February 2010 Medicaid Bulletin

In This Issue . . . **Page**

Providers are responsible for informing their billing agency of information in this bulletin.

Attention: All Providers

HP Enterprise Services Address Change

Beginning January 11, 2010, certified mail and UPS or Federal Express deliveries must be sent to HP at the following new address.

HP Enterprise Services
Suite 401
2610 Wycliff Road
Raleigh, NC 27607

Mail sent to any of HP's post office box addresses will not be affected.

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

Attention: All Providers

Basic Medicaid Seminars

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

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

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

Attention: All Providers

CPT Procedure Codes 34812 and 34820 with Modifier 50

Providers who received denials for CPT procedure codes 34812 (open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral) or 34820 (open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral) when billed with modifier 50 (bilateral procedure) for dates of service on January 1, 2009, and after, may resubmit new claims (not adjustments) for processing.

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

Attention: All Providers

Denials with CPT Procedure Code 72295

Coverage of CPT procedure code 72295 (discography, lumbar, radiological supervision and interpretation) was increased to five units per day effective with date of service November 1, 2008. The use of modifiers 76 and 77 for repeat procedures with CPT procedure code 72295 was end-dated effective with date of service November 1, 2008. However, some claims have denied with EOB 5201 (diagnostic procedure allowed once per day unless billed with appropriate modifier) or EOB 5202 (repeat diagnostic procedure allowed twice/day) when billing for multiple units.

If you received a denial with EOB 5201 or 5202 for CPT procedure code 72295 since November 1, 2008, please resubmit the denied charges as a new claim (not as an adjustment request) for processing.

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

Attention: All Providers

Denials of CPT Procedure Codes 93320, 93321, and 93325

Providers who received denials for CPT procedure codes 93320, 93321, and 93325 when billed with procedure code 93351 (echocardiography, transthoracic, real-time with image documentation, includes M-mode recording, when performed during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrographic monitoring, with physician supervision) for dates of service on January 1, 2009, and after, with one of the following EOB codes, may resubmit new claims (not adjustments) for processing.

CPT Code	Description	EOB	Description
93320	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; complete	7992	No payment for add-on (ZZZ) code allowed if the "primary" code in series is not paid for the same date of service, same provider.
		1478	Doppler echocardiography, pulsed wave; complete must bill with related procedure
93321	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; follow-up or limited study	7992	No payment for add-on (ZZZ) code allowed if the "primary" code in series is not paid for the same date of service, same provider.
		1479	Doppler echocardiography, pulsed wave; follow up must bill with related procedure
93325	Doppler echocardiography color flow velocity mapping	7993	No payment for add-on (ZZZ) code allowed if the "primary" code in series is not paid for the same date of service, same provider.

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

Attention: All Providers

North Carolina Medicaid's Use of CPT Consultation Codes

Effective January 1, 2010, CMS eliminated the use of all consultation CPT procedure codes. This includes inpatient codes (99251 through 99255) and office/outpatient codes (99241 through 99245) for applicable places of service. At this time, the N.C. Medicaid Program will not change the way it reimburses for consultation services. However, when billing for consultation services provided to dually eligible recipients, providers should bill according to Medicare's requirements.

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

Attention: All Providers

Prior Authorization for Non-emergency High-tech Outpatient Radiology and Ultrasound Procedures: Updates

Prior authorization (PA) is required for non-emergency, high-tech outpatient radiology and ultrasound procedures. If your claim was previously submitted and denied for no PA on file and you had received an approval letter from MedSolutions, please resubmit the claim for adjudication. This discrepancy is due to a system delay in updating some of the MedSolutions PA data in the Medicaid Management Information System (MMIS+). If you have any questions or concerns regarding your claim adjudication, please call HP Provider Services at 1-800-688-6696 or 919-851-8888.

Procedures performed during an inpatient stay, during an emergency department visit, during an observation stay or as a referral from a hospital emergency department do not require PA. Refer to the following information on billing for procedures provided in these circumstances. Claims reviewed post adjudication that fall into the categories listed below will be recouped with an EOB message advising you to resubmit based on the rules in the table.

