ISSUE 5 | VOL 6 | SEPTEMBER/OCTOBER 2012

Medicaid bulletin

BI-MONTHLY PUBLICATION FOR DC MEDICAID PROVIDERS

Hot Topics: Latest News

Dental Procedure for Code Update

Procedure code D2750 (Porcelain with metal) was inadvertently left off of the list of reinstated procedure codes in Transmittal #12-14. This procedure was reinstated. Please consult the fee schedule for reimbursement information.

Emergency Medicaid Hospital Services Policy for Alliance Beneficiaries

Transmittal #12-21 outlines policies and procedures governing the submission and reimbursement of hospital claims for Medicaid-reimbursable emergency medical services for DC Health Care Alliance beneficiaries. Effective October 1, 2012 through September 30, 2013, Medicaid-reimbursable emergency medical services will no longer be included in the Alliance benefit package and will not be paid to network hospital providers by managed care organizations participating in the Alliance program. Accordingly, hospitals providing Medicaid-reimbursable emergency medical services to Alliance beneficiaries must cease billing the beneficiary's health plan and, instead, submit claims for these services directly to the Department of Health Care Finance for reimbursement under Medicaid pursuant to the procedures set forth in section 8 of the hospital billing manual. This benefit change should have no impact on Alliance beneficiaries' access to emergency medical services.

Medicaid-reimbursable emergency medical services are services that are necessary to treat the **sudden onset** of an emergency medical condition. An emergency medical condition is defined as a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy. Refer to transmittal, #12-21 on the Web Portal at www.dc-medicaid.com for detailed information on this important change in policy.

DC Medicaid Requires Referring Provider Number on DME/POS Claims

Beginning October 1, 2012, the Department of Health Care Finance (DHCF) will require that all DME/POS Claims include the name and NPI of the physician/ARNP prescribing durable medical equipment or supplies. DME/POS providers should record and submit the prescribing physician/ARNP in the following manner:

CMS1500	Name entered in Field 17, NPI entered in Field 17B
837P	Name entered in Loop 2310A NM107 segment & NPI entered in Loop 2310A NM109 segment with qualifier XX in segment NM108
Web Portal	Answer **yes** to the question: i*s this service as a result of a referral?* Enter the NPI in the field referring provider and the name in the additional referring provider information.
WinASAP	In the drop down box for Reference Provider enter the NPI, Name, and Address. Click Save. Answer **no** to the question: *is this provider intended for Billing or Pay-To-Plan provider?* Select the appropriate provider in the Referring Provider 1 drop down box in the professional claim data screen.

Refer to transmittal, #12-22 on the Web Portal at www.dc-medicaid.com for detailed information on this important change in policy.

Helpful Hints for Submitting Claims for MRDD Waiver Recipients

When submitting claims for MRDD Waiver recipients, you may encounter the denial edit **5218 SERVICE COVERED BY HMO (DISPOSITIONS SET FOR CLAIMS OTHER THAN CAPITATION)**. Please take the following steps to ensure your claims are processed correctly.

- Always verify eligibility before rendering services. Eligibility can be verified via the DC Medicaid Web Portal (www.dc-medicaid.com) or by calling the IVR system at (202) 906-8319 (inside DC Metro area) or (866) 752-9233 (outside DC Metro area).
- If the Medicaid recipient has one of the following program codes: 873, 873A, 873Q, 873S then the claim must be manually reviewed by the DHCF. Note: If you would like to know what a specific program code means, please visit the following website for a detailed Program Code listing.
  http://dhs.dc.gov/dhs/cwp/view,a,1345,q,605825,dhsNav_GID,1728,.asp

- If the claim was originally submitted electronically, resubmit the claim on paper and send to:
  Department of Health Care Finance (DHCF)
  ATTN: Bernie Thomas
  609 H Street, NE
  2nd Floor
  Washington, DC 20002

AIDS Drug Assistance Program

On July 1, 2012 Xerox State Healthcare became the Pharmacy claims processor for the DC AIDS Drug Assistance Program (also known as DC ADAP). The program is authorized under Title II of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act and provides HIV-related prescription drugs to underinsured and uninsured individuals living with HIV/AIDS. The ADAP Pharmacy Network is a new list of pharmacies that HASTA has created to serve the medication needs for the ADAP program. Any Medicaid pharmacy provider interested in becoming a part of this network may contact HASTA at (202) 671-4900/ http://doh.dc.gov/page/hivaids-hepatitis-std-and-tb-administration-hahsta

