January 2008 Medicaid Bulletin

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National Provider Identifier

Attention: All Providers

National Provider Identifier (NPI) Seminars

N.C. Medicaid will hold National Provider Identifier (NPI) seminars during the month of February 2008. Seminars are intended for providers that would like more detailed information on how NC Medicaid will be implementing NPI. **New information as well as future changes will be addressed at these seminars.** Providers are encouraged to attend.

The seminars are scheduled at the locations listed below. **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 NPI seminars by completing and submitting the registration form on the next page or by registering online at www.ncdhhs.gov/dma/prov.htm. Sessions will begin at 9:00 a.m. and end at 12:00 p.m. Providers are encouraged to arrive by 8:45 a.m. to complete registration.

The registration form for the seminars is on the next page of this bulletin. Please see directions and contact phone numbers for venues.

February 5, 2008 A/B Tech Community College *Enka Campus* 1459 Sand Hill Rd Candler, NC	**February 6, 2008** Park Inn Gateway Conference Center 909 US Highway 70 SW Hickory, NC
February 14, 2008 Martin Community College 1161 Kehukee Park Rd Williamston, NC	**February 19, 2008** Holiday Inn Select 5790 University Parkway Winston-Salem, NC
February 20, 2008 Hilton University Place 8629 J.M. Keynes Drive Charlotte, NC	**February 26, 2008** McKimmon Center 1101 Gorman Street Raleigh, North Carolina
February 27, 2008 Coastline Convention Center 501 Nutt St Wilmington, North Carolina	

National Provider Identifier (NPI)
Seminar Registration
(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:
EDS Provider Services
P.O. Box 300009
Raleigh, NC 27622

Directions to A/B Tech Community College, Enka Campus 828.254.1921
Take I-40 to Exit 44. At the traffic light at the end of the exit ramp, turn right. Go to the fourth traffic light and turn left on Sand Hill Road. Go to the second entrance on the left and turn onto the campus. The Haynes Conference Center will be on your right and the Incubator will be on your left. You may park on the left or in the lots straight ahead of you.

Directions to Park Inn Gateway Conference Center, Hickory, NC (828) 328-5101 Exit 123B off of I-40 to 321 North (half a mile) take Exit 44. Park Inn Hickory is on the right hand side.

Directions to Holiday Inn Select- Winston-Salem (800) 465-4329
From the East or West: Take I-40 to NC Hwy 52 North, travel 8 miles to exit 115B (University Pkwy South). Hotel is on the right.
From the North: Take Hwy 52 South, to UNIVERSITY PKWY exit- EXIT 115. Keep RIGHT at the fork to go on UNIVERSITY PKWY.
From the South: Take Hwy 52 North to exit 115B (University Pkwy South). Hotel is on the right.

Directions to Hilton University Place, Charlotte NC (704) 547-7444
Exit from I-85 North or South at exit 45A, W.T. Harris Boulevard East. Hilton Charlotte University Place is 1/4 mile on the left in the University Place complex. The hotel is the highrise building in the complex, totally visible from Harris Boulevard. Then left turn at J M Keynes Drive goes directly into the hotel parking lot.

Directions to Martin Community College, Williamston, NC (252) 792-1521
From the West: U.S. Hwy. 64 to Williamston, Exit 512 from Hwy. 64.
Turn right on NC Hwy. 125 (Prison Camp Rd.) and left on Kehukee Park Road. Martin Community College will be on the right. Sign before Exit 512 states Senator Bob Martin Agricultural Center and Martin Community College. If you are coming in on Alternate Hwy. 64 (business), college will be on right.

From the North: U.S. Highways 13 and 17 run together from Windsor to Williamston. Both run in to Alternate Hwy. 64 (business) at Holiday Inn. Continue straight on Hwy. 64 West. College will be on left just outside of town.

From the East: From Jamesville/Plymouth on U.S. Hwy. 64 traveling west in Williamston, turn left at the stoplight at McDonald's. Keep straight at the Holiday Inn Intersection on Hwy. 64 West. College is on the left just outside of Williamston.

From the South: From Washington, take U.S. Hwy. 17 North to Williamston. At the Holiday Inn intersection in Williamston, take a left on Hwy. 64 West. College will be on the left just outside Williamston.

From Greenville, take Hwy. 264 bypass. Exit route Hwy. 11 & 13 North. Turn right on Route 903 through Stokes N.C.; take the first left after going through Stokes (still on Hwy. 903). After entering Martin County, turn right at yellow, blinking light onto Prison Camp Road (also known as State Road #1142). Pass Senator Bob Martin Eastern Agricultural Center, and keep on Prison Camp Rd. Turn left on Kehukee Park Road. College is on the right.

Directions to Jane S. McKimmon Center – Raleigh (919) 515-2277
Traveling East on I-40: Take Exit 295 and turn left onto Gorman Street. Travel approximately 2.5 miles. The McKimmon Center is located on the right at the corner of Gorman Street and Western Boulevard.

Traveling West on I-40: Take Exit 295 and turn right onto Gorman Street. Travel approximately 2.5 miles. The McKimmon Center is located on the right at the corner of Gorman Street and Western Boulevard.

Directions to Coastline Convention Center – Wilmington (910) 763-6739
From I-40 East / Raleigh Durham Area: Follow Interstate 40 East to Wilmington. As you approach Wilmington, turn right onto MLK Parkway/74 West/Downtown. Continue on route to downtown and it will become 3rd Street. Follow 3rd Street for five blocks until you reach Red Cross Street. Turn right onto Red Cross Street and follow for two blocks. Turn right onto Nutt Street. Second drive way on left is the entrance to the convention center.
From Hwy 17 S. (Jacksonville area): Stay on Hwy 17 S. as it turns into Market Street. Follow Market Street until you see the sign for 74 West / Downtown (MLK Parkway). Take 74 West (MLK Parkway) to downtown (approx 4 miles), turn right on Red Cross Street, come 2 blocks, turn right on Nutt Street. Second drive way on left is the entrance to the convention center.

From Hwy 17 N. or Hwy 74-76 (Myrtle Beach or Fayetteville area): Come across the Cape Fear Memorial Bridge into Wilmington. Take a left at the first stoplight onto 3rd Street and come downtown. Follow 3rd Street to Red Cross Street and turn left at the stoplight. Go to the bottom of the hill (approximately 3 blocks). Take a right onto Nutt Street, turn left into the main parking lot of the Coast Line Center.

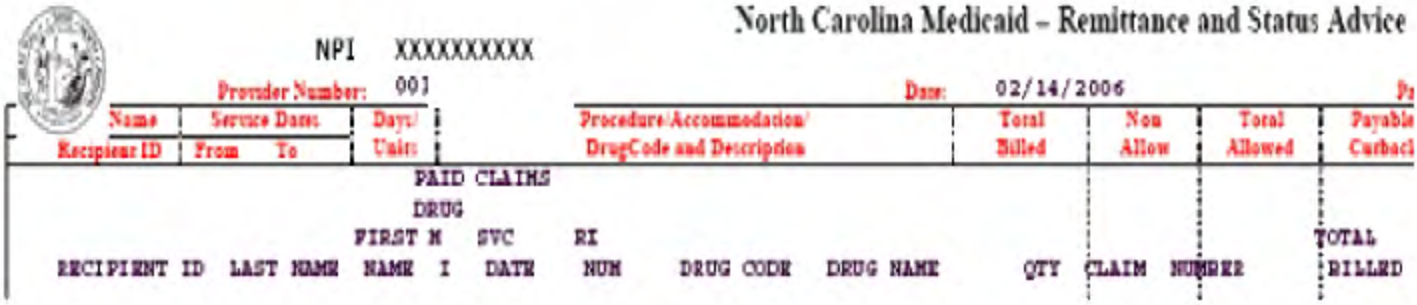
EDS, 1-800-688-6696 or 919-851-8888

National Provider Identifier

Attention: All Providers

NPI on Paper Remittance and Status Reports

Beginning in January 2008, paper Remittance and Status (RA) Reports will display the billing provider's NPI in addition to the Medicaid Provider Number. The NPI will appear directly above the Medicaid Provider Number on each page of the RA. Attending provider NPIs will not be displayed. The NPI shown on the RA will be the NPI reported to N.C. Medicaid for the billing Medicaid Provider Number. If no NPI appears, N.C. Medicaid does not have your NPI in the provider database and you need to report it as soon as possible. To report an NPI, visit the DMA NPI and Address Database at www.ncdhhs.gov/dma/npi.htm.
Please see the sample RA containing an NPI below:



North Carolina Medicaid – Remittance and Status Advice

NPI XXXXXXXXXX

Provider Number: 001

Date: 02/14/2006

Name / Recipient ID	Service Dates From / To	Days/ Units	Procedure/Accommodation/ DrugCode and Description	Total Billed	Non Allow	Total Allowed	Payable / Carbacl

PAID CLAIMS

RECIPIENT ID	LAST NAME	FIRST NAME	M I	SVC DATE	RX NUM	DRUG CODE	DRUG NAME	QTY	CLAIM NUMBER	TOTAL BILLED

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

Attention: All Providers

Include ZIP+4 on Claims

Providers are now required to include the last four digits of their ZIP codes in the billing address and service facility location address fields on all claims. Once NPI is implemented, the ZIP+4 will be an important component for claims processing. Therefore, it is imperative for providers to begin including this information on claims. Requirements for each claim form regarding ZIP+4 are listed below.

- **CMS-1500**: The ZIP+4 is required in blocks 32 (service facility location) and 33 (billing address), or electronic equivalent. Unless the place of service is the recipient's home, complete both fields even if the billing address and service facility location address are identical. Do not use the word "SAME." If the place of service on the claim is home, block 32 should remain blank.
- **UB-04**: The ZIP+4 is required in form locator 1, or electronic equivalent. Complete form locator 1 using the provider's site address. Form locator 2 (billing address) should be completed only if the billing address is different from the site address entered in form locator 1.
- **ADA**: The ZIP+4 is required in fields 48 (billing address) and 56 (site address), or electronic equivalent. Complete both fields even if the addresses are identical. Do not use the word "SAME."

