
Outpatient Behavioral Health: Overview of Clinical Coverage Policy 8C

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Division of Medical Assistance, Behavioral
Health Section

Clinical Policies and Programs

November 2011

There's a policy?

- Yes.
- <http://www.ncdhhs.gov/dma/mp/index.htm> -- Behavioral Health Policies are in Section 8, Outpatient is policy 8C
- This presentation should NOT take the place of reading the complete policy.
- How do I know if there are changes?
 - Monthly Medicaid Bulletins:
<http://www.ncdhhs.gov/dma/bulletin/index.htm>
- **STAY INFORMED!**

Change is coming . . .

- Changes to the policy are set to be implemented January 1, 2012.
- The proposed changes went to the Physician's Advisory Group (PAG) on June 28, 2011
- Proposed changes were posted for public comment in August.
- Comments were reviewed by DMA/DMHDDSAS Clinical Policy Workgroup
- Changes were made to the policy based on internal and external comments.
- Policy was/will be reposted for public comment

Services included in Policy 8C

- Outpatient therapy – individual, family, group
- Assessment – comprehensive clinical, psychological, psychiatric evaluation
- Medication Management

Enrollment – general

- To enroll as an Independent Outpatient Behavioral Health Provider – fill out the Individual, In-State/Border Application found at NC Tracks <http://www.nctracks.nc.gov/>
- To enroll as an Outpatient Behavioral Health Group – fill out the Organization In-State/ Border Application found at NC Tracks <http://www.nctracks.nc.gov/>
 - Must have at least one individual enrolled in order to obtain a group number
 - Individuals must be enrolled in a group in order to bill
- See pages 18 through 23 of the *Provider Qualifications and Requirements Checklist* –
<http://www.ncdhhs.gov/dma/provenroll/index.htm>

Enrollment – CABHAs

- To enroll as an Independent Outpatient Behavioral Health Provider – fill out the Individual, In-State/Border Application found at NC Tracks <http://www.nctracks.nc.gov/>
- To add or delete individuals who will be providing outpatient BH services to your CABHA, submit a provider change form (found at the website above) and an Electronic Claim Submission (ECS) Agreement

Service Limitations – in compliance with National Correct Coding Initiative (NCCI) and budget reduction

- Don't reimburse for same services billed twice in one day -- no matter if the attending provider is the same or different
- Only one code allowed per recipient *per attending* per date of service
- Only two codes allowed per recipient per date of service (must be different attending providers)
- Family therapy must only be billed once for the identified family member. Cannot bill for every family member.

Service Limitations – in compliance with NCCI and budget reduction

- Per federal regulations, licensed professionals must be direct-enrolled with Medicaid and must obtain authorizations and bill with their OWN number.
- Allowing anyone else to use the licensed professionals number is considered *fraud*.
- Only provide treatment within scope of training and expertise.
- Service must be rehabilitative – Medicaid will recoup if billing for recreational activities, transportation, etc.

Referral

- **Recipients under 21**
 - Must have a referral by a Community Care of North Carolina/Carolina Access (CCNC/CA) primary care provider, the local management entity, or a Medicaid-enrolled psychiatrist
 - Documentation of this referral must be in the medical record and must include the name and NPI of the individual/agency making the referral
 - What' s the purpose of this referral?
 - First step in coordination of Care
 - Integrated Care for the whole person

Referral continued . . .

- **Recipients 21 and over**
 - Referral is not necessary, but is still encouraged as we move towards health homes and increased integrated care
 - If the recipient is not self-referred, documentation of the referral must be in the medical record

Coordination of Care

- **Providers responsible for coordinating care and documenting said coordination**
 - Must coordinate with the following (if applicable): other behavioral health provider, CCNC/CA or other primary care physician, physician who is providing Incident To oversight, and the Local Management Entity / Managed Care Organization (LME/MCO).
 - Activities may include progress or summary reports, telephone communication, treatment planning processes, etc.

Medical Necessity

- Providers want a clear cut definition but this does not exist.
- Medical necessity is individual but some generally accepted components are:
 - Intended to prevent, diagnosis, correct, cure, alleviate, or preclude deterioration of a diagnosable condition that threatens life, causes pain or suffering, or results in illness or infirmity
 - Treatment is expected to improve the condition or level of functions in relationship to the presenting diagnosis

Medical Necessity

- Essential and consistent with nationally acceptable standard of practices
- Reflective of a level of service that is safe, where not equally effective, more conservative, and less costly treatment is available
- Not primarily intended for the convenience of the person, family, caretaker or provider. Is not based upon availability of provider.
- Empathy does not equal medical necessity
- Is individualized, specific and consistent with the symptoms and diagnosis
- Is not in excess of the person's needs

Comprehensive Clinical Assessments (CCAs)

- Required when individuals present for services – can be new CCA or can be update to recent CCA from another clinician
- If no CCA, how can you determine the needs of the recipient, the most effective treatment, and whether they meet medical necessity?
- Demonstrates medical necessity and is the basis of the Treatment Plan or PCP

CCA elements

- **No prescribed format but must include, at a MINIMUM, the following elements (refer to IU 36 and newly posted policy for further detail):**
 - General health and behavioral health history
 - Biological, psychological, familial, social, developmental and environmental dimensions and strengths, weaknesses, risks, and protective factors in each area
 - Description of presenting problem
 - Risk of harm, functional status, treatment history, recovery environment

CCA elements (cont.)

- Evidence of consumer and legally responsible person (if applicable) involvement in assessment
- Analysis and interpretation of assessment info
- Diagnoses on all five axes of DSM-IV and recommendations for additional assessments, services, support, etc.