Providers submitting claims in an institutional format:

Type of Stay	Billing Instruction
Inpatient stay	Enter Bill Type 11x in Form Locator 4
Emergency department visit	Enter Revenue Code 450 in Form Locator 42
Observation stay	Enter Revenue Code 762 in Form Locator 42
Hospital emergency department referral	Enter appropriate CPT code with modifier U2 in Form Locator 44.

Providers submitting claims in a professional format:

Type of Stay	Billing Instruction
Inpatient stay	Enter appropriate CPT code with modifier U2 in field 24D.
Emergency department visit	Enter appropriate CPT code with modifier U2 in field 24D.
Observation stay	Enter appropriate CPT code with modifier U2 in field 24D.
Hospital emergency department referral	Enter appropriate CPT code with modifier U2 in field 24D.

For assistance with requesting PA, refer to the following table:

Issue	Who to Contact
Provider information incorrect in the system	1. Go to http://www.ncdhhs.gov/dma/WebNPI/default.htm to verify the address that Medicaid has on file. 2. If the address or other information needs to be updated, go to the CSC NC Tracks website at http://www.nctracks.nc.gov/provider/cis.html.
Trouble locating the recipient or the provider in the system	Fill in one identifier and search for the provider or recipient. Do not fill in all the blanks. For example, for a recipient, fill in only the name and date of birth; for a provider, fill in only the name or the individual NPI number. • The MedSolutions Call Center is available from 8:00 a.m. to 9:00 p.m. (EST) at 1-888-693-3211. • For continuing issues, contact the Provider Assistance Desk at 1-800-575-4517, option 2. • If the recipient is not in the MedSolutions system, contact HP Enterprise Services at 1-800-688-6696 or 919-851-8888.
For denials	MedSolutions will fax the PA and denial letters to the ordering and the rendering provider within five business days of the request. Providers may initiate a **peer-to-peer discussion** with a MedSolutions physician about any PA decision by calling MedSolutions at 1-888-693-3211 during normal business hours, or the provider may elect to provide additional supporting clinical information in support of a **reconsideration request** of the original denial decision. Requests for a peer-to-peer consultation or the reconsideration request and the complete additional clinical information will be accepted for **three business days following the date of MedSolutions' adverse decision.** MedSolutions shall schedule the peer-to-peer consultation within one business day. MedSolutions will provide a decision either to uphold or to overturn the initial adverse decision within two business days following the consultation or reconsideration. The provider will be notified in writing of the decision.
Accuracy Management for providers	• To obtain a questionnaire about becoming a participating rendering provider, go to http://www.accuracymgmt.com and apply. • To contact the Accuracy Management department regarding completion, credentialing or appealing a decision, send requests to accuracymgmt@medsolutions.com. • The Accuracy Management department phone number is 1-800-457-2759.
To verify if the procedure requires PA	• Check the December 2009 Medicaid Bulletin for a complete list of radiology procedures that require PA. • Contact HP Enterprise Services at 1-800-688-6696 or 919-851-8888.

Practitioner and Clinic Services
DMA, 910-355-1883

Attention: All Providers

Adjusting North Carolina Medicaid Claims Electronically

The N.C. Medicaid Management Information System (MMIS+) has the capability to accept electronic adjustments or "void and replacement" claims as termed in the instruction guide. By using the tool described below, N.C. Medicaid providers can immediately correct or change most claims that were incorrectly billed and paid.

The NC Electronic Claims Submission/Recipient Eligibility Verification Web Tool (NCECSWeb Tool) is a web-based tool that is available to providers at no charge. It eliminates the need for providers to send paper refund checks and backup documentation to HP Enterprise Services. This process is much more efficient and less costly to providers and the financial impact is immediate so all 1099 information at the end of each financial period is up-to-date and correct.

Providers are required to receive a logon identification number and password to the tool (see **Enrollment** below). For additional information, refer to the September 2009 Special Bulletin, *North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool Instruction Guide,* on DMA's website at http://www.ncdhhs.gov/dma/bulletin/.