To determine your ZIP+4, visit the U.S. Postal Service Web site, www.usps.com, and use the ZIP Code Lookup function.

NPI – Get it! Share It! Use It! Getting one is free – Not having one can be costly!

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

Attention: All Providers

EOB Codes for NPI

This article is for informational purposes only. N.C. Medicaid is currently not accepting claims containing NPI only. As NPI implementation approaches, providers will begin seeing the following new and modified NPI EOB codes:

NEW EOB CODES FOR NPI:

- **EOB 3101**
  The taxonomy code for the attending provider is missing.
- **EOB 3102**
  The taxonomy code for the billing provider is missing.
- **EOB 3105** (For Pharmacy Claims only)
  The NPI submitted for the prescribing provider is missing or invalid.
- **EOB 3106** (For Pharmacy Claims only)
  The NPI submitted for the prescribing provider cannot be the same as the pharmacy's NPI.
- **EOB 3107**
  Claim should contain NPI only without Medicaid provider number as provider is not atypical.
- **EOB 3208**
  Void or adjustment cannot be processed. Billing NPI does not match NPI on file for original provider.
- **EOB 3209**
  Void or adjustment cannot be processed. Billing NPI does not match NPI filed on original claim.

MODIFIED EOB CODES FOR NPI:

- **EOB 270**
  Billing provider is not the recipient's Carolina Access PCP. Authorization is missing or unresolved. Contact PCP for auth or EDS Provider Services if auth is correct.

- **EOB 3007 (Hospice)**
  Patient facility identification is missing, invalid, or unresolved. Verify patient facility id and resubmit as a new claim or contact EDS Provider Services if id is correct.

- **EOB 8326**
  Attending provider id is missing or unresolved. Attending provider is required. Verify attending provider id and resubmit as a new claim or contact EDS Prov SVC if id is correct.

NPI – Get it! Share It! Use It! Getting one is free – Not having one can be costly!

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

National Provider Identifier

Attention: All Providers

Recommended Taxonomy Codes for NPI Mapping

N.C. Medicaid has designed a mapping solution to crosswalk the NPI to the Medicaid Provider Number. Ideally, each NPI will crosswalk to only one Medicaid Provider Number. If the NPI crosswalks to multiple Medicaid Provider Numbers, the mapping solution will attempt to determine the appropriate Medicaid Provider Number by taking the claim through a series of steps. The taxonomy will play an important role in determining the appropriate Medicaid Provider Number to use for claim processing. Therefore, N.C. Medicaid strongly recommends that providers use the table below when choosing an appropriate taxonomy. This will assist N.C. Medicaid in crosswalking to the correct Medicaid Provider Number in the event the provider chooses not to apply for a unique NPI for each of its Medicaid Provider Numbers.

NOTE: The taxonomies recommended below are to be used for claims processing only. Providers are not required to change the taxonomy that was previously reported to NPPES or N.C. Medicaid Provider Enrollment. Currently, N.C. Medicaid does not compare the taxonomy submitted on claims to what was reported to Provider Enrollment or NPPES.

Provider Type/Service Provided	Taxonomy Code
Nursing Home - Skilled Nursing Level of Care	314000000X
Nursing Home - Intermediate Care Level of Care	313M00000X
Nursing Home – Vent Level of Care	314000000X
Nursing Home – Head Level of Care	310500000X
Nursing Home – Indian Facility Billing Skilled Nursing Level of Care	314000000X
Nursing Home – Indian Facility Billing Intermediate Nursing Level of Care	313M00000X
Adult Care Home Level of Care	310400000X
Adult Care Home Enhanced Level of Care	310400000X
Adult Care Home Special Care Alzheimer's Level of Care	311500000X
Swing Bed – Any Facility	275N00000X
Personal Care Services	3747P1801X

Provider Type/Service Provided	Taxonomy Code
All Case Management Services (HIV, At Risk, MCC and CSC)	251B00000X
Home Health	251E00000X
Home Infusion Therapy (HIT)	251F00000X
Durable Medical Equipment	332B00000X
Pharmacy Prescription Services	333600000X
Federally Qualified Health Clinic (FQHC) – All services	261QF0400X
Rural Health Clinic (RHC) – All Services	261QR1300X
Physician - Groups	193200000X (Multi-specialty) 193400000X (Single specialty)
Physician – Individuals	Any of the Allopathic and Osteopathic Taxonomies
Private Duty Nurses	215J00000X
Nurse Practitioners – All Services except psychiatric related services	363L00000X
Nurse Practitioners – Mental Health/Psychiatric	363LP0808X
Clinical Nurse Specialist – Mental Health/Psychiatric	364SP0808X
Hospice Services Provided at Any Location	251G00000X
Hospital – Rehabilitation Services ('T' suffix on Medicaid Provider Number)	273Y00000X 276400000X
Hospital – Psychiatric Services ('S' suffix on Medicaid Provider Number)	273R00000X
Hospital – General Services	282N00000X
Hospital – Critical Access	282NC0060X
Area Mental Health (LME)	261QM0801X
Psychiatric Residential Treatment Facility (PRTF)	323P00000X
Residential Child Care	322D00000X
Independent and Outpatient Mental Health Services – Group	Any of the Behavioral Health and Social Service Taxonomies

Provider Type/Service Provided	Taxonomy Code
Community Intervention Services (All Enhanced Benefits	251S00000X
Psychiatric Hospital – Inpatient	283Q00000X
Health Department – All Services	251K00000X
Ambulance	341600000X
Respiratory Therapists Group/Individual	227800000X
Audiologists Group/Individual	231H00000X
Hearing Aid Dealer – Hearing Aid	237700000X
Speech Pathologists Group/Individual	235Z00000X
Physical Therapists Group/Individual	225100000X
Occupational Therapists Group/Individual	225X00000X
Chiropractic Group/Individual	111N00000X
Optometry Group/Individual	152W00000X
Optical Supply Dealer – Eyewear Supplier	332H00000X
Optical Supply Dealer – Optician	156FX1800X
Podiatry Group/Individual	213E00000X

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

Attention: Nursing Facility Providers

Recommended Taxonomy Codes for NPI Mapping

N.C. Medicaid recommends for NPI mapping that the following taxonomies are submitted on claims when nursing home services are provided.

Provider Type/Service Provided	Taxonomy Code
Nursing Home - Skilled Nursing Level of Care	314000000X
Nursing Home - Intermediate Care Level of Care	313M00000X
Nursing Home – Vent Level of Care	314000000X
Nursing Home – Head Level of Care	310500000X
Nursing Home – Indian Facility Billing Skilled Nursing Level of Care	314000000X
Nursing Home – Indian Facility Billing Intermediate Nursing Level of Care	313M00000X

Attention: Case Management Agencies

Recommended Taxonomy Codes for NPI Mapping

N.C. Medicaid recommends for NPI mapping that the following taxonomy is submitted on claims when case management services are provided.

Provider Type/Service Provided	Taxonomy Code
All Case Management Services (HIV, At Risk, MCC and CSC)	251B00000X

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

Attention: Personal Care Services, Personal Care Services–Plus

Recommended Taxonomy Codes for NPI Mapping

N.C. Medicaid recommends for NPI mapping that the following taxonomy is submitted on claims when personal care services are provided.

Provider Type/Service Provided	Taxonomy Code
Personal Care Services	3747P1801X

Attention: Home Health Agencies

Recommended Taxonomy Codes for NPI Mapping

N.C. Medicaid recommends for NPI mapping that the following taxonomy is submitted on claims when home health services are provided.

Provider Type/Service Provided	Taxonomy Code
Home Health	251E00000X

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

Attention: Home Infusion Therapists

Recommended Taxonomy Codes for NPI Mapping

N.C. Medicaid recommends for NPI mapping that the following taxonomy is submitted on claims when home infusion therapy services are provided.

Provider Type/Service Provided	Taxonomy Code
Home Infusion Therapy (HIT)	251F00000X

Attention: Durable Medical Equipment Providers

Recommended Taxonomy Codes for NPI Mapping

N.C. Medicaid recommends for NPI mapping that the following taxonomy is submitted on claims when billing for DME supplies.

Provider Type/Service Provided	Taxonomy Code
Durable Medical Equipment	332B00000X

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

Attention: Adult Care Home Providers

Recommended Taxonomy Codes for NPI Mapping

N.C. Medicaid recommends for NPI mapping that the following taxonomies are submitted on claims when adult care home services are provided.

Provider Type/Service Provided	Taxonomy Code
Adult Care Home Level of Care	310400000X
Adult Care Home Enhanced Level of Care	310400000X
Adult Care Home Special Care Alzheimer's Level of Care	311500000X

Attention: Health Departments

Recommended Taxonomy Codes for NPI Mapping

N.C. Medicaid recommends for NPI mapping that the following taxonomy is submitted on claims when services are provided at health departments.

Provider Type/Service Provided	Taxonomy Code
Health Department – All Services	251K00000X

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

Attention: Federally Qualified Health Centers, Rural Health Centers

Recommended Taxonomy Codes for NPI Mapping

N.C. Medicaid recommends for NPI mapping that the following taxonomies are submitted on claims when services are provided at FQHC/RHC. This will ensure accurate mapping for federal funding.

Provider Type/Service Provided	Taxonomy Code
Federally Qualified Health Clinic (FQHC) – All services	261QF0400X
Rural Health Clinic (RHC) – All Services	261QR1300X

Attention: Hospice Providers

Recommended Taxonomy Codes for NPI Mapping

N.C. Medicaid recommends for NPI mapping that the following taxonomy is submitted on claims when billing for hospice services.

Provider Type/Service Provided	Taxonomy Code
Hospice Services Provided at Any Location	251G00000X

NOTE: For hospice services being provided in a nursing home facility, N.C. Medicaid recommends for NPI mapping of the attending/rendering provider, the following taxonomies are submitted on the claim at the attending/rendering level.