Psychological Testing

- Administration of standardized test to assess an individual's psychological or cognitive functioning to assist with:
 - diagnosing difficult cases
 - offer medically necessary information pertaining to a recipient's emotional, behavioral, or cognitive functioning
 - offer diagnostic and treatment recommendations in cases where the recipient has not responded to standard treatment
- Shall only be performed by Licensed Psychologists and Licensed Psychological Associates
- Culturally and linguistically competent

Psychological Testing

- Psychological testing is not covered:
 - for the purpose of educational testing (provided by the school per federal mandate PL 94-142)
 - when requested by the school or legal system unless medical necessity exists
 - if the proposed psychological testing measures have no standardized norms or documented validity

Psychological Testing

Psychological Testing Pitfalls

- **Not familiar with submission of authorization requests**
- **Failure to document clinical justification for medical necessity**
- **Exceeding maximum testing hours identified by the designers of testing instruments**
- **Billing for psychological testing on dates of service where the recipient was not seen (for example billing for write-up separately).**
- **Utilization of psychological testing codes for more general assessment that should be billed using assessment or individual therapy codes.**

Psychological Testing Limits

- Each psychological testing code billed, counts towards unmanaged visit limits
- Prior authorization is required for psychological testing after the unmanaged visit limit
- Psychological testing limited to a maximum of five units (hours) of testing per date of service
- Psychological testing must be medically necessary

Providers eligible to direct-enroll and bill Medicaid

- Licensed Physicians
- Licensed psychologists (doctorate level)
- Licensed psychological associates (LPA)
- Licensed professional counselors (LPC)
- Licensed marriage and family therapists (LMFT)
- Licensed clinical social workers (LCSW)
- Nurse Practitioners -- advanced practice nurse practitioners certified in psychiatric nursing or under the sunset clause
- Clinical nurse specialists -- advanced practice psychiatric clinical nurse specialist (CNS)
- Certified clinical supervisors (CCS) under a sunset clause, requires licensure by July 1, 2016
- Licensed Clinical Addiction Specialists (LCAS)

Incident To – Policy Highlights

- Became available to provisionally licensed professionals in 2008
- Definitive guidelines have been available in the March 2009 Medicaid Bulletin – this language will be incorporated into revised policy
- Provisionally licensed professionals are not permitted to bill “Incident To” any other provider except a physician

Incident To Policy Highlights – Make sure to read the complete guidelines!

- Service intended to be primarily office-based; however if clinically indicated, and agreed upon by both the clinical supervisor and the supervising physician, the provisionally licensed professional may provide services in locations outside of the office
- Overarching supervision by the physician does not replace the supervision requirements of the respective licensing board
- The physician must have a face-to-face with the recipient on or before the first visit to confirm medical necessity and the appropriateness of the clinician assigned
- The physician must be readily available at all times (by phone and able to return to the office if the patient's condition requires it)

Records and Documentation

- **Individualized Plan**

- Based on the assessment
- Developed in partnership with the recipient or legally responsible person (if applicable) or both
- Should include
 - Outcomes
 - Strategies
 - Staff responsible
 - Schedule for regular review of the plan
 - Written consent or agreement by the individual or legally responsible person

Records and Documentation continued

- **Service notes and progress notes**
 - Must be a note for each treatment encounter
 - Must include:
 - Purpose of the contact (tied to specific goals)
 - Description of the treatment or interventions performed
 - Effectiveness and/or progress towards goals
 - Duration of service
 - Signature and credentials of clinician who provided the service (can be handwritten or see guidelines for electronic signatures in September Medicaid Bulletin)
- **Records Management and Documentation Manual:**
<http://www.ncdhhs.gov/mhddsas/statpublications/manualsforms/rmd09/rmdmanual-final.pdf>

Service Access – 24 Hour Coverage

- Enrolled providers shall provide, or have a written agreement with another entity, for access to 24-hour coverage for emergency services.
- Enrolled providers shall arrange for coverage in the event that he or she is not available to respond to a recipient in crisis.

Expected Clinical Outcomes

- Must relate to identified goals in the treatment plan
- Can be classified into a variety of categories – health, functioning, recipient satisfaction
- Should reflect changes in symptoms and behaviors that promote increased functioning
- See policy for National Outcome Measures developed by the Substance Abuse and Mental Health Services Administration (SAMHSA)

Best Practice/Evidence Based Practice

- Providers expected to offer a medically necessary outpatient services consistent with best practice models.
- Interventions based on North Carolina community practice standards as determined by an approved Medicaid utilization review vendor.
- Providers expected to offer evidence-based treatment that is expected to produce positive outcomes for the population being treated.
- Providers expected to have completed training in the evidence-based treatment model(s) being utilized.
- Outpatient behavioral health services should be culturally and linguistically competent.

Codes

- Elimination of H Codes for fully licensed professionals
- Limits on H Codes for provisionally licensed professionals billing through the LME (per November 2011 Bulletin)
 - For individual and family therapy – can bill up to 4 units
 - (Codes H0004, H0004HR, H0004HS)
 - For group therapy – can bill up to 6 units
 - (Codes H0004HQ, H0005)
 - For assessment – can bill up to 8 units
 - (Codes H0001, H0031)

Codes Continued

- Difference between 90801 and 90802
 - 90801 is standard assessment
 - 90802 is for assessment of those who are nonverbal
- If you don't have one, get the most current CPT manual! Just referencing the fee schedule is not enough!

The future of behavioral health services in North Carolina – Managed Care Organizations (MCOs)

- Information on managed care (1915 b/c waiver) expansion:
<http://www.ncdhhs.gov/dma/lme/MHWaiver.htm>
 - The LMEs who become MCOs will be operating “mini-Medicaid” programs which include enrolling/credentialing behavioral health providers (the application for each MCO will be the same state-wide), performing prior authorization/UR functions, processing claims, etc.
 - Each MCO is required to offer a one-year contract to all behavioral health providers in their area. After the first year, they have the option to renew contracts based on the needs in their area.
-

The future of behavioral health services in North Carolina – Managed Care Organizations (MCOs)

- MCOs will be looking to contract with providers who use evidence-based treatments and who see improved outcomes for their consumers.
- Strongly encourage you to get to know your future MCOs and to make them aware of the skills and expertise that you bring to the table. (needs of network)

Further policy questions or concerns?

- Contact the DMA Behavioral Health Section – (919) 855-4290
- Questions specific to MCOs – contact Kathy Nichols at katherine.nichols@dhhs.nc.gov

Program Integrity Corporate Compliance Planning

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Chief, Behavioral Health Review Section

Program Integrity
November 2011

PROGRAM INTEGRITY

AUTHORITY:

42 CFR 455 and 456 (Program Integrity & Utilization Control)

NC GS 108A – 70.10 thru 70.17 (False Claims)

NC Medicaid State Plan

10A NCAC 27G (MH/DD/SAS Services)

10A NCAC 22F (Program Integrity)

10A NCAC 22P (CABHA)

Program Integrity

Mission Statement

It is the mission of Program Integrity to *ensure compliance, efficiency, and accountability within the N.C. Medicaid Program by detecting and preventing fraud, waste, program abuse, and by ensuring that Medicaid dollars are paid appropriately by implementing tort recoveries, pursuing recoupment, and identifying avenues for cost avoidance.*

Program Integrity

Governor's Initiatives to address Medicaid fraud and abuse:

- Signed Senate Bill 695, Medicaid Anti-Kickback law
- Increased technology to detect and prevent Medicaid fraud and abuse
- Allocated staff to increase on-site investigations
- Campaigned to encourage the public and providers to report suspected Medicaid fraud and abuse
- Increased staff in the Prosecution Unit of AGO to handle Medicaid fraud and abuse cases

Program Integrity

- Medicaid behavioral Health services are provided to recipients in all 100 North Carolina counties.
- The Division of Medical Assistance has approximately 74,000 providers
- The Current number of eligible Medicaid recipients is 1.4 million and HealthChoice is approximately 130,000 recipients.
- Over 9,000 behavioral Health Providers

Program Integrity

- BHRS staff performs post-payment administrative and clinical reviews of behavioral health provider claims and services to determine if the services were medically necessary /clinically appropriate and verify behavioral health providers' compliance with Medicaid coverage policies and Provider Participation Agreements.
- Behavioral health provider reviews are conducted at on-site and off-site locations.

