers" indicated and those MPNs may be for a direct-enrolled professional, an LME (for provisionally licensed), a physician (for "incident to"), and for any combination of these three provider types. All attending MPNs/providers listed will be authorized for identical service codes, frequencies, and durations if the service request is deemed medically necessary. No provider names need to be listed on the ORF2 when multiple MPNs are listed.

Provisionally licensed professionals who bill "incident to" a physician in a CABHA should request prior authorization with the MPN of the individual physician as the "attending provider." This individual physician MPN is an individual physician in the CABHA practice that the provisionally licensed professional practices "incident to." In this scenario, provisionally licensed providers do not need to list separate MPNs on the ORF2 for "reserve" therapists if all authorization requests are for provisionally licensed professionals billing "incident to" the same physician. In this scenario, the physician's MPN only needs to be listed once on the "Attending Provider" line of the ORF2. However, if the "reserve" therapist is a direct-enrolled provider or a provisionally licensed therapist is the "reserve" therapist to a direct-enrolled provider, the direct-enrolled provider's MPN **AND** the MPN of the individual physician are both included and separated by a comma. An ORF2 could have up to three "attending providers" indicated and those MPNs may be for a direct-enrolled professional, an LME (for provisionally licensed), a physician (for "incident to") and for any combination of these three provider types. All MPNs/providers will be authorized identical service codes, frequencies, and durations if the service request is deemed medically necessary. No provider names need to be listed on the ORF2 when multiple MPNs are listed.

To ease the transition to the new authorization process, providers will only need to list the "Attending Provider Name/Medicaid #" on the ORF2 form. The "Billing Provider Name/Medicaid #" field is not required through December 31, 2010. ORF2s submitted without the "Attending Provider Name/Medicaid #" will be returned by ValueOptions as "Unable to Process."

Authorizations will not be made to the CABHA MPN.

As a reminder, prior authorization is only required after the 26 unmanaged visits for children and 8 unmanaged visits for adults.

Behavioral Health Unit
DMA, 919-855-4290

Attention: Critical Access Behavioral Health Agencies

Enrollment/Authorization/Billing Seminars for Critical Access Behavioral Health Agencies

Enrollment/Authorization/Billing seminars for Critical Access Behavioral Health Agencies (CABHAs) are scheduled for August 2010 at the sites listed below. Information presented at the seminars is applicable to all providers who have been certified as CABHAs or are in the process of certification.

Materials will be provided at the training though you are encouraged to review DHHS Implementation Updates #73, Special #75, #76, and #77 in preparation.

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

Providers may register for the seminars by completing and submitting the online registration form (<http://www.ncdhhs.gov/dma/provider/seminars.htm>) or providers may register by fax using the form below (fax it to the number listed on the form). Please indicate the session you plan to attend on the registration form.

Sessions will begin at 9:00 a.m. and end at 12:00 noon. Providers are encouraged to arrive by 8:45 a.m. to complete registration. Lunch will not be provided at the seminars. **Because meeting room temperatures vary, dressing in layers is strongly advised.**

Seminar Dates and Locations

Date	Location
August 17, 2010	Eastern Region Southeastern Regional LME 450 Country Club Road Lumberton NC 28360
August 24, 2010	Western Region Pathways LME 901 South New Hope Road Gastonia NC 28054
August 31, 2010	Central Region Wake Commons Conference Room 100A 4011 Cary Drive Raleigh NC 27610

In addition, on-site provider visits will be provided by HP Enterprise Services upon request.

Medicaid enrollment (<http://www.nctracks.nc.gov/provider/providerEnrollment/>) questions may be directed to CSC at 1-866-844-1113.

Authorization questions may be directed to ValueOptions (http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm):

- 1-888-510-1151 – Medicaid
- 1-800-753-3224 – Health Choice

Medicaid claims questions may be directed to HP Enterprise Services at 1-800-688-6696 or 919-851-8888.

HP Enterprise Services

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

**CABHA Enrollment/Authorization/Billing Workshops
August 2010 Seminar Registration Form
(No Fee)**

Provider Name _____

Medicaid Provider Number _____ NPI Number _____

Mailing Address _____

City, Zip Code _____ County _____

Contact Person _____ E-mail _____

Telephone Number (_____) _____ Fax Number _____

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

**Please fax completed form to: 919-851-4014
Please mail completed form to:
HP Provider Services
P.O. Box 300009
Raleigh, NC 27622**

Attention: Obstetrical Providers, Physicians, and Radiology Services

***P*roposed Obstetrical Ultrasound Requirements**

Proposed obstetrical ultrasound requirements for Medicaid providers are available for review and comment on DMA’s website at <http://www.ncdhhs.gov/dma/mpproposed/>. To submit a comment related to these requirements, 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

**Diana Holder, RN
DMA, 910-355-1883**

Attention: Nursing Facility Providers**Minimum Data Set 3.0 Validation Program Seminars**