Provider Type/Service Provided	Taxonomy Code
Nursing Home - Skilled Nursing Level of Care	314000000X
Nursing Home - Intermediate Care Level of Care	313M00000X

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

National Provider Identifier

Attention: All Providers (Except Pharmacy)

New Requirements for NPI, Medicaid Provider Number, and Taxonomy on Claims

Effective January 1, 2008, with the exception of pharmacy, all submitted claims must contain the Medicaid Provider Number, NPI, and Taxonomy. This data is needed to ensure that providers' claims are mapping and paying to the correct Medicaid Provider Number prior to NPI implementation.

Beginning in March 2008, claims will deny if one of the above data elements is missing. For placement of data on the 837 transaction, consult the HIPAA Implementation Guide at www.wpc-edi.com. The NCECS Webtool now contains fields to report this information. For UB and ADA paper claims, consult the New Claim Form Instructions Special Bulletin at http://www.ncdhhs.gov/dma/bulletin/NewClaimForm0607.pdf.

Please note the following change for CMS-1500 paper claim forms: Report the Billing Taxonomy in Box 19, and the Attending Taxonomy (if applicable) in Box 32b. Placement of NPI and Medicaid provider number on paper claims remain the same.

Reminder: on CMS-1500 and UB paper claims, the ZZ qualifier must precede the taxonomy. Qualifiers are not used on the ADA form.

NPI – Get it! Share It! Use It! Getting one is free – Not having one can be costly!

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

Attention: All Providers

National Provider Identifier and Address Information Database

The Division of Medical Assistance (DMA) has implemented a searchable National Provider Identifier (NPI) and address database. Providers can access the database by NPI or Medicaid provider number, at http://www.ncdhhs.gov/dma/NPI.htm.

Please access the database as soon as possible to verify your NPI, site address, and billing address.

- If all information is correct, no action is necessary.
- To correct typographical errors: print the form, make corrections, and fax to the number on the printable form.
- To correct more serious (non-typographical) errors, submit a Provider Change Form (http://www.ncdhhs.gov/dma/Forms/changeprovstatus.pdf) and include any other applicable documentation.

If your NPI is not in the database, previously submitted documentation was either not sufficient to update the database or has not been submitted at all. Providers should print the form and submit your NPI with a copy of your National Plan and Provider Enumeration System (NPPES) certification.

Provider Services
DMA, 919-855-4050

Attention: NCECS

Attention: Webtool Users

Updated Fields for National Drug Code (NDC) and NPI

New fields are now available on the NCECS Webtool for submitting NDC and NPI information. The NDC fields include: the 11 digit National Drug Code and the NDC units (quantity). Physicians, nurse practitioners, nurse midwives, Federally Qualified Health Centers, Rural Health Clinics, local health departments, and non-hospital based dialysis centers are required to submit NDCs when billing for rebatable drugs through the Physician's Drug Program (PDP). For more information regarding NDC, see the October 2007 NDC Special Bulletin.

The NPI fields include: attending provider NPI, referring provider NPI, billing provider taxonomy and attending provider taxonomy. The existing NPI field now has the ability to save data. Effective January 1, 2008, NCECSWeb users are required to submit the NPI, Medicaid Provider Number, and taxonomy on all claims. For more information regarding NPI, see the DMA NPI webpage: www.ncdhhs.gov/dma/npi.htm.

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

Attention: All Providers

Current Procedural Terminology Code Update 2008

Effective with date of service Jan. 1, 2008, the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA) have added some new *Current Procedural Terminology* (CPT) codes, deleted others, and changed the descriptions of some existing codes. (For complete information regarding all CPT codes and descriptions, refer to the 2008 edition of *Current Procedural Terminology,* published by the American Medical Association.) New CPT codes that are covered by the N.C. Medicaid program are effective with date of service Jan. 1, 2008. Claims submitted with deleted codes will be denied for dates of service on or after Jan .1, 2008. Previous policy restrictions continue in effect unless otherwise noted.

New Covered CPT Codes (effective 01/01/2008)									
99367	99477	01935	01936	20555	21073	22206	22207	22208	24357
24358	24359	27267	27268	27269	27726	27767	27768	27769	29828
29904	29905	29906	29907	32421	32422	32550	32551	32560	33257
33258	33259	33864	34806	35523	36593	41019	49203	49204	49205
49440	49441	49442	49446	49450	49451	49452	49460	49465	50385
50386	51100	51101	51102	52649	55920	57285	57423	58570	58571
58572	58573	60300	67041	67042	67043	67113	67229	68816	75557
75561	80047	82610	83993	84704	86356	86486	87500	87809	90769
90770	90771	96125							

End-Dated CPT Codes (effective 12/31/2007)									
01905	24350	24351	24352	24354	24356	32000	32002	32005	32019
32020	36540	36550	43750	47719	49200	49201	51000	51005	51010
52510	60001	67038	74350	75552	75553	75554	75555	75556	78615
86586	99361	99362	99371	99372	99373				

New CPT Codes Not Covered Pending Further Review									
75559	75563	95980	95982						

New CPT Codes Not Covered									
99366	99368	99406	99407	99408	99409	99441	99442	99443	99444
20985	20986	20987	27416	28446	36591	36592	50593	75558	75560
75562	75564	88381	89322	89331	90284	90661	90662	90663	90776
93982	95981	98966	98967	98968	98969	99174	99605	99606	99607

CPT Codes from Previous CPT Updates That Are Now Covered (effective 01/01/2008)									
22523	22524	22525	51798						

Billing Information

CPT CODE	BILLING INFORMATION	DIAGNOSIS EDITING	PRIOR APPROVAL
68816	This procedure is approved for recipients ages 1 and older.	N/A	N/A
82610	Cystatin C is covered only for the FDA-approved indication, renal function testing.	N/A	N/A
90769 90770 90771	These procedures are not billable when the service is provided in a facility.	N/A	N/A
99367	This procedure is for 30 minutes or more of a physician's time during a medical team conference. The code will be allowed once per conference per day. This procedure will be covered only as a replacement for deleted CPT codes 99361 and 99362, and only when it is used as described in Clinical Coverage Policy 1A-5, "Case Conference for Sexually Abused Children," available online at http://www.ncdhhs.gov/dma/mp/mpindex.htm.	Allowed diagnoses for this procedure are outlined in the policy.	N/A

Additional information will be published as necessary in future general Medicaid bulletins.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: Dental Providers and Health Department Dental Centers

Dental Rate Change

Effective with dates of service January 1, 2008, reimbursement rates for the following dental procedures were increased. **No adjustments will be accepted from providers for these dental rate changes.** Providers are reminded to bill their usual and customary charges rather than the Medicaid rate**.**

CDT 2007/2008 Code	Description	Reimbursement Rate
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	24.99
D0240	Intraoral - occlusal film	15.19
D0250	Extraoral - first film	22.54
D0260	Extraoral - each additional film	18.62
D0270	Bitewing - single film	10.78
D0290	Posterior-anterior or lateral skull and facial bone survey film	47.04
D0310	Sialography	100.94
D0320	Temporomandibular joint arthrogram, including injection	205.80
D0340	Cephalometric film	49.98
D0470	Diagnostic casts	40.80
D0473	Accession of tissue, gross and microscopic examination	50.96
D1110	Prophylaxis - adult	35.35
D1120	Prophylaxis - child	25.50
D2161	Amalgam - four or more surfaces, primary or permanent	100.10
D2390	Resin-based composite crown, anterior	163.35
D2931	Prefabricated stainless steel crown - permanent tooth	150.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	181.77
D2940	Sedative filling	41.65
D2950	Core buildup, including any pins	102.90
D2951	Pin retention - per tooth, in addition to restoration	24.99
D2970	Temporary crown (fractured tooth)	132.79
D3310	Root canal therapy - anterior (excluding final restoration)	269.50
D3320	Root canal therapy - bicuspid (excluding final restoration)	318.50
D3330	Root canal therapy - molar (excluding final restoration)	389.55
D3351	Apexification/recalcification - initial visit	131.32
D3352	Apexification/recalcification - interim medication replacement	95.55
D3353	Apexification/recalcification - final visit	191.10
D3410	Apicoectomy/periradicular surgery - anterior	246.96
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth per quadrant	236.18
D4211	Gingivectomy or gingivoplasty - one to three teeth per quadrant	87.71
D4240	Gingival flap procedure, including root planing - four or	278.32

CDT 2007/2008 Code	Description	Reimbursement Rate
	more contiguous teeth per quadrant	
D4241	Gingival flap procedure, including root planing - one to three teeth per quadrant	235.20
D4341	Periodontal scaling and root planing - four or more contiguous teeth per quadrant	95.55
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	61.25
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	70.56
D4910	Periodontal maintenance	51.94
D5110	Complete denture - maxillary	612.50
D5120	Complete denture - mandibular	612.50
D5130	Immediate denture - maxillary	664.44
D5140	Immediate denture - mandibular	664.44
D5211	Maxillary partial denture - resin base	454.23
D5212	Mandibular partial denture - resin base	454.23
D5213	Maxillary partial denture - cast metal framework with resin denture bases	656.60
D5214	Mandibular partial denture - cast metal framework with resin denture bases	656.60
D5410	Adjust complete denture - maxillary	33.32
D5411	Adjust complete denture - mandibular	33.32
D5421	Adjust partial denture - maxillary	33.32
D5422	Adjust partial denture - mandibular	33.32
D5520	Replace missing or broken teeth - complete denture (each tooth)	68.11
D5620	Repair cast framework	109.76
D5640	Replace broken teeth - per tooth	68.60
D5650	Add tooth to existing partial denture	83.30
D5730	Reline complete maxillary denture (chairside)	142.10
D5731	Reline complete mandibular denture (chairside)	142.10
D5740	Reline maxillary partial denture (chairside)	139.65
D5741	Reline mandibular partial denture (chairside)	139.65
D5750	Reline complete maxillary denture (laboratory)	180.81
D5751	Reline complete mandibular denture (laboratory)	180.81
D5760	Reline maxillary partial denture (laboratory)	176.40
D5761	Reline mandibular partial denture (laboratory)	176.40
D6985	Pediatric partial denture, fixed	359.17
D7111	Extraction, coronal remnants - deciduous tooth	49.00
D7140	Extraction, erupted tooth or exposed root	60.50
D7210	Surgical removal of erupted tooth	104.00
D7220	Removal of impacted tooth - soft tissue	118.09
D7230	Removal of impacted tooth - partially bony	158.60
D7240	Removal of impacted tooth - completely bony	183.75
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	220.50