PROGRAM INTEGRITY

Post payment Reviews

- Reporting and Analytics Software (FAMS/FADS)
- Complaints & referrals
- Desk review /On-site review
 - Cooperate with investigations and audits (NC GS 108C-11, SB496)
- Sampling & Extrapolation methodology
- Administrative Action/Sanction
- Appeals process (DHHS, OAH, Superior Court)

Program Integrity

Prepayment Review

- Remedial measure to correct errors/problems
- Documentation Review
- No appeal process
- Approve / deny claim
- 70% clean claims over a consecutive 3 months
 - If 70% or greater clean claims, remove from prepayment
 - If less than 70% clean claim, sanction is rendered

Program Integrity

Vendors:

- Public Consulting Group (post-payment)
- The Carolinas Center for Medical Excellence (post-payment and prepayment reviews)

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Quality of Care Concerns/Issues

- Recipients/family members/providers/UR Vendors/Media
- Phone calls
- Records requests/documentation review
- Administrative Action
- Extended investigation/review

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Public Concern

- Fraud and abuse takes money from needy children, the elderly, blind, and disabled. Therefore, identifying, investigating, preventing and recovering money billed improperly to Medicaid is an important mission for this agency
- Cost taxpayers millions of dollars

Program Integrity

Public Concern

The majority of providers and their billings are honest and accurate. However, one dishonest provider can take thousands of dollars slowly over time by billing for services not rendered or medically unnecessary.



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Provider Abuse

10A NCAC 22F .0301

Provider abuse includes any incidents, services, or practices inconsistent with accepted fiscal or medical practices which cause financial loss to the Medicaid program or its beneficiaries, or which are not reasonable or which are not necessary

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Provider Fraud

Individual participating or non-participating providers who deliberately submit claims for services not actually rendered, or bill for higher-priced services than those actually provided.

Providers submission of claims for payment for which there is no supporting documentation available.

Program Integrity

CONFIDENTIALITY

10A NCAC 22F .0106

All investigations by the North Carolina Division of Medical Assistance concerning allegations of provider fraud, abuse, over-utilization, or inadequate quality of care shall be confidential, and the information contained in the files of such investigations shall be confidential...

Program Integrity

Trends in Behavioral Health:

- Overutilization of behavioral health services.
- Billing for care and services that are provided by an unauthorized, unqualified, or unlicensed person.
- Limiting access to services
- Denying access to services

Program Integrity

Trends in Behavioral Health:

- Diagnosis does not correspond to treatment rendered
- Failure to provide and maintain:
 - proper quality of care,
 - appropriate care and services, or
 - medically necessary care and services.
- Breach of the terms and conditions of participation agreements, or a failure to comply with requirements of certification, or failure to comply with the provisions of the claim form.

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Trends in Behavioral Health:

- Abandoning clinical/medical records
- Providers closing business without proper notification
- Providers failing to transition recipients
- Improper changes in dates on documentation
- Failure to submit documentation when requested

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Trends in Behavioral Health:

- Altered signatures on documentation
- “Canned Notes”
- Double billing
- Excessive use of CPT or H Codes
- Billing for services not rendered
- Billing for excessive recipients per workday
- Excessive billing beyond a 24 hour period

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Trends in Behavioral Health:

- Failure to provide supervision of staff when required
- Failure to obtain criminal disclosure or obtain criminal background checks
- Recipients obtaining gifts for services or use of MID number
- Recipients ineligible for NC Medicaid-handled by QA of PI

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False Claims Act 31 U.S.C. §§3729-3733

Imposes liability for person or entity who:

- Knowingly files a false or fraudulent claim for payments to Medicare, Medicaid, or other federally funded health care program.
- Knowingly uses false record or statement to obtain payment on a false or fraudulent claim from Medicare, Medicaid or other federally health care program; or
- Conspires to defraud Medicare, Medicaid or other federally funded health care

Program Integrity

False Claims

Under this Act, 31 U.S.C. Chapter 8, §3801, any person who makes, presents or submits a claim that is false or fraudulent is subject to a civil penalty of not more than \$5,000 for each claim and also an assessment of not more than twice the amount of the claim.

Program Integrity

False Claims Act

Medical Assistance Provider False Claims Act (MAPFC) of 1997 makes it unlawful for any Medicaid provider to knowingly make or cause to be made a false claim for payment. Under MAPFC “knowingly” means that a provider:

- Has actual knowledge of the information
- Acts in deliberate ignorance of the truth or falsity of the information; or
- Acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

PROGRAM INTEGRITY

Assessment of Categorical risk level-High
(NC GS 108C/Session Law 2011-399 -3 & 42 CFR 455)

Corporate Compliance Plan

QA & QI Program

Self-Audit

Self-reporting

Program Integrity

Respond to an Investigation

- DMA or CMS may initiate an investigation. The investigation determines compliance with all regulations in implementing the State's agreement with CMS.
- May be planned or unannounced
- Agency-wide or a specific provider site
- Cooperate with Reviewers and Investigators
- Interviews, observations, and review provider records; medical/clinical, financial, and personnel
- Provider's Participation Agreement
- Electronic Claims Submission Agreement

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Respond to an Investigation

- Findings of an investigation may be referred to the Attorney General's Office
- The State's AG's office and the US Attorney's Office has the authority to investigate and prosecute potential Medicaid fraud as contained in the Federal False Claim Act, Federal Civil Monetary Penalty Law and Medical Assistance Provider False Claims Act (State criminal and civil law).
- The lack of knowledge is not a defense for fraud.