- Xerox State Healthcare provides a helpdesk for providers to obtain assistance with drug information and claim processing assistance. The hours of operation are 8:00am through 5:00pm Mon. - Fri. For helpdesk assistance contact: 1-(855) 401-3731 or **dcrph@xerox.com**.
- For a complete listing of the pharmacies that are enrolled in the ADAP Pharmacy Network, go to the DC ADAP Pharmacy Directory at: http://doh.dc.gov/node/236872
- Under the DC ADAP formulary the following drugs require prior authorization:
  1. Suboxone/ Subutex - Buprenorphine
  2. Serostim

For DC ADAP claims needing Prior Authorization review contact: Dr. Shazia Kazi, MD, MPH, DC ADAP Manager at (202) 671-4810.

Pharmacy Hot Topics

- Synagis Season is here! The DC Medicaid Fee for Service program will allow 5 fills for Synagis between the months of October – May with proper clinical documentation.
- **Revatio** is a non-preferred medication and recipients are expected to try the preferred medication **Adcirca** for at least 30 days before the non-preferred **Revatio** can be authorized. **Revatio's** maximum dose is 240mg per day (12 tablets every day).

FAQ

Q: How often are changes or updates made to the Preferred Drug List (PDL)?

A: The DC Medicaid Fee for Service Preferred Drug List (PDL) updates quarterly in September, December, March and June. The newest PDL has been in effect since September 14, 2012.

Health Information Exchange

(Following article is a reprint of article found on Department of Health Care Finance webpage http://dhcf.dc.gov/page/health-information-exchange)

DC-HIE is the statewide Health Information Exchange (HIE) for the District of Columbia. The primary service DC-HIE offers is Direct Secure Messaging (DIRECT). DIRECT is a safe, confidential, electronic system to support the exchange of patient medical records among healthcare providers, both within the District and beyond. This initiative is being led by the Department of Health Care Finance with governance from the DC-HIE Policy Board.

DIRECT has many benefits including permitting health care providers to have more complete medical information in order to provide higher quality care for patients. DIRECT also facilitates coordination of treatment with other health care providers.

Unless patients decline in writing to allow their protected health information (PHI) to be exchanged via DIRECT, their information can be shared among the health care providers who care for them.

For more information please check out the DIRECT Brochure [http://dhcf.dc.gov/node/173832].

Mission and Vision

The DC-HIE mission is to foster and sustain trust, collaboration and information sharing among consumers, providers and purchasers of health care services in the District of Columbia, leading to measurable improvement in outcomes and cost-effective delivery of services.

The vision of DC-HIE is that consumers and providers of health services are empowered to make good decisions based on secure, timely, accurate, comprehensive and easily-accessible information, available to authorized users for coordination of care, improvements in safety and quality, and advancements in the provision of health care.

How Does the DC-HIE Help Providers?

Every day, health care professionals have to make important health care decisions for patients often without access to past or current medical information. When information is shared, it is usually done via phone, mail and fax which is slow, inconvenient, expensive and likely not compliant with applicable privacy standards.

Better access to vital information about prior conditions, medications, allergies, and tests may improve the accuracy of diagnoses, enhance the quality of care, and eliminate duplicate tests. DIRECT will allow health care professionals the ability to quickly share and view patient information electronically with other participating providers.

In addition, the ability to exchange clinical information with other providers is a key component of achieving Meaningful Use of EHRs and CMS financial incentives.

DC-HIE Statement on Privacy and Security

DC-HIE takes its responsibility in maintaining the privacy and security of PHI very seriously. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), among other federal and state laws, requires covered entities to protect the privacy and security of PHI. While DC-HIE is not a covered entity, it is a business associate of its client health care providers. It is through this business associate relationship with its clients that HIPAA and other laws become applicable to DC-HIE.

To fulfill its commitments as a business associate and recognizing that compliance with privacy laws is of the utmost importance to its clients and stakeholders, DC-HIE has implemented many policies and procedures as well as proactive, preventative security features. State-of-the-art systems and the latest technical standards are employed to secure records to the greatest degree possible and prevent access by unauthorized persons.