CDT 2007/2008 Code	Description	Reimbursement Rate
D7250	Surgical removal of residual tooth roots (cutting procedure)	113.19
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	200.90
D7280	Surgical access of an unerupted tooth	180.81
D7283	Placement of device to facilitate eruption of impacted tooth	203.35
D7285	Biopsy of oral tissue - hard (bone, tooth)	143.08
D7310	Alveoloplasty in conjunction with extractions - four or more tooth spaces, per quadrant	107.80
D7311	Alveoloplasty in conjunction with extractions - one to three tooth spaces, per quadrant	100.80
D7320	Alveoloplasty not in conjunction with extractions - four or more tooth spaces, per quadrant	157.29
D7321	Alveoloplasty not in conjunction with extractions - one to three tooth spaces, per quadrant	141.12
D7411	Excision of benign lesion greater than 1.25 cm	221.48
D7412	Excision of benign lesion, complicated	292.04
D7413	Excision of malignant lesion up to 1.25 cm	243.04
D7414	Excision of malignant lesion greater than 1.25 cm	355.74
D7415	Excision of malignant lesion, complicated	426.30
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	196.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	186.20
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	238.63
D7465	Destruction of lesion(s) by physical or chemical method, by report	146.51
D7472	Removal of torus palatinus	274.40
D7473	Removal of torus mandibularis	272.93
D7485	Surgical reduction of osseous tuberosity	245.98
D7490	Radical resection of mandible with bone graft	3,109.05
D7530	Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue	132.30
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	245.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	400.82
D7610	Maxilla - open reduction (teeth immobilized, if present)	1,604.75
D7620	Maxilla - closed reduction (teeth immobilized, if present)	1,260.77
D7630	Mandible - open reduction (teeth immobilized, if present)	1,581.23
D7640	Mandible - closed reduction (teeth immobilized, if present)	1,242.15
D7650	Malar and/or zygomatic arch - open reduction	1,434.72
D7660	Malar and/or zygomatic arch - closed reduction	1,219.12
D7670	Alveolus - closed reduction, may include stabilization of teeth	498.82
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches	2,408.35

CDT 2007/2008 Code	Description	Reimbursement Rate
D7710	Maxilla - open reduction	1,690.50
D7720	Maxilla - closed reduction	1,230.88
D7730	Mandible - open reduction	1,715.00
D7740	Mandible - closed reduction	1,327.90
D7750	Malar and/or zygomatic arch - open reduction	1,512.14
D7760	Malar and/or zygomatic arch - closed reduction	1,673.84
D7770	Alveolus - open reduction stabilization of teeth	980.00
D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches	2,884.14
D7810	Open reduction of dislocation	1,565.55
D7820	Closed reduction of dislocation	191.10
D7830	Manipulation under anesthesia	250.88
D7840	Condylectomy	2,025.17
D7850	Surgical discectomy, with/without implant	2,041.34
D7870	Arthrocentesis	129.85
D7920	Skin graft	895.23
D7940	Osteoplasty - for orthognathic deformities	1,321.53
D7941	Osteotomy - mandibular rami	3,454.01
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft	3,181.08
D7944	Osteotomy - segmented or subapical	2,642.08
D7945	Osteotomy - body of mandible	2,744.00
D7946	LeFort I (maxilla - total)	3,218.32
D7947	LeFort I (maxilla - segmented)	3,253.11
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla	1,006.95
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	168.07
D7972	Surgical reduction of fibrous tuberosity	269.50
D7982	Sialodochoplasty	611.03
D7983	Closure of salivary fistula	401.80
D7990	Emergency tracheotomy	453.25
D7991	Coronoidectomy	1,440.60
D8670	Periodic orthodontic treatment visit (as part of contract)	92.40
D9110	Palliative (emergency) treatment of dental pain - minor procedure	44.59
D9220	Deep sedation/general anesthesia - first 30 minutes	141.61
D9221	Deep sedation/general anesthesia - each additional 15 minutes	60.27
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	56.35
D9410	House/extended care facility call	78.40
D9440	Office visit - after regularly scheduled hours	61.25
D9610	Therapeutic parenteral drug, single administration	36.75

For current pricing on these and all dental codes, please refer to the fee schedule on the Division of Medical Assistance (DMA) Web site at http://www.ncdhhs.gov/dma/fee/fee.htm. For coverage criteria and additional billing guidelines, please refer to *Clinical Coverage Policy 4A, Dental Services,* and *Clinical Coverage Policy 4B, Orthodontic Services,* on DMA's Web site at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

Dental Program
DMA, 919-855-4280

Attention: Local Education Agencies and Independent Practitioners

Code Addition

Effective with date of service Jan. 1, 2008, the following new CPT code has been added to the list of appropriate codes that independent practitioner and Local Education Agency speech language pathologists and occupational therapists may bill.

New CPT Code	Description
96125	Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report. (*1 unit = 1 hour)*

Clinical Coverage Policies 10B, *Independent Practitioners*, and 10C, *Local Education Agencies*, have been updated to reflect this code addition and are available on the Division of Medical Assistance Web site at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

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

Attention: Orthotic and Prosthetic Providers

2008 HCPCS Code Changes for Orthotics and Prosthetics

Effective with date of service Dec. 31, 2007, the following codes were end dated and removed from the Orthotics and Prosthetics (O&P) fee schedule.

L0960	L1855	L1858	L1870	L1880
L3800	L3805	L3810	L3815	L3820
L3825	L3830	L3835	L3840	L3845
L3850	L3855	L3860	L3907	L3910
L3916	L3918	L3920	L3922	L3924
L3926	L3928	L3930	L3932	L3934
L3936	L3938	L3940	L3942	L3944
L3946	L3948	L3950	L3952	L3954
L3985	L3986			

Effective with date of service Jan. 1, 2008 the following code description change was made:

Code	New Description
L3806*	Wrist hand finger orthosis, includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, custom fabricated, includes fitting and adjustment.

Effective with date of service Jan. 1, 2008 the following codes were added to the O&P fee schedule:

New Code	Description	Modifier	Lifetime Expectancy/Quantity Limitations
L3925*	Finger orthosis, proximal interphalangeal (PIP)/distal interphalangeal (DIP), nontorsion joint/spring, extension/flexion, may include soft interface material, prefabricated, includes fitting and adjustment.	New Left Right	6 months: ages 00-20; 1 year ages 21 and older
L3927*	Finger orthosis, proximal interphalangeal (PIP)/distal interphalangeal (DIP), without joint/spring, extension/flexion, (e.g. static or ring type), may include soft interface material, prefabricated, includes fitting and adjustment.	New Left Right	6 months: ages 00-20; 1 year ages 21 and older

New Code	Description	Modifier	Lifetime Expectancy/Quantity Limitations
L3929 *	Hand finger orthosis, includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, prefabricated, includes fitting and adjustment.	New Left Right	6 months: ages 00-20; 1 year ages 21 and older
L3931*	Wrist hand finger orthosis, includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, prefabricated, includes fitting and adjustment.	New Left Right	6 months: ages 00-20; 1 year ages 21 and older
L7611*	Terminal device, hook, mechanical, voluntary opening, any material, any size, lined or unlined, pediatric	New Left Right	1 year: ages 00-20
L7612*	Terminal device, hook, mechanical, voluntary closing, any material, any size, lined or unlined, pediatric	New Left Right	1 year: ages 00-20
L7613*	Terminal device, hand, mechanical, voluntary opening, any material, any size, pediatric	New Left Right	1 year: ages 00-20
L7614*	Terminal device, hand, mechanical, voluntary closing, any material, any size, pediatric	New Left Right	1 year: ages 00-20
L7621*	Terminal device, hook or hand, heavy duty, mechanical, voluntary opening, any material, any size, lined or unlined	New Left Right	1 year: ages 00-20; 3 years ages 21 and older
L7622 *	Terminal device, hook or hand, heavy duty, mechanical, voluntary closing, any material, any size, lined or unlined	New Left Right	1 year: ages 00-20; 3 years ages 21 and older

Please refer to the O&P Fee Schedule on DMA Web site at www.ncdhhs.gov/dma/fee/fee.htm.
Note: In the tables above, HCPCS codes with an asterisk (*) require prior approval and bold type indicates the item is covered by Medicare. A Certificate of Medical Necessity and Prior Approval (CMNPA) must be completed for all items, regardless of the requirement for prior approval. The coverage criteria for these items have not changed. Refer to the Clinical Coverage Policy 5B, *Orthotics and Prosthetics*, on the Web site at www.ncdhhs.gov/dma/mp/mpindex.htm, for detailed coverage information.

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

Attention: Durable Medical Equipment Providers

2008 HCPCS Code Changes for Discontinued, Description Changes and Code Additions for Durable Medical Equipment

Effective with date of service December 31, 2007, in order to comply with the Centers for Medicare and Medicaid Services (CMS) HCPCS coding changes, the following codes were end dated and removed from the DME fee schedule:

W4210	**B4086**	**E2618**

Effective with date of service January 1, 2008 the following code description changes were made:

Code	New Description
B4034	Enteral Feeding Supply Kit; Syringe Fed, Per Day
E0630	Patient Lift, Hydraulic or Mechanical, Includes Any Seat, Sling, Strap(s) Or Pad(s)
E2205	Manual Wheelchair Accessory, Handrim Without Projections (Includes Ergonomic or Contoured), Any Type, Replacement Only, Each
E2373	Power Wheelchair Accessory, Hand Or Chin Control Interface, Compact Remote Joystick, Proportional, Including Fixed Mounting Hardware

Effective with date of service January 1, 2008 the following codes were added to the DME fee schedule:

New Code	Description	Modifier	Lifetime Expectancy/Quantity Limitations
A7027	Combination, oral/nasal mask used with CPAP device, each	New	2/year
A7028	Oral cushion for combination oral/nasal mask, replacement only, each	New	2/year
A7029	Nasal pillows for combination oral/nasal mask, replacement only, pair	New	2/year

New Code	Description	Modifier	Lifetime Expectancy/Quantity Limitations
B4087	Gastrostomy/Jejunostomy tube, standard, any material, any type, each	New	2/month
B4088	Gastrostomy/Jejunostomy tube, low-profile, any material, any type, each	New	2/month
E2227	Manual Wheelchair accessory, gear reduction drive wheel, each	New Used Rental	1 year
E2228	Manual wheelchair accessory, wheel braking system and lock, complete, each	New Used Rental	1 year
E2312*	Power wheelchair accessory, hand or chin control interface, mini-proportional remove joystick, proportional, including fixed mounting hardware, each	New Used Rental	4 yrs/ 2yrs 00-20
E2313*	Power wheelchair accessory, harness for upgrade to expandable controller, including all fasteners, connectors and mounting hardware, each	New Used Rental	4 yrs/ 2yrs 00-20

Note: For these and all maximum allowable rates, please refer to the DME fee schedule found the website http://www.dhhs.state.nc.us/dma/fee/fee.htm.