Myers and Stauffer LC, under contract with DMA, have scheduled seminars across the state beginning August 2010 for the Minimum Data Set (MDS) Validation Program. Information presented at the seminars is applicable to all nursing facility providers completing the MDS 3.0 and will include important updates to the RUG-III classification model as it relates to the MDS 3.0, Activities of Daily Living (ADL) calculation, the Supportive Documentation Guidelines, the review process, and other case mix updates. Myers and Stauffer will provide MDS 3.0 training documents as it applies to the MDS Validation Program in preparation for the October 1, 2010 transition from MDS 2.0 to 3.0. **This seminar will not include MDS 3.0 coding instruction.**

How to Register: To register online go to <http://nc.mslc.com> and click on “Seminars” or complete the registration form provided. The deadline for receiving mailed registration is five days prior to the seminar date. Due to limited seating, registration will be accepted on a first-come, first-served basis. Providers are encouraged to register early. If you require assistance or need to make any changes to your registration, please contact the Myers and Stauffer office at 317-815-2959.

Registration begins at 8:00 a.m. The seminar begins promptly at 8:30 a.m. and will conclude by 4:00 p.m. Lunch will not be provided at the seminars. Morning and afternoon beverages will be provided. **Because meeting room temperatures vary, dressing in layers is strongly advised.**

Seminar Dates and Locations

Date	Location
August 23 and 24, 2010 Two separate sessions Register for only one	Asheville Crowne Plaza Resort One Resort Drive Asheville NC 28806
August 25 and 26, 2010 Two separate sessions Register for only one	Charlotte Marriott Charlotte Executive Park 5700 Westpark Drive Charlotte NC 28217
August 27, 2010	Winston-Salem Clarion Collection Hotel Sundance Plaza 3050 University Parkway Winston-Salem NC 27105
August 30, 2010	Raleigh Hilton North Raleigh 3415 Wake Forest Road Raleigh NC 27609
August 31, 2010	Greenville Hilton Greenville 207 SW Greenville Boulevard Greenville NC 27834

Date	Location
September 1, 2010	Fayetteville Doubletree Hotel 1965 Cedar Creek Road Fayetteville NC 28312

Myers and Stauffer, LC
317-815-2959

MDS 3.0 Validation Program Training
“BECOME THE EXPERT”
MDS 3.0 Overview, RUG-III Update and Case Mix
 Registration is also available on-line at <http://nc.mslc.com> – Click on “Seminars”
 (One registration per form, please. Copy form for additional registration)

Please Print

Name: _____ Title: _____

Facility/Company Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ Email: _____

Will you need Continuing Education Hours for: Nursing Administrators None Needed

If Nursing, enter the state abbreviation: _____ License #: _____ RN LPN

If Administrator, enter the state abbreviation: _____ License #: _____

Please check the date you would like to attend:

- Asheville (August 23) Asheville (August 24) Charlotte (August 25)
- Charlotte (August 26) Winston-Salem (August 27) Raleigh (August 30)
- Greenville (August 31) Fayetteville (September 1)

MAIL REGISTRATION FORM TO:
Myers and Stauffer LC,
Attn: North Carolina Training
9265 Counselors Row, Suite 200
Indianapolis, IN 46240-6419

Attention: All Providers***E*limination of Coverage for Bariatric Surgery**

Due to legislative changes, the N.C. Medicaid Program will no longer cover surgical procedures for clinically severe obesity. Clinical Coverage Policy 1A-15, *Surgery for Clinically Severe Obesity*, will be end-dated effective October 1, 2010. The following codes will become non-covered services. Recipients who met with their surgeon and began participating in the surgeon's surgical preparatory regimen prior to July 1, 2010, may be allowed to complete their program if the following conditions are met:

1. the request for prior approval must be submitted and **approved** prior to November 30, 2010.
2. the surgery must be completed prior to December 31, 2010.

Providers are responsible for notifying recipients enrolled in their surgical preparatory regimen after July 1, 2010, that Medicaid no longer covers surgery for clinically severe obesity. Providers who received payment from the recipient for parts of the regimen that are not covered by Medicaid must refund the payment to the recipient if the service has not yet been provided.

CPT Procedure Code	Description
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and roux-en-Y gastroenterostomy (roux limb 150 cm or less)
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption
43659	Unlisted laparoscopy procedure, stomach
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (e.g., gastric band and subcutaneous port components)
43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only
43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty
43845	Gastric restrictive procedure, with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)
43846	Gastric restrictive procedure, with gastric bypass, for morbid obesity; with short limb (150 cm or less) roux-en-Y gastroenterostomy
43847	Gastric restrictive procedure, with gastric bypass, for morbid obesity; with small intestine reconstruction to limit absorption
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)
43999	Unlisted procedure, stomach

HP Enterprise Services
1-800-688-6696 or 919-855-8888

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Proposed Clinical Coverage Policies

In accordance with NCGS §108A-54.2, proposed new or amended Medicaid clinical coverage policies are available for review and comment on DMA's website at <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
August	8/5/10	8/10/10
	8/12/10	8/17/10
	8/19/10	8/26/10
September	9/2/10	9/8/10
	9/9/10	9/14/10
	9/16/10	9/23/10

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.

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

Melissa Robinson
Executive Director
HP Enterprise Services