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Sanctions & Remedial Measures

- Termination of provider's participation
- Withholding Payments
- Recoup overpayments
- Warning Letters
- Suspension of a provider for a period of time
- Probation
- Prepayment Claims Review
- Provider Lock-out

Program Integrity

Credible Allegation of Fraud

42 CFR 455 –

New Federal Rules, March 25, 2011

**Credible Allegations of Fraud –
Suspension of Medicaid payments**

<http://charlotte.news14.com/content/648431/federal-documents-spell-out-2-cases-of-medicaid-fraud>

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Fraud and Abuse Reporting (Provider):

- Contact the Division of Medical Assistance by calling the DHHS Customer Service Center at 1-800-662-7030 (English or Spanish) or;
- Call the Medicaid fraud, waste and program abuse tip-line at 1-877-DMA-TIP1 (1-877-362-8471); or
- Call the Health Care Financing Administration Office of Inspector General's Fraud Line at 1-800-HHS-TIPS; or
- Call the State Auditor's Waste Line: 1-800-730-TIPS; or
- Complete and submit a Medicaid fraud and abuse confidential online complaint form at:
<http://www.ncdhhs.gov/dma/fraud/reportfraudform.htm>

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Fraud and Abuse Reporting (Recipient):

- Call your [County Department of Social Services \(DSS\)](#) office; or
- Contact the Division of Medical Assistance by calling the [DHHS Customer Service Center](#) at 1-800-662-7030 (English or Spanish) or;
- Call the [Medicaid fraud, waste and program abuse tip-line](#) at 1-877-DMA-TIP1 (1-877-362-8471); or
- [Complete and submit a Medicaid fraud and abuse confidential online complaint form](#) at:
<http://www.ncdhhs.gov/dma/fraud/reportfraudform.htm>

NC Department of Health and Human Services

Division of **Medical Assistance**



QUESTIONS or COMMENTS

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The Medicaid Authorization Process

Presented By:

ValueOptions

The Durham Center

Eastpointe

Behavioral Health Medicaid Vendors for Clinical Coverage Policy 8C

- DMA currently contracts with 3 vendors for Medicaid Utilization Review
 - The Durham Center (Covers Durham County)
 - Eastpointe (Covers Medicaid Consumers from Duplin, Sampson, Lenoir, and Wayne Counties)
 - ValueOptions (Covers all the other counties not previously mentioned)

Note-PBH is a waiver site and the counties covered within their area are covered within their waiver and would not submit to any of the vendors above. (Cabarrus, Davidson, Rowan, Stanly, Union and now Alamance and Caswell also)

When is Prior Authorization required?

- Outpatient services have “unmanaged” visits that do not require prior authorization.
 - Adults- 8 unmanaged visits
 - Children (under 21)- 16 unmanaged visits
- If services are needed beyond the unmanaged visits, Prior Authorization (PA) must be obtained before the 9th visit for adults and before the 17th visit for children
- If unsure about the # of unmanaged visits remaining, get PA!



Service Orders

- Visits beyond 8 for adults and 16 for children per calendar year require a written order by a medical doctor, licensed psychologist (doctorate level), nurse practitioner or physician assistant and prior approval from the utilization review contractor. Prior authorization requests should be submitted prior to the 9th/17th visit. A new written order is required within 12 months of the initial visit and at least annually thereafter.

How do I submit a request?

- You must complete the ORF 2 Form for outpatient service requests.
- All submissions must be submitted electronically effective 10/1/11 per Appropriations Act of 2011- House Bill 200.
- Supporting documentation must also be submitted electronically.

Electronic Submissions



- Links for Electronic Submissions:
 - ValueOptions: <https://www.valueoptions.com/pc/eProvider/providerLogin.do>
 - Eastpointe: <https://carelink.carenetasp.com/EastpointePC/>
 - Durham Center: <https://carelink.carenetasp.com/DurhamPC/>

Electronic System Training:

- ValueOptions: Scroll to the bottom of the page to Provider Training Opportunities
http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm
- Durham Center: Scroll to the Provider Connect Section
<http://www.durhamcenter.org/index.php/provider/docs/service>
- Eastpointe: Scroll to the bottom of the page to Webinars
<http://www.eastpointe.net/providers/MedicaidUR/mur.asp>
[X](#)

Numbers needed for Prior Authorization Requests

- **Attending Provider Number-** This is the Medicaid Provider Number (MPN) of the directly enrolled clinician who will be rendering the service.
 - *You can have up to 3 attending numbers per service request at the time of the request.*
 - *Any changes in provider numbers associated with an approved authorization would require the provider to follow the provider number transfer process and not the authorization process.*
- **Billing Provider-** This is the number that you will be billing under. If you work for a CABHA or an outpatient group provider this would be the CABHA MPN or the group MPN.

Numbers Needed, Continued . . .

- **Provisionally licensed professionals**
 - Providing services ‘incident to’ the physician – authorization will be made to the physician’s MPN
 - Providing services through the LME – authorization is made to the LME’s provider number

Note: When billing, the NPI on the attending line of the claim must match up with the MPN that received the Prior Authorization.

Psychological Testing



- Psychological Testing requests require a psychological testing form to be submitted with the ORF 2 form.
 - ValueOptions:
http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm
 - Durham Center:
http://www.durhamcenter.org/index.php/provider/ur_resources/outpatient_behavioral
 - Eastpointe:
<http://www.eastpointe.net/providers/providerforms/misc/Psychological%20Testing%20Request%20Form.doc>

How am I notified about the status of my authorization?

- Each of the Medicaid UR Vendors are required to complete standardized form letters from DMA regarding the status of your authorization. Those letters shall be received electronically when the provider downloads the letter from the vendor's electronic submission system.
- Types of letters that may be received:
 - Unable to Process
 - Approval
 - Pended- missing information
 - Administrative Denial- missing information
 - Clinical Denial

Timelines

- It is very important that the provider pays attention to their authorization request in the electronic system upon submission. If items are needed, the provider will have 10 business days to submit the request before it is administratively denied.
- A verbal request may be made for the missing information. A letter will be sent to the provider informing them of what items are missing. This letter will also be uploaded in the system.

Due Process

- Due Process Rules were updated/changed and became effective 5/27/11.
- Providers should be aware of Due Process Rules and Regulations. It is recommended that you review the following for more information:
<http://ncdhhs.gov/dma/bulletin/DueProcessSpecialBulletin5311.pdf>



Health Choice

- Requests are submitted to ValueOptions online via ProviderConnect[®].
- Customer Service is available via ProviderConnect or by calling (800) 753-3224.
- Additional information is found at http://www.valueoptions.com/providers/Network/North_Carolina_Health_Choice.htm.
- Health Choice service criteria mirror Medicaid as of 10/1/11.
 - No EPSDT.
 - Different appeals process from Medicaid.