In the tables above, HCPCS codes with an asterisk (*) require prior approval and bold type indicates the item is covered by Medicare. A Certificate of Medical Necessity and Prior Approval form must be completed for all items regardless of the requirement for prior approval. The coverage criteria for these items have not been changed. Refer to the Clinical Coverage Policy 5A, Durable Medical Equipment on DMA's website @ www.ncdhhs.gov/dma for detailed coverage information. Also for these and all maximum allowable rates, please refer to the DME fee schedule found on DMA's website @ www.ncdhhs.gov/dma.

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

Attention: All Providers

HCPCS Procedure Code Changes for the Physician's Drug Program

The following HCPCS procedure code changes have been made to comply with the Centers for Medicare and Medicaid Services (CMS) HCPCS procedure code changes.

End-Dated Codes with No Replacement Codes

Effective with date of service Dec. 31, 2007, HCPCS procedure code **A9527** (iodine I-125 sodium iodide solution, therapeutic, per millicurie) was end-dated. Claims submitted for dates of service on or after Jan. 1, 2008, using the end-dated code will be denied. This **therapeutic radiopharmaceutical agen**t is used for research purposes only.

New HCPCS Procedure Codes

The following HCPCS procedure codes were added to the list of covered codes for the Physician's Drug Program effective with date of service Jan. 1, 2008.

New HCPCS Code	Description	Unit
J1573	Hepatitis B immune globulin, (Hepagam B), IV	0.5 ml
A9564	Radiopharmaceutical: Chromic phosphate P-32 suspension, therapeutic	Per mCi
A9600	Radiopharmaceutical: Strontium Sr-89 chloride, therapeutic	Per mCi
A9605	Radiopharmaceutical: Samarium Sm-153 lexidronamm, therapeutic	Per 50 mCi

End-Dated Codes with Replacement Codes

The following HCPCS procedure codes were end-dated with date of service Dec. 31, 2007, and replaced with new codes effective with date of service Jan. 1, 2008. Claims submitted for dates of service on or after Jan. 1, 2008, using the end-dated codes will be denied.

End-Dated HCPCS Code	Description	Unit	New HCPCS Code	Description	Unit
Q4079	Natalizumab (Tysabri)	1 mg	J2323	Natalizumab (Tysabri)	1 mg
Q4083	Hyalgan or Supartz, for intra-articular injection		J7321	Hyaluronan or derivative, Hyalgan or Supartz, for intra-articular injection	Per dose
Q4084	Synvisc, for intra-articular injection		J7322	Hyaluronan or derivative, Synvisc, for intra-articular injection	Per dose
Q4085	Euflexxa, for intra-articular injection		J7323	Hyaluronan or derivative, Euflexxa, for intra-articular injection	Per dose
Q4086	Orthovisc, for intra-articular injection		J7324	Hyaluronan or derivative, Orthovisc, for intra-articular injection	Per dose
Q4087	Immune globulin, Octagam, IV non-lyophilized	500 mg	J1568	Immune globulin, Octagam, IV non-lyophilized (e.g. liquid)	500 mg
Q4088	Immune globulin, Gammagard liquid, IV, non-lyophilized	500 mg	J1569	Immune globulin, (Gammagard liquid), IV, non-lyophilized (e.g. liquid)	500 mg
Q4089	Rho(D) immune globulin, (Rhophylac), IM or IV, non-lyophilized	100 IU	J2791	Rho(D) immune globulin, (Human) Rhophylac, IM or IV, non-lyophilized	100 IU

End-Dated HCPCS Code	Description	Unit	New HCPCS Code	Description	Unit
Q4090	Hepatitis B immune globulin, (Hepagam B), IM,	0.5 ml	J1571	Hepatitis B immune globulin, (Hepagam B), IM	0.5 ml
Q4091	Immune globulin (Flebogamm a), IV, non-lyophilized (e.g. liquid)	500 mg	J1572	Immune globulin (Flebogamma), IV, non-lyophilized (e.g. liquid)	500 mg
Q4092	Immune globulin (Gamunex) IV, non-lyophilized (e.g. liquid)	500 mg	J1561	Immune globulin (Gamunex) IV, non-lyophilized (e.g. liquid)	500 mg
Q4095	Zoledronic acid (Reclast)	1 mg	J3488**	Zoledronic acid (Reclast)	1 mg
S0180	Etonogestrel contraceptive implant system, including implants and supplies		J7307*	Etonogestrel contraceptive implant system, including implants and supplies	

Note:*Implanon must be billed with the family planning (FP) modifier and with the appropriate CPT administration code, also billed with FP.

****Zoledronic acid (Reclast) has been included in the PDP since July 1, 2007, for Paget's disease of the bone (N.C. general Medicaid bulletin, July 2007). **The FDA has recently approved its use for post-menopausal osteoporosis** as well and Medicaid has added it to the PDP for this purpose, effective with date of service **Sept. 1, 2007.**

The ICD-9-CM diagnosis codes required for billing Reclast are 731.0 [Osteitis deformans without mention of bone tumor (Paget's disease of bone)] **OR** 733.01 (Post-menopausal osteoporosis).

New Codes That Were Previously Billed with the Miscellaneous Drug Codes J3490, J3590, and J9999

Effective with date of service Jan. 1, 2008, the N.C. Medicaid program covers the individual HCPCS procedure codes for the drugs listed in the following table. Claims submitted for dates of service on or after Jan. 1, 2008, using the unlisted drug codes J3490, J3590, or J9999 for these drugs will be denied. An invoice is not required.

Old HCPCS Code	Description	Old Unit	New HCPCS Code	New Unit
J3590	Eculizumab (Soliris)	300 mg	J1300	10 mg
J3490	Idursulfase (Elaprase)	1 mg	J1743	1 mg
J3590	Protein C Concentrate, human (Ceprotin)	1 IU	J2724	1 IU
J3590	Ranibizumab (Lucentis)	0.5	J2778	0.1 mg
J9999	Panitumumab (Vectibix)	100 mg/ml	J9303	10 mg
J3490	Histrelin implant (Supprelin LA)	50 mg	J9226	50 mg
J3590	Pegylated interferon alfa-2b (Peg-Intron)	10 mcg	S0146	10 mcg per 0.5 ml

Refer to the fee schedule for the Physician's Drug Program on DMA's Web site at http://www.ncdhhs.gov/dma/fee/fee.htm for the latest available fees.

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

Attention: All Providers

2008 ICD-9-CM Procedure and Diagnosis Codes

The following new 2008 ICD-9-CM procedure codes have been implemented effective with date of service October 1, 2007.

00.94	01.10	01.16	01.17	07.83	07.84	07.95	07.98	32.20	32.30
32.39	32.41	32.49	32.50	32.59	33.20	34.06	34.20	34.52	50.13
50.14	70.53	70.54	70.55	70.63	70.64	70.78	70.93	70.94	70.95
88.59	92.41								

The following new 2008 ICD-9-CM diagnosis codes have been implemented effective with date of service October 1, 2007.

040.41	040.42	058.10	058.11	058.12	058.21	058.29	058.81	058.82	058.89
079.83	200.30	200.31	200.32	200.33	200.34	200.35	200.36	200.37	200.38
200.40	200.41	200.42	200.43	200.44	200.45	200.46	200.47	200.48	200.50
200.51	200.52	200.53	200.54	200.55	200.56	200.57	200.58	200.60	200.61
200.62	200.63	200.64	200.65	200.66	200.67	200.68	200.70	200.71	200.72
200.73	200.74	200.75	200.76	200.77	200.78	202.70	202.71	202.72	202.73
202.74	202.75	202.76	202.77	202.78	233.30	233.31	233.32	233.39	255.41
255.42	258.01	258.02	258.03	284.81	284.89	288.66	315.34	331.5	359.21
359.22	359.23	359.24	359.29	364.81	364.89	388.45	389.05	389.06	389.13
389.17	389.20	389.21	389.22	414.2	415.12	423.3	440.4	449	488
569.43	624.01	624.02	624.09	664.60	664.61	664.64	733.45	787.20	787.21
787.22	787.23	787.24	787.29	789.51	789.59	999.31	999.39	V12.53	V12.54
V13.22	V16.52	V25.04	V49.85	V72.12	V73.81				

The following new 2008 ICD-9-CM procedure codes are not covered effective with date of service October 1, 2007:

00.19	84.80	84.81	84.82	84.83	84.84	84.85

The following new 2008 ICD-9-CM diagnosis codes are not covered effective with date of service October 1, 2007.

525.71	525.72	525.73	525.79	V17.41	V17.49	V18.11	V18.19	V26.41	V26.49
V26.81	V26.89	V68.01	V68.09	V84.81	V84.89				

Providers must use current national codes from the 2008 ICD-9-CM manual when submitting claims to N.C. Medicaid.