In the Spotlight: Provider Field Representatives

Our Provider Field Representatives (Field Reps) pro-actively assist in the provider community. Every week they are out meeting & greeting providers in their territories and assisting them with billing, providing additional resources, and web portal trainings. We want to ensure that our provider community is well prepared and educated as it relates to billing. From these efforts, we are receiving positive feedback from you, the provider: *"The training I received from my rep has increased my office efficiency"; " I didn't even know we had field reps, thanks for letting us know".* Please take note of your Provider Field Representative listed below. Note, the Field Reps are assigned based on **billing address** not **service address**:

⇒ **Barbara Dolan, Provider Outreach Manager**

Barbara Dolan, the Provider Outreach Manager, has worked in the Medicaid service field in Florida, Maryland and now the District of Columbia for over 13 years. Her vast knowledgebase of the Medicaid system, as well as, years of teaching experience, assist her in knowing all aspects of the Medicaid arena from provider enrollment to provider outreach. Barbara works along with the provider outreach team to ensure that all providers are assisted in an efficient and effective manner.

⇒ **Donna Black, Provider Field Representative**

Serving providers located in Southern Maryland, Donna has been with Xerox for almost 7 years. Donna's expertise is enhanced in that she started out in the Provider Inquiry Department and therefore is very familiar with the varied issues that arise in the provider community. She is now a part of the Provider Outreach department where she assists providers with escalated issues.

⇒ **Tonya Hutson, Provider Field Representative**

Serving providers located in NE and NW (20011 and above), Tonya has been with Xerox for over 3 years, joining the DC Medicaid team after years of service with Maryland Medicaid. She specializes in resolving provider claims issues and providing the necessary training for the web portal and WINASAP 5010.

⇒ **Leon Johnson, Jr., Provider Field Representative**

Assisting providers located in SE, SW, and NW (20001, 20004-20010), Leon brings to Xerox an extensive background in DC healthcare and provider outreach experience. He specializes in web portal training and helping providers resolve claims issues.

⇒ **Eleazar Grant, Provider Field Representative**

Assisting providers located in New Carrollton to Germantown and Northern Virginia, Eleazar (pronounced Elijah) is new to the Xerox team, but is a teacher of billing and coding and comes to Xerox with a vast knowledge of claims processing, billing and coding. Eleazar utilizes his knowledge to assist providers in getting their claims paid in a timely and efficient manner.

We want to be even more visible in the provider community. If you are in need of personal assistance, have any questions, issues or concerns please don't hesitate to contact us at DC.ProviderReps@xerox.com or (202) 906-8319. We truly look forward to hearing from you.

Reminder: National Correct Coding Initiative (NCCI) Edits

The Department of Healthcare Finance (DHCF) adopted the Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) standard payment methodologies. As part of the federal mandate for implementing these edits, the DHCF is required to re-adjudicate all claims for service dates on or after October 1, 2010, that were impacted by these edits. Implementation of these edits applies immediately to any new claims submitted. Adjustments for any previously submitted claims have begun. The NCCI implementation will ensure that services are paid correctly in accordance with state and federal policy and regulations.

What is the National Correct Coding Initiative (NCCI)?

The National Correct Coding Initiative (NCCI) (also known as CCI) was implemented to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. NCCI code pair edits are automated prepayment edits that prevent improper payment when certain codes are submitted together for Part B-covered services. In addition to code pair edits, the NCCI includes a set of edits known as Medically Unlikely Edits (MUEs). An MUE is a maximum number of Units of Service (UOS) allowable under most circumstances for a single Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code billed by a provider on a date of service for a single beneficiary.

Reminder: National Correct Coding Initiative (NCCI) Edits

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Why Would a Health Care Professional, Supplier, or Provider Use the NCCI Web Page, Tables, and Manual?

Accurate coding and reporting of services are critical aspects of proper billing. Service denied based on NCCI code pair edits or MUEs may not be billed to Medicare beneficiaries; a provider cannot utilize an Advance Beneficiary Notice of Non-coverage (ABN) to seek payment from a Medicare beneficiary. The NCCI tools found on the Centers for Medicare & Medicaid Services (CMS) website (including the "National Correct Coding Initiative Policy Manual for Medicare Services") help providers avoid coding and billing errors and subsequent payment denials. It is important to understand, however, which addresses HCPCS Level 2 codes, and Chapter 13 which addresses Category III CPT Codes. Each chapter is subdivided by subject to allow easier access to a particular code or group of codes.