Questions

- Our Provider Representatives are available to assist you at the following numbers:
 - ValueOptions: 1-888-510-1150
 - Durham Center: (877) 839-0301
 - Eastpointe: 800-513-4002 Option #2



OUTPATIENT BEHAVIORAL HEALTH SERVICES BILLING

Chris Lawhorn & Mary Elizabeth Lipcsak
HPES Travel Representative
November 2011



HOW PRIOR APPROVAL CAN AFFECT BILLING

Managed vs.
Unmanaged

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HOW ARE UNMANAGED VISITS COUNTED?

- Count begins each calendar year January 1 through December 31
- Defined by procedure code per DOS **NOT** by individual units of service provided
- System counts each procedure code per DOS as 1 visit with exception of:
 - Group Therapy Codes – 90849, 90853, 90857, H0005, H0004:HQ
 - The previous listed 5 codes above are counted as ½ visit for unmanaged counts



HOW ARE UNMANAGED VISITS COUNTED?

- When maximum number of unmanaged visits have been reached, the following visits will be denied unless PA has been obtained
- Example:
 - A child has reached 15 ½ visits and next DOS is for 90806 (individual therapy), claim will deny unless PA has been obtained for that procedure code
 - An adult has reached 8 visits, next claim for H0004:HQ (group therapy) will deny unless PA is on file



HOW ARE UNMANAGED VISITS COUNTED?

- Provider's responsibility to recognize when PA is required
- Once PA is on file for the recipient, system considers unmanaged visits as "used" for that calendar year regardless of the number of services previously provided
- When in doubt, get PA



CAROLINA ACCESS FOR UNDER AGE 21

Policy Guidelines

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REFERRAL FOR RECIPIENTS UNDER AGE 21

- Community Care of North Carolina/Carolina ACCESS (CCNC/CA) Primary Care Provider (PCP)
- Local Management Entity (LME)
- Medicaid Enrolled Psychiatrist

****Note:** Services provided by a physician do not require a referral



NPI and CAROLINA ACCESS

- If a group is listed on the card as the PCP, obtain the group NPI
- If an individual's name is listed as the PCP, obtain the individual's NPI

Note: To ensure that the information on the card is current, verify the recipient's PCP and Eligibility using one of the current verification methods



RECIPIENT ELIGIBILITY AND PCP VERIFICATION METHODS

- EDI
 - HIPAA Transaction
270/271
 - Real-time Eligibility
 - Batch Transaction
- AVR
 - 1-800-723-4337, option 6
 - Recipient Eligibility and
Coordination of Benefits

- NCECSWeb Tool
 - Recipient Eligibility
Inquiry
- DMA Claims Analysis
 - 919-855-4045
 - Over 12 months
- Appendix F
 - Overview of Recipient
Eligibility Verification
Methods
 - Basic Medicaid/ NC
Health
Choice Billing Guide
Billing Guide



NATIONAL CORRECT CODING INITIATIVE

NCCI



OVERVIEW

The Patient Protection and Affordable Care Act [(H.R. 3590) Section 6507 (Mandatory State Use of National Correct Coding Initiative)] requires State Medicaid programs to incorporate "NCCI methodologies" in their claims processing systems



NCCI EDITS CONSIST OF TWO TYPES OF EDITS

1) Procedure-to-Procedure Edits (CCI Edits)

2) Medically Unlikely Edits (MUE)



NCCI Procedure-to-Procedure Edits

NCCI procedure-to-procedure (CCI) edits that define pairs of Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons



NCCI - BEHAVIORAL HEALTH SERVICES – ASSESSMENT CODES

Assessment Codes (ex. 90801, 90802, H0001, & H0031)
CANNOT be billed by the same attending provider on the same DOS as individual, group, and family therapy codes (ex. 90804 - 90808, 90847, 90849, and H0004) or other assessment or psychological or developmental testing codes (ex. 96101 and 96111)



NCCI - BEHAVIORAL HEALTH SERVICES – THERAPY CODES

Individual, group, and family therapy codes (90804, 90806, 90847, 90853, H0004, & H0005) **CANNOT** be billed by the same attending provider for the same recipient for the same DOS as other individual, group, and family therapy codes (90804, 90806, 90847, 90853, H0004, & H0005) or psychological or developmental testing codes (ex. 96101 and 96111)



NCCI - BEHAVIORAL HEALTH SERVICES – PSYCHOLOGICAL and DEVELOPMENTAL

Psychological and developmental testing (ex. 96111 and 96101) **CANNOT** be billed by the same attending provider for the same recipient for the same DOS as other psychological and developmental testing codes (ex. 96111 and 96101)



COMMON NCCI PROCEDURE-TO-PROCEDURE DENIALS

Rejected Code		Paid Code	
90801	PSY DX Interview	90808	PSYTX Office 75-80 Min
90804	PSYTX Office 20-30 Min	90846	Family PSYTX w/o Patient
90804	PSYTX Office 20-30 Min	90847	Family PSYTX w/ Patient
90806	PSYTX Off 45-50 Min	90853	Group Psychotherapy
90814	INTAC PSYTX Off 75-80 Min	90857	INTAC Group PSYTX
90862	Medication Management	90806	PSYTX Off 45-50 Min



How To Correct Claims

Procedure-to-Procedure Process

HOW TO KNOW IF A CLAIM CAN BE MODIFIED

<http://www.cms.gov/NationalCorrectCodInitEd>

Downloads

[How to Use The National Correct Coding Initiative \(NCCI\) Tools \[PDF, 2.94MB\]](#) 

[CR5824 \[PDF 154KB\]](#) 

[MM5824 \[PDF 72KB\]](#) 

[NCCI Policy Manual for Medicare Services, Version 16.3 - Effective October 1, 2010 \[PDF/ZIP 551KB\]](#) 

[Medicare Claims Processing Manual \(Sec. 20.9\) \[PDF, 1.2MB\]](#) 

[Modifier 59 Article: Proper Usage Regarding Distinct Procedural Service \[PDF, 20KB\]](#) 