Enrollment

1. Complete an ECS Agreement Form (available on the NC Tracks website at http://www.nctracks.nc.gov/provider/forms/).
2. Once the form is completed and submitted, call 1-800-688-6696 or 919-851-8888, option 1, to obtain a "Submitter ID and Password."

Filing Adjustments Electronically

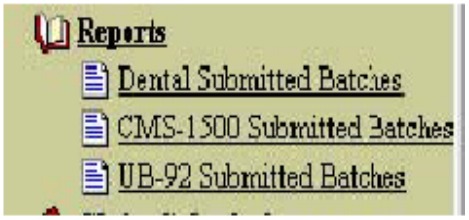
Providers can file two types of adjustments electronically:

1. **Void** – Entire claim will be recouped.
2. **Replacement** – claim will be recouped and reprocessed.

For specific claim type instructions, please refer to pages 48 through 50 in the September 2009 Special Bulletin, *North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool Instruction Guide,* on DMA's website at http://www.ncdhhs.gov/dma/bulletin/.

Filing a Professional (CMS-1500) "VOID" Claim

1. Log into NCECS Web Tool.
2. Click on "Reports" menu.



3. Click on "Professional (hard copy CMS-1500) Submitted Batches."
4. Click on the "Copy" button at the top of the screen. This will automatically pull all the past submitted claims to the "Claims Entry" screen.
5. Once the "Claims Entry" screen is accessed, click on the circle button next to the individual claim you would like to submit a void claim.
6. Click "Edit."
7. You will see all the previous submitted claim information on the screen. Scroll about mid-way down underneath the "Miscellaneous Claim Information" section.

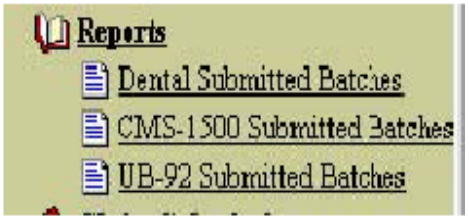
8. There is a box titled "Original ICN." In this box, type in the 15-digit claim number from the original paid claim. (This can be found on your Remittance and Status report from Medicaid.)

9. In the box directly to the right of "Original ICN," you will see a drop down menu titled "Claim Submission Reason Code." Select option 8 for "Void."

Click "Save." This will bring you back again to the "Claims Entry" screen where you can repeat the steps for other claims in the copied batch.

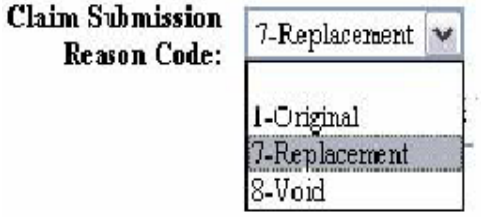
Filing a Professional (CMS-1500) "REPLACEMENT" Claim

1. Log into NCECS Web Tool.
2. Click on "Reports" menu.



3. Click on "Professional (hard copy CMS-1500) Submitted Batches."
4. Click on the "Copy" button at the top of the screen. This will automatically pull all the past submitted claims to the "Claims Entry" screen.
5. Once the "Claims Entry" screen is accessed, click on the circle button next to the individual claim you would like to submit a replacement claim.
6. Click "Edit."
7. You will see all the previous submitted claim information on the screen. Scroll about mid-way down underneath the "Miscellaneous Claim Information" section.
8. There is a box titled "Original ICN." In this box, type in the 15-digit claim number from the original paid claim. (This can be found on your Remittance and Status report from Medicaid.)

9. In the box directly to the right of "Original ICN," you will see a drop down menu titled "Claim Submission Reason Code." Select option 7 for "replacement".



10. If there are any changes that need to be made to the body of the claim, those may be edited as well. Examples include changes to the billed amount, CPT code, units, etc.

If there are no changes to be made, scroll to the top of the page and click "Save." This will bring you back again to the "Claims Entry" screen where you can repeat the steps for other claims in the copied batch.