The NCCI manual can be obtained in two ways:

1. The manual is available as a compressed (zipped) set of PDF documents on the NCCI Overview page on the CMS website. To download or access the manual: Go to **http://www.cms.gov/NationalCorrectCodInitEd** on the CMS website.
2. National Technical Information Service (NTIS) is the official distributor of the NCCI edits. The "NCCI Policy Manual" or sections of the manual can be ordered from NTIS on their website at **http://www.ntis.gov/products/cci.aspx** or by calling 1-800-363-2068.

NCCI Edits

The NCCI is comprised of two provider-type choices of code pair edits and three provider-type choices of MUEs:

Code Pair Edits	
NCCI Edits - Physicians These code pair edits are applied to claims submitted by physicians, non-physician practitioners, and Ambulatory Surgery Centers (ASCs)(provided the code is listed as one of the Medicare-approved ASC procedures). **NCCI Edits - Hospital Outpatient Prospective Payment System (PPS)** This set of code pair edits is applied to the following Types of Bills (TOBs) subject to the Outpatient Code Editor (OCE): Hospitals (TOB 12X and 13X), Skilled Nursing Facilities (SNFs) (TOB 22X and 23X), Home Health Agencies (HHAs) Part B (TOB 34X), Outpatient Physical Therapy and Speech-Language Pathology Providers (OPTs) (74X), and Comprehensive Outpatient Rehabilitation Facilities (CORFs) (TOB 75X).	**MUEs** **Practitioner MUEs** All physician and other practitioner claims are subject to these edits. **Durable Medical Equipment (DME) Supplier MUEs** These edits are applied to claims submitted to DME MACs. (At this time, this file includes HCPCS A-B, D-H, K-V codes in addition to HCPCS codes under the DME MAC jurisdiction.) **Facility Outpatient MUEs** Claims for TOB 13X, 14X, and Critical Access Hospitals (85X) are subject to these edits.

Reminder: National Correct Coding Initiative (NCCI) Edits

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How do you know when an appropriate modifier may be used?

Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier should not be appended to a HCPCS/CPT code solely to bypass an NCCI edit if the clinical circumstances do not justify its use. If the Medicare Program imposes restrictions on the use of a modifier, the modifier may only be used to bypass an NCCI edit if the Medicare restrictions are fulfilled. In the modifier indicator column, the indicator 0, 1, or 9 shows whether an NCCI-associated modifier allows the code pair to bypass the edit. The following Modifier Identifier Table provides a definition of each of these indicators.

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.
9 (Not Applicable)	This indicator means that an NCCI edit does not apply to this code pair. The edit for this code pair was deleted retroactively.

RESOURCES

CMS HCPCS Web Page - http://www.cms.gov/MedHCPCSGenInfo
This web page provides background information, coding updates and transmittals, and coding process and criteria information for the Healthcare Common Procedure Coding System (HCPCS) code set.

CMS Help with File Formats & Plug-Ins - **http://www.cms.gov/AboutWebsite/11_Help.asp**
Where possible, CMS posts information in open-standard, accessible formats (e.g., HTML). However, there are some areas of the website where specialized media must be used and plug-ins or special viewers may be needed to access the content. This web page provides a list of file types that are used on the website as well as further information on getting the plug-ins.

CMS Outpatient Code Editor (OCE) Web Page - http://www.cms.gov/OutpatientCodeEdit/01_Overview.asp
This web page provides an overview of the OCE, as well as information on the OCE versions and updates.

CMS Quarterly Provider Updates Electronic Mailing List - http://www.cms.gov/AboutWebsite/EmailUpdates
CMS offers a free e-mail subscription service, which provides notifications electronically when new information is available. The Quarterly Provider Updates electronic mailing list notifies subscribers via e-mail immediately of any regulations or program instructions released during the quarter that affect Medicare providers, including transmittals of the quarterly updates to the NCCI.