How To Correct Claims

Procedure-to-Procedure Process

Service Type ▲ ▼	Code Range ▲ ▼
Category III Codes	0001T-9999T
Anesthesia Services	00100-00999
Anesthesia Services	01000-09999
Surgery: Integumentary System	10000-19999
Surgery: Musculoskeletal System	20000-29999
Surgery: Respiratory, Cardiovascular, Hemic and Lymphatic Systems	30000-39999
Surgery: Digestive System	40000-49999
Surgery: Urinary, Male Genital, Female Genital, Maternity Care and Delivery Systems	50000-59999
Surgery: Endocrine, Nervous, Eye and Ocular Adnexa, Auditory Systems	60000-69999
Radiology Services	70000-79999

Service
Type

Code
Range



How To Correct Claims

Procedure-to-Procedure Process

Column 1	Column 2	Effective Date	Deletion Date * =no data	Modifier 0=not allowed 1=allowed 9=not applicable
90378	G0345	20050101	20050101	9
90378	G0347	20050101	20050101	9
90378	36000	20021001	*	1
90378	36410	20021001	*	1
90378	90780	20010701	20041231	1
90378	90783	20010701	20041231	0
90378	90784	20010701	20041231	0
90378	90788	20010701	20041231	0
90460	G0008	20110101	*	1
90460	G0009	20110101	*	1
90460	G0010	20110101	*	1



How To Correct Claims

Modifier Indicator	Definition
"0" Not Allowed	There are no modifiers associated with NCCI that are allowed to be used with this code pair; there are no circumstances in which both procedures of the code pair should be paid for the same beneficiary on the same day by the same provider.
"1" Allowed	The modifiers associated with NCCI are allowed with this code pair when appropriate.



Appeals Process

Providers may submit a letter requesting reconsideration of a CCI/MUE denial to DMA at the address listed below. The request must include documentation supporting medical necessity.

Division of Medical Assistance
Appeals Unit
Clinical Policy and Programs
2501 Mail Service Center
Raleigh, NC 27699-2501



BILLING “INCIDENT TO” A PHYSICIAN

HPES – Chris Lawhorn

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PROVIDERS ELIGIBLE TO PROVIDE SERVICES “INCIDENT TO” A PHYSICIAN

- **PROVISIONALLY LICENSED PROFESSIONALS**
 - a. Provisional Licensed Psychologists
 - b. Provisional-Licensed Clinical Social Workers
 - c. Licensed Professional Counselor Associates
 - d. Licensed Marriage and Family Therapist Associates
 - e. Provisional Licensed Clinical Addiction Specialists



PROVIDERS ELIGIBLE TO PROVIDE SERVICES "INCIDENT TO" A PHYSICIAN

PROVISIONALLY LICENSED PROFESSIONALS

Effective July 1, 2008 provisionally licensed professionals can provide reimbursable services that can be billed "incident to" the services of a physician under the physician provider number

***Note:** Provisionally licensed professionals are not permitted to bill "incident to" any other provider except a physician



HOW TO BILL “INCIDENT TO” FOR PROVISIONALLY LICENSED PROFESSIONALS

- Utilize the appropriate procedure code (CPT) for the service rendered
- The **SC** modifier must be appended to all CPT codes used to bill for the services of the provisionally licensed professional
- CPT codes include:
 - 90801, 90802, 90804, 90806, 90846, 90847, 90853, 99408, and 99409



HOW TO BILL “INCIDENT TO” FOR PROVISIONALLY LICENSED PROFESSIONALS

- Bill under the physician's NPI
- Provisionally Licensed Professionals offering services under a CABHA, may bill "incident to" a physician (including the medical director) in the CABHA
- Documentation must clearly reflect who provided the service



HOW TO BILL “INCIDENT TO” FOR PROVISIONALLY LICENSED PROFESSIONALS

- If providing services "Incident to" the CABHA Medical Director or another CABHA physician, medical director's or physician's name and MPN must have been included on the enrollment application
- If this was not completed at the time of the original CABHA enrollment, providers may complete:
 - Provider Change Form (item #4)
 - Electronic Claim Submission (ECS) Agreement



HOW TO BILL “INCIDENT TO” FOR PROVISIONALLY LICENSED PROFESSIONALS

- When submitting a claim for a core service that was rendered "Incident to":
 - CABHA NPI is the billing number
 - Individual physician's NPI (associated with the MPN that was used to obtain prior authorization) is the attending number
 - Documentation in the chart must clearly indicate who provided the service and that it was rendered "Incident to"



NCCI and “INCIDENT TO” FOR PROVISIONALLY LICENSED PROFESSIONALS

- As a result of NCCI, if a physician were to provide Med Management (90862) and a provisionally licensed professional billing "incident to" were to provide another outpatient service on the same date of service, the second code would deny as it would look like that same attending provider had provided the service
- In the situation above, NCCI modifier 59 may be appended to CPT codes 90801, 90802, 90846, 99408, or 99409
- **SC** modifier should also be appended to indicate billing "incident to"



NCCI and “INCIDENT TO” FOR PROVISIONALLY LICENSED PROFESSIONALS

- CPT codes 90804, 90806, 90847, and 90853 **CANNOT** be overridden by appending NCCI modifiers
- The above codes can continue to be billed "incident to" but will need to be provided on separate DOS
- Alternatively, if individual therapy (90804, 90806) and Med Management are provided on the same DOS, once code (90805 or 90807) may be billed to indicate that both individual therapy and Med Management were provided
- **SC** modifier should also be appended to indicate billing "incident to"



PROVISIONALLY LICENSED PROFESSIONALS BILLING THROUGH THE LME

- Provisionally Licensed Professionals billing through the LME has been extended through June 30, 2012
- The following HCPCS procedure codes may be utilized:
 - H0001
 - H0004
 - H0005
 - H0031

***Refer to the DMA Clinical Policy Presentation for limits on H codes**



CMS-1500 CLAIM FORM

HPES-Billing



READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of assessment benefits either to myself or to the party who accepts assignment below.