For additional information, refer to the September 2009 Special Bulletin, *North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool Instruction Guide,* on DMA's website at http://www.ncdhhs.gov/dma/bulletin/.

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

Attention: All Providers

Program Integrity Prepayment Claims Review

A provider's claims may be manually reviewed prior to payment when DMA has evidence of inappropriate billing and/or program abuse [10A NCAC 22F.0104(c)].

On October 29, 2009, the Carolinas Center for Medical Excellence (CCME) was awarded a contract with DMA to provide prepayment claim review services for enrolled Medicaid providers. DMA's Program Integrity (PI) section will contact the provider informing them that their claims are to be placed on prepayment claims review. After this initial contact, CCME will contact the provider with information on the review process requirements, and will work closely with the provider, DMA, and the fiscal agent throughout the claims submission and review process. CCME will advise the provider where and how to submit its claims for review, and will address provider questions regarding the prepayment review process.

Prepayment claims review is a process whereby a provider's claims are temporarily pended in the payment system while the provider's supporting documentation is reviewed. CCME will closely review the provider's documentation in order to determine whether the claim is appropriate for Medicaid payment based on criteria including, but not limited to, evidence that the documentation has established that

1. services were provided according to DMA policy requirements;
2. the billed services were medically necessary, appropriate, and not in excess of the recipient's need pursuant to physician order, etc. as documented in policy or service standards;
3. both the provider and the recipient were Medicaid-eligible on the date the service was provided;
4. prior authorization was obtained if required by policy;
5. the provider's staff were qualified as required by Medicaid policy; and
6. the provider possessed the proper license, certification, or other accreditation requirements specific to the provider's scope of practice, Medicaid policy, and conditions of participation with the N.C. Medicaid Program at the time the service was provided to the recipient.

Reasons for placement of a provider's claims on prepayment claims review include, but are not limited to

1. a review of compliance audit(s) having revealed significant and/or continuing noncompliance with Medicaid policies;
2. prior PI reviews having revealed billing and/or billing patterns indicative of program abuse; and
3. DMA agreeing to allow the provider to participate in prepayment claims review as a requirement for continued Medicaid participation in lieu of participation termination.

Note: Providers must achieve a minimum of 75% accuracy in claim submission as reported to DMA by CCME for three consecutive months. Providers will be allowed up to six months to achieve the 3-month consecutive accuracy rate. If the minimum performance benchmark rate is not met, the provider will be terminated from participation with the N.C. Medicaid Program.

Program Integrity
DMA, 919-647-8000

Attention: Personal Care Services Providers

Implementation of PCS PACT Reviews and Independent Assessments

Independent assessment of PCS recipients is being implemented in response to Session Law 2009-451 (Senate Bill 202), Section 10.68A.(a)(3) (http://www.ncga.state.nc.us/Sessions/2009/Bills/Senate/PDF/S202v8.pdf). The Carolinas Center for Medical Excellence (CCME) was awarded the contract to conduct PCS independent assessments.

All PACT forms submitted to CCME by January 8, 2010, in response to DMA's November 3, 2009, notice to providers have been reviewed. Notifications and prior authorizations based on the PACT Review have been delayed due to a legal challenge by the Association for Home and Hospice Care.

Continue to conduct new referral assessments, annual reassessments, and change of status reviews, and **complete and submit your weekly assessment and discharge updates to CCME using and following instructions in the Weekly Summary Form (see the PACT Review website at http://www.qireport.net).** Include PACT forms for all newly admitted and reassessed PCS and PCS-Plus recipients.

Implementation of independent assessment of all individuals applying for PCS and PCS-Plus and all reassessments and change of status reviews is scheduled for March 2010. Refer to the PACT Review website (http://www.qireport.net) and future Medicaid bulletin articles for additional information and updates on this change. Questions may be directed to the CCME PACT Help Line at 1-800-228-3365 or by e-mail to PACTreview@thecarolinascenter.org.