CPT Manual - https://catalog.ama-assn.org/Catalog/cpt/cpt_home.jsp
CPT codes are defined in the American Medical Association's (AMA's) "CPT Manual" which is updated and published annually. Use this web page to purchase hard copy or electronic versions of the "CPT Manual."

Internet-Only Manual (IOM) Pub 100-04 "Medicare Claims Processing Manual - http://www.cms.gov/manuals/downloads/clm104c23.pdf
Chapter 23 is entitled "Fee Schedule Administration and Coding Requirements." Section 20.9, "Correct Coding Initiative (CCI)," provides instructions regarding implementation of NCCI edits and MUEs including information on modifiers.

MLN Matters® Articles - http://www.cms.gov/MLNMattersArticles
Quarterly updates (and corresponding information) to the NCCI are published as Medicare Learning Network® (MLN) Matters® articles. Select the year and search for the word initiative to return all quarterly updates.

Modifier 59 Article - http://www.cms.gov/NationalCorrectCodInitEd/Downloads/modifier59.pdf
This article provides information about CPT Modifier -59, an important NCCI-associated modifier that is often used incorrectly.

Medicare Claim Review Programs: MR, NCCI Edits, MUEs, CERT, and RAC - http://www.cms.gov/MLNProducts/downloads/MCRP_Booklet.pdf
This Medicare Learning Network® (MLN) booklet provides an overview of the Medical Review (MR), NCCI, MUE, Comprehensive Error Rate Testing (CERT), and Recover Audit Contractor (RAC) programs.

MUE Frequently Asked Questions (FAQs) - http://www.cms.gov/NationalCorrectCodInitEd/08_MUE.asp
Further information about MUEs may be viewed in the FAQ link from the CMS MUE web page.

National Correct Coding Initiative Policy Manual for Medicare Services - http://www.cms.gov/NationalCorrectCodInitEd
The manual is available to providers as a reference tool for correct coding and to explain the rationale for NCCI edits.

NCCI FAQs - http://www.cms.gov/NationalCorrectCodInitEdA
Searchable list of commonly-asked questions about the NCCI may be viewed in the FAQ link from the CMS NCCI Overview web page.

Important Numbers & Addresses

Provider Inquiry **PO Box 34734** **Washington, DC 20043-4734**	(202) 906-8319 (inside DC metro area) (866) 752-9233 (outside DC metro area) (202) 906-8399 (Fax)	Hours of Operation Monday - Friday 8:00 am - 5:00 pm
Provider Enrollment **PO Box 34761** **Washington, DC 20043-4761**	(202) 906-8318 (inside DC metro area) (866) 752-9231 (outside DC metro area) (888) 335-8465 (Fax) www.dc-medicaid.com	Hours of Operation Monday - Friday 8:00 am - 5:00 pm
Pharmacy Benefits Management	Xerox Technical Call Center: (800) 272-9679 Xerox Clinical Call Center (Prior Authorizations): (800) 273-4962 Xerox PBM Fax Number: (866) 535-7622 http://www.dcpbm.com	Hours of Operation 24/7/365
ACS EDI Gateway Services	(866) 407-2005 http://www.acs-gcro.com	Hours of Operation Monday - Friday 8:00 am - 5:00 pm
Transportation Broker **Medical Transportation Management, Inc. (MTM)**	(888) 561-8747 (866) 796-0601 (to schedule appointment) http://www.mtm-inc.net/index.asp	
Dental Help Line	(866) 758-6807	
Fraud Hotline	(877) 632-2873	
Health Care Ombudsman	(877) 685-6391	
Provider Outreach	dc.providerreps@xerox.com	

Claims Department	
UB04 Claim Forms	PO Box 34693 Washington, DC 20043-4693
CMS1500 Claim Forms	PO Box 34768 Washington, DC 20043-4768
ADA and Pharmacy Claim Forms	PO Box 34714 Washington, DC 20043-4714
Adjustment/ Void Forms	PO Box 34706 Washington, DC 20043-4706
Medicare Crossover Claim Forms	PO Box 34770 Washington, DC 20043-4770
278 Prior Authorization Transaction Attachments	PO Box 34756 Washington, DC 20043-4756
837 Claim Transaction Attachments	PO Box 34631 Washington, DC 20043-4631
Claim Appeals	PO Box 34734 Washington, DC 20043-4761

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