SIGNED _____

17a. 1D qualifier only if entering CA override or an atypical provider number. Otherwise leave blank

14. DATE OF CURRENT ILLNESS (INJURY) PREGNANT

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17b. NPI **1234567890**

10. RESERVED FOR LOCAL USE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

20. OUTSIDE LAB? YES NO \$ CHARGES _____

21. DIAGNOSIS OR NATURE OF ILLNESS

1. _____

2. _____

24i and 24j. (shaded) ZZ qualifier and attending taxonomy if applicable

	A. DATE(S) OF SERVICE			B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. CREDIT Family Ref	I. QUAL.	J. RENDERING PROVIDER ID.#
	From MM DD YY	To MM DD YY	YY									
1											ZZ	321X00000Z
2											NPI	2234567222
3											NPI	
4											NPI	
5											NPI	
6											NPI	

24j. (not shaded) NPI for attending provider if applicable

25. FEDERAL TAX I.D. NUMBER SSN EIN

29. TOTAL CHARGE \$ _____ 29. AMOUNT PAID \$ _____

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof)

32. SERVICE PROVIDER LOCATION INFORMATION

**123 That St
That City, NC 27606-1234**

33. BILLING PROVIDER INFO & PH #

**Provider Name or Organization
123 Any St
Any City, NC 27523-5678**

SIGNED _____ DATE _____

a. NPI **1987654320** b. ZZ **123D00000X**

33a. Billing NPI

33b. ZZ qualifier with billing taxonomy if applicable

NC HEALTH CHOICE

Policy Guidelines - DMA

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NC HEALTH CHOICE PROVIDERS

- HPES processes all Health Choice Claims effective with dates of service 10/1/2011
- File all claims to BCBSNC for dates of service through 9/30/2011 by 2/29/2012
- For professional claims do not span dates of service prior to October 1, 2011 and after October 1, 2011 to HPES
- For inpatient claims (admission date prior to October 1, 2011 and discharge date is after October 1, 2011) submit to BCBSNC



NC HEALTH CHOICE PROVIDERS

- No enrollment action for active NC Medicaid providers who want to render service to NCHC recipients
- New providers must complete the Medicaid enrollment application

NCTracks Website

<http://www.nctracks.nc.gov>



NC HEALTH CHOICE PROVIDERS

- New Call Center – HPES Provider Services
- 1-800-688-6696 option 3, then option 6
- New Address for Claims:
 - HP Enterprise Services
 - P.O. Box 30100
 - Raleigh, NC 27622



NC HEALTH CHOICE ID CARDS

- New Annual ID Card Effective 10/1/2011
- Similar to Medicaid ID Card
- NCHC enrollees must select PCP
- Follow same guidelines as Medicaid for referrals
- Retroactive eligibility does not apply



NCHC ID CARD

North Carolina Health Choice for Children

COPAYS: Provider/Outpatient: \$0.00/\$5.00 Pharmacy: \$1.00-\$1.00-\$3.00/\$10.00 OTC \$1.00 Non-emergency ER: \$10.00/\$25.00

Client Name

Address 1

Address 2

Address 3

Address 4

Address 5

Recipient

Signature _____

(Not valid unless signed)

USE OF THE CARD BY ANYONE NOT LISTED ON THE CARD IS FRAUD AND IS PUNISHABLE BY A FINE, IMPRISONMENT OR BOTH.



N.C. DEPT. OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE

RECIPIENT ID

###-##-####-M

RECIPIENT NAME

John A. Doe

BIRTH DATE MM/DD/YYYY

ISSUE DATE MM/DD/YYYY

PCP NAME

ADDRESS 1

ADDRESS 2

ADDRESS 3

ADDRESS 4

ADDRESS 5

PHONE NUMBERS

For Questions about your Health Choice coverage and/or to report Health Choice fraud, waste, or program abuse, please contact DHHS Customer Service at 1-800-662-7030.



HEALTH CHOICE ELIGIBILITY CRITERIA

- Children ages 6-18
- Does not qualify for Medicaid, Medicare, or other federal government sponsored health insurance
- NC resident
- Has paid enrollment fee (if applicable)



HEALTH CHOICE COVERAGE

- Same as Medicaid, except:

No Long Term Care

No Non-emergency medical transportation

No EPSDT

Dental services provided on a restricted basis

NCHC Clinical Coverage Policies

www.ncdhhs.gov/dma/hcmp/index.htm



HEALTH CHOICE COPAYMENTS

- Vary depending on assistance category
- Copay amount listed on card

North Carolina Health Choice for Children

COPAYS: Provider/Outpatient: \$0.00/\$5.00 Pharmacy: \$1.00-\$1.00-
\$3.00/\$10.00 OTC \$1.00 Non-emergency ER: \$10.00/\$25.00



HEALTH CHOICE PRIOR APPROVAL

- **Unmanaged visits will begin anew on October 1, 2011**
Limited to 16 visits per calendar year
PA required beyond 16th visit
- **PA requests for behavioral health services should continue to be submitted to ValueOptions.**



REMITTANCE AND STATUS REPORT



NORTH CAROLINA MEDICAID REMITTANCE AND STATUS ADVICE

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

NPI 1234567890
Provider Number: XXXXXXXX

DATE: 08/10/2010

PAGE: 2

NAME RECIPIENT ID	SERVICE DATE		DAYS/ UNITS	PROCEDURE/ACCOMMODATION/ DRUGCODE AND DESCRIPTION	TOTAL BILLED	NON ALLOW	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDCHG	PAID AMOUNT	EXP CODES
	FROM	TO										

PAID CLAIMS MEDICAL

RECIPIENT JANE CO=92 CLAIM NUMBER= 25201011111111111111NCXIX EST AMT DUE =
 123456789K PAT ACCT= XYZ123 MED REC = ATTN PROV= 8900000
 07072010 07072010 1 99213 OV ESTAB PT MODERATE PHY 65.00 9.06 55.94 .00 55.94 .00 55.94 98

SCHIP

DED = .00 PT LIB = .00 CO PAY = .00 TPL = .00 DIFF = 65.00 9.06 55.94 .00 55.94 .00 55.94

CARC=XXX RRC=XXXXX ADJUSTMENT AMOUNT=9999999.99



DIAGNOSIS CODES

HPES



DIAGNOSIS CODES THAT SUPPORT MEDICAL NECESSITY

Bill the ICD-9-CM diagnosis code to the highest
level of specificity that meets medical
necessity



RECIPIENTS UNDER AGE 21

- Medicaid covers 6 unmanaged visits without diagnosis of Mental Illness or Substance Abuse
- First 2 visits can be coded with ICD-9-CM code **799.9** (other unknown and unspecified cause)
- Following 4 visits can be coded with "V" diagnosis codes

-OR-



RECIPIENTS UNDER AGE 21

- First visit can be coded with diagnosis **799.9** and remaining 5 can be coded with "V" diagnosis codes
- A specific diagnosis code should be used as soon as a diagnosis is established
- Visits 7 and beyond require an ICD-9-CM code between **290** (Dementias) and **319** (unspecified mental retardation)

NOTE: This service coverage ends on the last day of the birthday month in which a recipient turns 21 years of age