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

Attention: All Providers

Revised Procedures for Prescribing Synagis to Include EPSDT Information

Procedures for prescribing Synagis for the 2007–2008 Respiratory Syncytial Virus season have been revised to include Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) information. See the September 2007 North Carolina General Medicaid Bulletin and October 2007 North Carolina Pharmacy Newsletter for the original procedure. Synagis is administered under Medicaid's Outpatient Pharmacy Program (Clinical Coverage Policy 9, available on the Web at http://www.ncdhhs.gov/dma/mp/mpindex.htm). Therefore, all administrative policy requirements, **including EPSDT,** found in that policy apply to Synagis administration.

The Synagis procedure is consistent with currently published American Academy of Pediatrics RedBook guidelines (on the Web at http://aapredbook.aappublications.org/cgi/content/full/2006/1/3.107, subscription required, or in RedBook: 2006 Report of the Committee on Infectious Diseases—27th edition). It is important to note the following:

1. The decision to approve or deny a request for Synagis that exceeds the guidelines specified in the above publications will be based on the recipient's medical need to correct or ameliorate a defect, physical [or] mental illness, or condition [health problem]. "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.
2. The specific coverage criteria (e.g., particular diagnoses, signs, or symptoms) specified in the above publications do **not** have to be met for recipients under 21 years of age if Synagis is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problems]. For these recipients, the Request for Medical Review for Synagis Outside of Criteria form is used to request Synagis.
3. The specific numerical limits (number of hours, number of visits, or other limitations on scope, amount or frequency, age of the recipient) specified in the above publications do **not** apply to recipients under 21 years of age if Synagis is **medically necessary** to correct or ameliorate a defect, physical or mental illness, or condition [health problem]. Under EPSDT, Synagis (like any other Medicaid service) may be prescribed as often as needed for any Medicaid recipient under age 21 if it is **medically necessary** to correct or ameliorate the recipient's health problem.
4. Other restrictions specified in the publications above may be waived under EPSDT as long as exceeding those restrictions is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

For further information about EPSDT, see the August 2007 EPSDT Policy Instructions Update, on the Web at http://www.dhhs.state.nc.us/dma/EPSDT/EPSDTPolicyInstructionsUpdate081707.pdf

Submitting the Request for Medical Review Form
When a recipient does not meet the guidelines published in the Synagis procedure but the provider still wishes to prescribe Synagis, submit the Request for Medical Review for Synagis Outside of Criteria Form by doing the following:

- Prescriber completes the form, including the medical necessity justification, signs it, and faxes it to DMA at (919) 715-1255. This is the only form that prescribers should fax to DMA.
- The Request for Medical Review for Synagis Outside of Criteria Form is found at http://www.ncdhhs.gov/dma/Forms/SynagisMedicalReview.pdf.
- The request will be reviewed and either approved or denied. Notification of the result will be sent to prescribers.
- Pharmacy distributor maintains a copy of the approval letter on site.

Justification documentation must clearly address how exceeding policy limits is medically necessary as described in the EPSDT Policy Instructions Update [will correct or ameliorate (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)]. Should additional information be required, the provider will be contacted.

Note: Processing delays can occur if the recipient does not have a Medicaid identification number or the form is not complete.

Pharmacy and Ancillary Services
DMA, 919-855-4300

Attention: Physicians, Nurse Practitioners and Pharmacies

Additions to Over-the-Counter Medications Coverage List

Effective with date of service Nov. 10, 2007, numerous additional over-the-counter (OTC) drug codes are eligible for reimbursement by N.C. Medicaid if the drugs are purchased in conjunction with a prescription order by a physician. The updated list is available on the N.C. Division of Medical Assistance Web site in General Clinical Coverage Policy A-2, which can be found at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

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

Attention: Pharmacies

Change in the Determination of the Prescription Count for Global Limits, the FORM and Recipient Opt-In Programs

Effective Jan. 1, 2008, the Division of Medical Assistance (DMA) will count only unique, unduplicated prescriptions when counting prescriptions for global limits and for the FORM and Recipient Opt-In programs. Duplicate prescriptions filled during the month, for example early refills, will no longer be included in the monthly prescription counts. Duplicate prescriptions are defined as prescriptions that have the same GCN sequence number (same drug, strength and dosage form) as a prescription previously filled within the same calendar month.

DMA will continue to systematically review recipients who have opted into a pharmacy under the FORM and Recipient Opt-In programs and will automatically remove them from both programs when fewer than 12 prescriptions have been dispensed in two out of the last three months or when fewer than 12 prescriptions have been dispensed in the sixth month. With this change, some recipients who have qualified for the FORM and Recipient Opt-In programs in the past may no longer qualify for either of these programs.

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

Attention: All Providers

Tamper-Resistant Prescription Pads for Medicaid Outpatient Prescriptions

Important legislation was passed by Congress in May 2007 requiring prescriptions for all Medicaid outpatient drugs to be written on tamper-resistant prescription pads by October 1, 2007. On September 29, 2007, President George W. Bush signed the Extenders Law, delaying this implementation date to April 1, 2008.

On September 6, 2007, the NC Division of Medical Assistance (DMA) published guidance regarding the use of tamper-resistant prescription pads for prescriptions written for NC Medicaid recipients. This previously issued guidance will become effective as of April 1, 2008.

This guidance is available on DMA's Web site at: http://www.dhhs.state.nc.us/dma/TamperResistantPrescriptionPads.pdf. More detailed information regarding this new requirement can also be found in the January 1, 2008 Special Bulletin available on DMA's Web site at http://www.dhhs.state.nc.us/dma/bulletin.htm.

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

Attention: All Providers

Clinical Coverage Policies

The following new or amended clinical coverage policies are now available on the Division of Medical Assistance's Web site at http://www.ncdhhs.gov/dma/mp/mpindex.htm:

- 1I, Dietary Evaluation and Counseling
- 5A, Durable Medical Equipment
- 8A, Community Support Adult and Child

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

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

Update: FluMist Availability in the UCVDP/VFC Program

Effective immediately, the Universal Childhood Vaccine Distribution Program/Vaccines for Children Program (UCVDP/VFC) has expanded its coverage criteria to include children 2 to 5 years of age. Therefore, the N.C. Medicaid program will now reimburse for the administration of FluMist for VFC children from 2 through 18 years of age. Refer to "Influenza Vaccine and Reimbursement Guidelines for 2007–2008," on p. 9 of the October general Medicaid bulletin, for billing guidelines and other information regarding Medicaid coverage of the influenza vaccines.

EDS, 1-800-688-6696 or 919-688-6696

Attention: Ambulatory Surgical Centers

Ambulatory Surgical Centers Revised Payment System

The Centers for Medicare and Medicaid Services (CMS) has revised the ambulatory surgical center (ASC) payment system. The final CMS rule establishes the ambulatory surgery center list of covered surgical procedures, identifies covered ancillary services and sets forth the amounts and factors that will be used to determine the payment rates for calendar year 2008 under the revised payment system.

The Division of Medical Assistance is reviewing the list of codes added for 2008 and the revised payment methodology. The Current Procedural Terminology codes added to the ASC list effective January 1, 2008 will not be covered by NC Medicaid when provided in an ASC on or after January 1, 2008 pending further review by the Division. Providers will be informed of coverage decisions in a future Medicaid bulletin when this process and review are completed.

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

Attention: Physicians, Nurse Practitioners and Local Health Departments

Drugs Added to the Physician's Drug Program - Billing Guidelines

Effective with date of service **Jan. 1, 2008,** the N.C. Medicaid program covers the following drugs for use in the Physicians Drug Program when the requirements specified below are met: aglucosidase (Myozyme); aripiprazole (Abilify); decitabline (Dacogen); naltrexone (Vivitrol); and nelarabine (Arranon). Effective with date of service **Jan. 1, 2005**, histrelin implant (Vantas) is covered.

Reminders That Apply to All Drugs in This Article

- Providers must indicate the number of units given in block 24G on the CMS-1500 claim form.
- Effective with date of service December 28, 2007, providers must indicate the National Drug Code (NDC) number in the upper shaded portion of block 24A-H on the CMS-1500 claim form. Refer to the October 2007 Special Bulletin, *National Drug Code (NDC) Implementation* at the DMA Web site (http://www.ncdhhs.gov/dma/bulletin.htm#special)
- Providers must bill their usual and customary charges.
- The fee schedule for the Physician's Drug Program is available on DMA's Web site at http://www.ncdhhs.gov/dma/fee/fee.htm.
- Direct questions to EDS, 1-800-688-6696 or 919-851-8888.

Aglucosidase Alfa (Myozyme)—HCPCS procedure code J0220

Myozyme is indicated for the treatment of Pompe's disease, and is usually given every 2 weeks as an intravenous infusion. The infusion dosage is calculated on 20 mg/kg of body weight, and should be administered over approximately 4 hours.

The ICD-9-CM diagnosis code required for billing Myozyme is 271.0 (Pompe's disease). One unit of coverage is 10 mg. Physicians and nurse practitioners may bill for this drug.

Aripiprazole (Abilify)—HCPCS procedure code J0400

Abilify injection is indicated for the treatment of 1) agitation associated with schizophrenia or bipolar disorder, manic or mixed; and 2) depression. Abilify is an atypical antipsychotic.

The recommended dose of Abilify injection is 9.75 mg/1.3 ml via intramuscular injection, administered once per day. If agitation warranting a second dose persists following the initial injection, cumulative doses up to a total of 30 mg/day may be given. If ongoing Abilify therapy is clinically indicated, oral Abilify in a range of 10 mg to 30 mg per day should replace Abilify injection as soon as possible.

One unit of coverage is 0.25 mg. Physicians, nurse practitioners and local health departments may bill for this drug.

Decitabine (Dacogen)—HCPCS procedure code J0894

Decitabine, an antineoplastic agent indicated for the treatment of patients with myelodysplastic syndromes (MDS), is administered as an intravenous infusion. The recommended dosage is 15 mg/m^2 over 3 hours, every 8 hours, on three consecutive days every six weeks. Treatment may be continued as long as the patient continues to benefit.

The ICD-9-CM diagnosis codes required for billing decitabine are V58.11 (admission or encounter for chemotherapy) **AND EITHER** 238.7 through 238.79 (myelodysplastic syndrome) **OR** 205.10 (chronic myelomonocytic leukemia). One unit of coverage is 1 mg. Physicians and nurse practitioners may bill for this drug.

Histrelin Acetate (Vantas)

Coverage effective Jan. 1, 2005: Vantas is indicated for the palliative treatment of prostate cancer. Each kit contains one implant, which releases about 50 to 60 mcg of histrelin acetate per day over 12 months, and an insertion tool. Vantas is administered as one 50-mg subcutaneous implant every 12 months, with removal of the implant no later than 12 months after implantation.

For dates of service Jan. 1, 2005, through Dec. 31, 2005, use HCPCS procedure code J3490. The original invoice or copy of the invoice must be submitted with the claim. For dates of service on and after Jan. 1, 2006, use HCPCS procedure code J9225. An invoice should not be submitted. The ICD-9-CM diagnosis code required for billing Vantas is 185 (malignant neoplasm of prostate). One unit of coverage is one 50-mg implant kit. Providers must not bill for Vantas more than once every 12 months for each recipient. Physicians and nurse practitioners may bill for this implant.

Naltrexone (Vivtrol)—HCPCS procedure code J0894

Naltrexone, which is indicated for the treatment of patients with alcohol dependence, is an opiate antagonist that is administered as an intramuscular injection. The recommended dosage is 380 mg per treatment day once a month or every four weeks.

The ICD-9-CM diagnosis code required for billing Naltrexone is 303.9 (other or unspecified alcohol dependence). One unit of coverage is 1 mg. Physicians, nurse practitioners and local health departments may bill for this drug.

Nelarabine (Arranon)—HCPCS procedure code J9261

Nelarabine is indicated for the treatment of patients with T-cell acute lymphoblastic leukemia (T-ALL) and T-cell lymphoblastic lymphoma (T-TBL) whose disease has not responded to or has relapsed following treatment with at least two chemotherapy regimens. Nelarabine is administered as an intravenous infusion. The recommended adult dosage is 1,500 mg/m^2 administered over 2 hours on days 1, 3 and 5 and repeated every 21 days. The recommended pediatric dosage is 650 mg/m^2 over 1 hour daily for 5 consecutive days and repeated every 21 days.

The ICD-9-CM diagnosis codes required for billing nelarabine are V58.11 (chemotherapy admission or encounter) **AND** 204.00 through 204.09 (lymphoblastic leukemia) **OR** 200.10 through 200.19, 200.20 through 200.29 or 202.80 through 202.89 (lymphoblastic lymphoma). One unit of coverage is 50 mg. Physicians and nurse practitioners may bill for this drug.

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

Attention: All Providers

Updated EOB Code Crosswalk to HIPAA Standard Codes

The list of standard national codes used on the Electronic Remittance Advice (ERA) has been cross-walked to EOB codes as an informational aid to adjudicated claims listed on the Remittance and Status Report (RA). An updated version of the list is available on the Division of Medical Assistance Web site at http://www.ncdhhs.gov/dma/prov.htm.

With the implementation of standards for electronic transactions mandated by the Health Insurance Portability and Accountability Act (HIPAA), providers now have the option to receive an ERA in addition to the paper version of the RA.

The EOB codes that providers currently receive on a paper RA are not used on the ERA. Because the EOB codes on the paper RA provide a greater level of detail on claim denials, all providers will continue to receive the paper version of the RA, even if they choose to receive the ERA transaction. The crosswalk is current as of the date of publication. Providers will be notified of changes to the crosswalk through the general Medicaid bulletin.

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

Attention: Adult Care Home Providers

Update: Prior Approval Process for Medicaid's Enhanced Rate for the Special Care Unit for Alzheimer's and Related Disorders

Please Note: Instructions here replace any previous instructions.

Effective October 1, 2006, the N.C. Medicaid Program (DMA) implemented a prior approval process for adult care home (ACH) providers to receive an enhanced Medicaid reimbursement rate for operating special care units for persons with Alzheimer's and related disorders (SCU-As). This enhanced rate does not include any provisions for special care units for recipients with mental health and related disorders noted in the Adult Care Home Rules 10NCAC 13F.1400.

The enhanced rate is based on submitted documentation. ACH providers must obtain prior approval for the enhanced rate for the care of eligible recipients **if the potential resident has a primary diagnosis of Alzheimer's or related disorders, is not currently receiving hospice care, and meets the prior approval criteria documented below.**

1. a. A documented primary diagnosis of Alzheimer's or related disorders. The related disorder diagnoses are limited to those supported by the National Alzheimer's Association. Therefore, we will no longer accept a general diagnosis of "dementia." Only the following primary diagnoses are acceptable for purposes of the enhanced rate:

Diagnosis	ICD-9-CM Code
Alzheimer's Disease	331.0
Multi-Infarct Dementia	290.4
Creutzfeldt-Jakob Disease	294.10
Pick's Disease	331.11
Lewy Body Dementia	331.82
Parkinson's Disease	332
Huntington's Disease	333.4

   b. If the resident also has a major psychiatric diagnosis, then the physician must provide additional information indicating that the resident's psychiatric disorder is not active, that the resident is not a threat to other residents and is appropriate for a unit such as that described in 10NCAC13F.1300.
2. ACH providers who have a current ACH license in good standing with a SCU-A designation may apply for prior approval from Medicaid for care of recipients with the above-approved diagnoses.
3. Providers must obtain prior approval from DMA *before* admitting a current resident of the ACH to a SCU-A bed.
4. Providers must obtain prior approval from DMA within 7 days of admitting a resident who is new to the home into the home's SCU-A in order to receive the Medicaid SCU-A

rate from the date of admission to that unit. Otherwise, *if approved*, prior approval will be effective the date the request was received by DMA.

5. If information is not complete, DMA will request additional information, and the approval date *may* be delayed. If the information is not received within 14 calendar days of the request for additional information, the resident's prior approval will be denied.
   NOTE:
   Effective with date of service Febuary. 1, 2008, the Division of Aging and Adult Services (DAAS) will be notified monthly of any prior approval denials.
6. Providers must send the following information to obtain this prior approval by Medicaid and avoid delays. All information *must* be clear and legible:
   a. Completed DMA SCU-A Prior Approval Request Form, showing the accurate ACH provider number and the recipient's Medicaid ID number, date of birth and date of admission to the facility
   b. Current FL-2 signed by a physician, with a *primary* diagnosis of Alzheimer's or one of the above-specified related disorders
   c. Copy of the completed Pre-Admission Screening that the home uses to evaluate the appropriateness of an individual's placement in the SCU-A as required by current Rule (10A NCAC 13F.1302)
   d. Copy of the current *individualized* care plan that states how the home will strive for the maintenance of the resident's abilities and promote the highest level of physical and mental functioning; manage behavior in ways that preserve the recipient's dignity; and deliver programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities as required by Rule (10 NCAC 13 F. 1307)
   e. Copy of the provider's current ACH license with SCU-A designation
   f. Copy of the provider's current ACH SCU-A disclosure statement
7. Upon approval of the resident-specific information, DMA will communicate to the fiscal agent the specific SCU-A effective date and end date. The end date is one year from the date of the care plan that is submitted with the recipient's prior approval packet of information.
8. DMA will send an approval notification to the home indicating that the resident was approved and specifying the effective date and the end date of the approval.
   If prior approval is denied, notification will come from the fiscal agent.
9. In the event that the resident is discharged from the home due to death, level of care change, or any other reason, then the home must notify DMA by telephone and follow up by faxing the following information within two business days: the recipient's name, MID number, discharge date and discharge destination. DMA will then notify the fiscal agent as appropriate.
10. The end date of the prior approval is one year from the date of the last submitted care plan. Recertification is required yearly. If the recertification/continued need review is not received by the end date, payment will stop.
11. Yearly recertification requirements include submission of the following documents to DMA: a current signed and dated FL-2, a new care plan, and a copy of the ACH's current license. Mail to DMA (see specific instructions in #12 and #15 below) within seven days of the end date to ensure continuous payment.

12. Providers send the requested information via U.S. Mail to
    Division of Medical Assistance
    Facility and Community Care Section, ACH Unit
    1985 Umstead Drive
    2501 Mail Service Center
    Raleigh NC 27699-2501
13. Only requested follow-up and/or discharge information may be faxed to DMA (Attention: SCU-A Approval) at 919-715-2372.
14. The newly revised DMA SCU-A form and instructions are on the DMA Web site at http://www.ncdhhs.gov/dma/Forms/DMASCUA.pdf.
15. THIS IS A HIPAA REQUIREMENT: The completed form and information must be sealed in an envelope on which "CONFIDENTIAL" is written in red, then placed in another envelope and addressed as in #12 above. Do not fax the actual original recipient prior approval request information.
16. The following are contacts for the ACH unit. We do not have secured e-mail.
    Do not send recipient-specific information by e-mail.

Tamara Derieux	919-855-4364	Tamara.Derieux@ncmail.net
Linda Perry	919-855-4363	Linda.R.Perry @ncmail.net

Instructions for Completing the Adult Care Home SCU-A Prior Approval Form

1. This form, which is available on DMA's Web site at http://www.ncdhhs.gov/dma/forms.html#prov, is to be used only by Adult Care Homes with Special Care Unit designations. Print this form in landscape orientation.
2. Print clearly.
3. All copies of items submitted must be legible.
4. The complete facility information is due only once per year according to the date on the care plan, or upon facility status change, or as otherwise needed.
5. THIS IS A HIPAA REQUIREMENT: The completed form and information must be sent in a sealed envelope with "confidential" written in red and then placed in another envelope and addressed as in #6 below. DMA will not accept faxed records.
6. Send the completed form via U.S. Mail to the following address: N.C. Division of Medical Assistance, ACH Unit—Facility and Community Care, 1985 Umstead Drive, 2501 Mail Service Center, Raleigh, NC 27699-2501
7. Direct questions to:

    - Linda R. Perry, RN(1-919-855-4363) Linda.R.Perry@ncmail.net) **or**
    - Tamara Derieux (1-919-855-4364) Tamara.Derieux@ncmail.net).