MEDICARE AND MEDICAID RECIPIENTS

HPES



COORDINATION OF BENEFITS

- Must bill Medicare as primary prior to submitting claim to Medicaid
- Medicaid is the Payor of Last Resort
- If both Medicare and Medicaid allow the service, Medicaid will pay the lesser of:
 - Medicare cost-sharing amount
 - Medicaid maximum allowable for the service less the Medicare payment



CABHA CROSSOVER CLAIMS

- DMA has made provisions to allow Medicare crossover claims processing for CABHAs who bill Medicare for outpatient behavioral health services
- CABHA providers will receive a percentage of the Medicare coinsurance/deductible
- Percentages can be found on DMA website
<http://www.ncdhhs.gov/dma/fee/>



CABHA CROSSOVER CLAIMS

- Retro-active to July 1, 2010
- CABHA crossover claims for DOS July 1, 2010 and after that paid \$0.00
- Resubmit electronically as 837 void transaction and a new day claim or manual adjustment using Medicaid Claim Adjustment Form
- Claims must be resubmitted on or before December 31, 2011



EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

HPES

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EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)



MEDICAID FOR CHILDREN

Contacts: Frank Skwara, MA, LMFT, BSN, RN
EPSDT Nurse Consultant
Jane Plaskie, MS, RN
Manager Medicaid Appeals and EPSDT
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501
Telephone: 919-855-4350
Fax: 919-715-7659



WHY HEALTH CHECK / EPSDT ARE IMPORTANT

- Promotes preventative health care by providing for early and regular medical and dental screenings.
- Provides medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening.



HEALTH CHECK / EPSDT OVERVIEW

- **Early Periodic Screening, Diagnosis, and Treatment (EPSDT) defined by federal law and includes:**
 - Periodic Screening Services
 - Vision Services
 - Dental Services
 - Hearing Services
 - Other Necessary Health Care



EPSDT OVERVIEW

- Recipients under 21 must be afforded access to the full array of EPSDT services within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. Refer to the EPSDT provider web page or the Health Check or Basic Medicaid Billing Guides for a listing of these services.

NOTE: Under EPSDT, North Carolina Medicaid must make available a variety of individual and group providers qualified and willing to provide EPSDT services.



EPSDT CRITERIA

- Must be listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act].

- Must be medically necessary "to correct or **ameliorate** a defect, physical or mental illness, or a condition [health problem] identified by screening".



EPSDT CRITERIA

"Ameliorate" means to:

- Improve or maintain the recipient's health in the best condition possible,
- Compensate for a health problem,
- Prevent it from worsening, or
- Prevent the development of additional health problems.



EPSDT CRITERIA

- Must be determined to be medical in nature.
- Must be generally recognized as an accepted method of medical practice or treatment.
- Must not be experimental, investigational.
- Must be safe.
- Must be effective.



EPSDT

- **Basic Medicaid Billing Guide**

<http://www.ncdhhs.gov/dma/basicmed/index.htm>

Healthcheck Billing Guide

<http://www.ncdhhs.gov/dma/healthcheck/index.htm>

EPSDT Provider Page

<http://www.ncdhhs.gov/dma/epsdt/index.htm>



HELPFUL RESOURCES

HPES

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DMA WEBSITE

www.ncdhhs.gov/dma/provider/library

▼ Medicaid Providers

A-Z Provider Topics
Calendars
Claims and Billing
Community Care (CCNC/CA)
Contacts for Providers
Enrollment
EPSDT and Health Check
Fee Schedules/Cost Reports
Forms
Fraud and Abuse
HIPAA
Library (bulletins, policies)
National Provider Identifier
Programs and Services
Seminars

ABOUT DMA

CONTACT DMA

Related Site

[Implementation Updates from DMH/DD/SAS](#)

Provider Library

Published information on covered services

Bulletins and Newsletters

- [General and Special Medicaid Bulletins](#)
- [Pharmacy Newsletters](#)
- [The Provider Insider](#), Information Resource for Electronic Health Record Incentives

Medicaid State Plan and Related Documents

- [Medicaid State Plan](#)
- [N.C. Administrative Code](#)
- [Waivers to the Medicaid State Plan](#)

Policies and Manuals

- [Basic Medicaid Billing Guide](#)
- Clinical Coverage Policies and Manuals
 - [Medicaid](#)
 - [N.C. Health Choice](#)
- [Early and Periodic Screening, Diagnosis and Treatment \(EPSDT\)](#)
- [Health Check Billing Guides](#)
- Proposed Clinical Coverage Policies
 - [Medicaid](#)
 - [N.C. Health Choice](#)
- [Provider Seminar Handouts](#)



DMA CLINICAL POLICY WEBPAGE

www.ncdhhs.gov/dma/mp/index

The screenshot displays the NC Division of Medical Assistance website. The header includes the logo for the NC Department of Health and Human Services and the text "NC Division of Medical Assistance". A navigation bar contains links for "DMA SERVICES", "FOR COUNTY STAFF", "For Providers", and "STATISTICS AND REPORTS". The main content area is titled "Medicaid Clinical Coverage Policies and Provider Manuals" and includes a breadcrumb trail: "DHHS > DMA > Medicaid Providers > Provider Library > Clinical Coverage Policies and Provider Manuals". The page features a left sidebar with a menu of topics such as "A-Z Provider Topics", "Calendars", "Claims and Billing", "Community Care (CCNC/CA)", "Contacts for Providers", "Enrollment", "EPSDT and Health Check", "Fee Schedules/Cost Reports", "Forms", "Fraud and Abuse", "HIPAA", "Library (bulletins, policies)", "National Provider Identifier Programs and Services", "Seminars", "ABOUT DMA", and "CONTACT DMA". The main content area contains a section on "Prior approval (PA)" with a list of links to PDF documents, including "Due Process Special Bulletin, May 2011", "Medicaid Recipient Due Process Rights and Prior Approval Policies and Procedures", and "Medicaid Recipient Due Process and Prior Approval Policies and Procedures Seminar Presentation January 2011". It also includes a section on "Early and Periodic Screening, Diagnosis and Treatment (EPSDT)" with links to "EPSDT Provider Page" and "EPSDT Policy Instructions". A section on the "Patient Protection and Affordable Care Act of 2010" explains the requirements for the "National Correct Coding Initiative (NCCI)". A final section titled "Behavioral Health (8A through 8M)" lists various services and their effective dates, such as "8A. Enhanced Mental Health and Substance Abuse Services (8/1/11)" and "8M. Community Alternatives Program for Persons with Mental Retardation and Developmental Disabilities (CAP-MR/DD) (7/1/10)".



Q&A