Facility and Community Care
DMA, 919-855-4363

Attention: All Providers

Accepting a Medicaid Recipient

According to 10A NCAC 22J.0106 a provider has a choice whether or not to accept or refuse a patient as Medicaid patient. However, providers may not discriminate against Medicaid recipients based on the recipient's race, religion, national origin, color, or handicap.

Providers are reminded of the following:

- Medicaid providers must be consistent with their policy and procedures when accepting or refusing Medicaid recipients
- Acceptance of the recipient's Medicaid ID card and/or submission of a claim for payment to the Medicaid program constitutes agreement to accept the Medicaid payment (in addition to any authorized co-payment or third party payment) as payment in full
- Recipients may not be billed for the difference between the charges and the Medicaid payment in addition to co-payment and third-party payment.
- Recipients may not be billed for any service covered by the Medicaid program unless the provider has specifically informed the recipient that Medicaid will not be billed, and the recipient understands and agrees to accept liability for payment. Providers are encouraged to obtain a signed statement from the patient agreeing to be financially responsible for these charges.
- Recipients must be informed of, and agree to liability for non-covered services *before* such services are rendered.
- Recipients may not be billed for covered services for which the provider is denied payment because the provider failed to follow program regulations. This includes errors on the claim form, late submission, lack of prior approval, failure to bill third-party resources, etc.

A provider *may* bill a Medicaid recipient if the recipient, rather than the provider, receives payments from either the commercial insurance or Medicare; if the recipient fails to provide proof of eligibility by presenting a current Medicaid card; if the recipient loses eligibility for Medicaid as defined in 10A NCAC 21B; or if the recipient owes an allowable Medicaid deductible or co-payment. The following services may also be billed to the recipient:

- Services not covered by Medicaid if the recipient has MEDICARE-AID coverage (MQB-Q; buff colored card)
- Prescriptions in excess of the 11-per month limit, unless the recipient is locked into their pharmacy of record
- Visits in excess of the ambulatory visit limit for the state fiscal year (July 1 through June 30)
- The portion of psychiatric services for a Medicare-eligible recipient that is subject to the 37.5% psychiatric reduction in Medicare reimbursement

For recipients under the age of 21 and EPSDT requirements see Section 2 and 6 of the *Basic Medicaid Billing Guide*, available at www.ncdhhs.gov/dma/medbillcaguide.htm.

Providers are encouraged to make use of the resources available to assist in filing claims

- General and special bulletins (www.ncdhhs.gov/dma/cptclickbulletin.htm)
- Clinical coverage policies containing billing information (www.ncdhhs.gov/dma/mp/mpindex.htm)
- Provider Relations staff at EDS, 1-800-688-6696
- Division of Medical Assistance Staff
- EDS voice response system for eligibility verification 1-800-723-4337
- EDS 1-800-688-6696 or 919-851-8888

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

Attention: Durable Medical Equipment Providers

Revised Oxygen, Oxygen Supplies and Equipment Clinical Coverage Policy

Beginning with date of service Jan. 1, 2008, newly revised clinical coverage policies for oxygen and oxygen supplies and equipment will be in effect. There are several significant changes from the old policy. Please see Clinical Coverage Policy #5A, *Durable Medical Equipment*, on DMA's Web site (www.ncdhhs.gov/dma/mp/mpindex.htm) for more coverage details.

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

Attention: All Providers

Payment Error Rate Measurement in North Carolina

In compliance with the Improper Payments Information Act of 2002, the Centers for Medicare and Medicaid Services (CMS) implemented a 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 one of 17 states required to participate in PERM reviews of claims paid in Federal fiscal year 2007 (October 1, 2006-September 30, 2007).

CMS is using three national contractors to measure improper payments. One of the contractors, Livanta LLC (Livanta), will be communicating directly with providers and requesting medical record documentation associated with the sampled claims (approximately 800-1200 claims for North Carolina). Providers will be required to furnish the records requested by Livanta, within a timeframe indicated by Livanta.

Livanta began requesting medical records for the NC sampled claims on November 20, 2007. Providers are urged to respond to these requests promptly. Records are required to be submitted by providers no later than 60 days after issuance of the contractor's letter requesting such records (PERM Final Rule, Federal Register/Vol. 72, No. 169/Friday, August 31, 2007/Rules & Regulations, pg. 50496).

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

Provider cooperation to furnish requested records is critical in this CMS project. No response to requests and/or insufficient documentation will be considered a payment error. This can result in a payback by the provider and a monetary penalty for North Carolina Medicaid.

Program Integrity
DMA, 919-647-8000

Attention: Physicians, Nurse Practitioners, Nurse Midwives, Federally Qualified Health Centers, Rural Health Centers, Local Health Departments and Certified Dialysis Providers

Changes in Drug Rebate Manufacturers

The following changes are being made in manufacturers with Drug Rebate Agreements. They are listed by manufacturer code, which are the first five digits of the NDC.

Additions

The following labelers have entered into Drug Rebate Agreements and have joined the rebate program effective on the dates indicated below:

Code	*Manufacturer*	*Date*
25010	Aton Pharma. Inc.	10/22/2007
31722	Camber Pharmaceuticals, Inc	10/03/2007

Voluntarily Terminated Labelers

The following labelers requested voluntary termination effective October 1, 2007:

Laser Pharmaceuticals, LLC.	(Labeler 64860)
PediaMed Pharmaceuticals, Inc	(Labeler 96346)

The following labelers have requested voluntary termination effective January 1, 2008:

Elan Pharmaceuticals, LLC.	(Labeler 00086)
Stada Pharmaceuticals, Inc.	(Labeler 55370)
Stada Pharmaceuticals, Inc.	(Labeler 64860)

For a complete list of Manufacturers participating in the Drug Rebate Program, visit http://www.ncdhhs.gov/dma/pharmacy/labeler_file.pdf

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

Attention: Hospital Outpatient Clinics, Physicians, Health Departments, Federally Qualified Health Centers, and Rural Health Clinics

Dietary Evaluation and Counseling

Effective with date of service April 1, 2007, Clinical Coverage Policy 1I, Dietary Evaluation and Counseling, hospital outpatient clinics and physicians were added as providers who may receive reimbursement for dietary evaluation and counseling (also referred to as Medical Nutrition Therapy) when the service is performed by a registered dietitian or licensed nutritionist. Local health departments, federally qualified health centers and rural health clinics will continue to receive coverage for the services described in the policy. Children ages zero through twenty and pregnant women until the end of the month in which the sixtieth day postpartum falls are eligible for this service. Refer to the Dietary Evaluation and Counseling policy on the the DMA web site @ www.ncdhhs.gov/dma/prov.htm.

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

Attention: UB - 92 / UB - 04 Providers

Updated Effective Date for Revised UB Claim Form

The National Uniform Billing Committee (NUBC) has issued the revised institutional paper claim format.

All UB paper claims received on or after February 29, 2008 must be filed on the UB-04 claim format regardless of the date of service.

Providers who submit the UB-92 claim form for processing on or after February 29, 2008 will receive denial EOB 9960 on their remittance advice. EOB 9960 states, "Resubmit on the new UB04 Claim Form." Refer to New Claim Form Instructions Special Bulletin June 2007 and the National Uniform Billing Committee (NUBC) website at www.nubc.org for specific billing guidelines.

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

Attention: All Providers

Community Care of North Carolina/Carolina ACCESS (CCNC/CA) Override Policy

Currently, 74% of North Carolina's Medicaid population is enrolled in CCNC/CA. For these recipients, their medical home becomes the primary place where well care and routine sick care are provided. PCPs coordinate care for members by providing and arranging for the recipient's health care needs. It is at the discretion of the primary care provider to refer or authorize payment for services performed by another provider. If a service is provided and the PCP refuses to authorize the service, a request for an override may be submitted to EDS via fax at 919-816-4420. Only requests made on the Carolina ACCESS Override Request form will be considered. If a patient is in the requesting provider's office, the provider may contact EDS by telephone at 919-816-4321. The division provides the following guidelines:

1. Overrides will be granted only when extenuating circumstances beyond the control of the PCP or the patient affect access to care. Examples: patient is incorrectly enrolled; system problem that impacts the ability to determine enrollment or current PCP.
2. Overrides for past, current, or future dates of service will not be considered unless the current PC, as identified on the patient's Medicaid care, has been contacted and has refused authorization of payment for services.
3. The override request form must be completed in its entirety or it will be returned to the provider requesting the override. The provider may resubmit the request when all information is provided.
4. PCPs are required to see patients based on the standards of appointment availability or authorize another provider to see the patient as stated in the Carolina ACCESS agreement.
5. If requesting an override, it must be made within six (6) months of the date the service was provided.

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

Proposed Clinical Coverage Policies

In accordance with Session Law 2005-276, proposed new or amended Medicaid clinical coverage policies are available for review and comment on DMA's Web site at http://www.ncdhhs.gov/dma/prov.htm. To submit a comment related to a policy, refer to the instructions on the Web site. Providers without Internet access can submit written comments to the address listed below.

Loretta Bohn
Division of Medical Assistance
Clinical Policy Section
2501 Mail Service Center
Raleigh NC 27699-2501

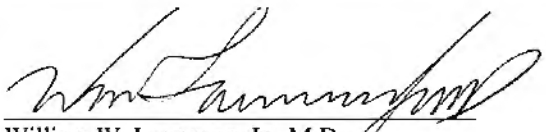
The initial comment period for each proposed policy is 45 days. An additional 15-day comment period will follow if a proposed policy is revised as a result of the initial comment period.

2008 Checkwrite Schedule

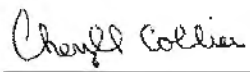
Month	Electronic Cut-Off Date	Checkwrite Date
January 2008	01/03/08	01/08/08
	01/10/08	01/15/08
	01/17/08	01/24/08
February 2008	01/31/08	02/05/08
	02/07/08	02/12/08
	02/14/08	02/19/08
	02/21/08	02/28/08
March 2008	2/28/08	3/04/08
	3/06/08	03/11/08
	03/13/08	03/18/08
	3/20/08	3/27/08

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.

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



William W. Lawrence, Jr., M.D.
Acting Director
Division of Medical Assistance
Department of Health and Human Services



Cheryll Collier
Executive Director
EDS