CCME, 1-800-228-3365

Attention: Hospital Outpatient Clinics, Independent Practitioners, and Physicians

Outpatient Specialized Therapies Video Conference Seminars

Outpatient specialized therapies video conference seminars are scheduled for the month of April 2010. Information presented at these seminars will include a review of policy and billing for outpatient specialized therapy services (speech, occupational, physical, and respiratory therapy) and prior approval guidelines. This will be an interactive video conference seminar providing virtual training with live video and audio communication. The video conference seminar sites and dates will be announced in the March 2010 Medicaid Bulletin (http://www.ncdhhs.gov/dma/bulletin/).

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

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

Attention: Orthotics and Prosthetics Providers

2010 HCPCS Code Changes for Orthotics and Prosthetics

Effective with date of service December 31, 2009, the following codes were end-dated and removed from the Orthotics and Prosthetics (O&P) Fee Schedule.

A6542	A6543	L0210	L1800	L1815
L1825	L1901	L2770	L3651	L3652
L3700	L3701	L3909	L3911	L6639

Effective with date of service January 1, 2010, the following code descriptions were changed:

Code	New Description
A6549	Gradient compression stocking/sleeve, not otherwise specified
L4396	Static or dynamic ankle foot orthosis, including soft interface material, adjustable for fit, for positioning, may be used for minimal ambulation, prefabricated, includes fitting and adjustment
L8030	Breast prosthesis, silicone or equal, without integral adhesive

Effective with date of service January 1, 2010, the following codes were added to the O&P Fee Schedule:

New Code	Description	Modifier	Lifetime Expectancy/Quantity Limitations
L2861	Addition to lower extremity joint, knee or ankle, concentric adjustable torsion style mechanism for custom fabricated orthotics only, each	New Left Right	6 months: ages 00-20; 3 years ages 21 and older
L3891	Addition to upper extremity joint, wrist or elbow, concentric adjustable torsion style mechanism for custom fabricated orthotics only, each	New Left Right	6 months: ages 00-20; 3 years ages 21 and older

Note: A Certificate of Medical Necessity and Prior Approval must be completed for all items, regardless of the requirement for prior approval. The coverage criteria for these items have not changed.

Refer to Clinical Coverage Policy 5B, *Orthotics and Prosthetics*, on DMA's website (http://www.ncdhhs.gov/dma/mp/) for detailed coverage information. Please refer to the O&P Fee Schedule on DMA's website (http://www.ncdhhs.gov/dma/fee/) for the maximum allowable rates for these new codes and for all of the codes covered by N.C. Medicaid for O&P.

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

Attention: Nurse Practitioners and Physicians

Fondaparinux Sodium Injectable 0.5 mg (Arixtra, HCPCS Code J1652): Billing Guidelines

Effective with date of service August 1, 2009, the N.C. Medicaid Program covers fondaparinux sodium injectable (Arixtra) for use in the Physician's Drug Program when billed with HCPCS code J1652 (fondaparinux sodium, 0.5 mg). Arixtra is a drug for the prophylaxis or treatment of deep vein thrombosis and the treatment of pulmonary embolus.

Arixtra is provided in a single-dose, prefilled syringe (2.5 mg; 5 mg; 7.5 mg; or 10 mg) affixed with an automatic needle protection system. Arixtra is administered by subcutaneous injection. It must not be administered by intramuscular injections. The dosage of Arixtra and the length of treatment are dependent on the diagnosis for which it is given.

For Medicaid Billing

- Providers must bill Arixtra with HCPCS code J1652 (injection, fondaparinux sodium, 0.5 mg).
- Providers must indicate the number of HCPCS units billed.
- One Medicaid unit of coverage is 0.5 mg. The maximum reimbursement rate, per 0.5 mg, is $6.01.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Arixtra may be reported as "ML" or "UN." For example, to bill for an entire 10-mg/0.8-ml prefilled syringe, report the NDC units as "ML0.8" **OR** "UN1." If the drug was purchased under the 340-B Drug Pricing Program, place a "UD" modifier in the modifier field for that drug detail.
- Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III,* on DMA's website (http://www.ncdhhs.gov/dma/bulletin/) for additional instructions.
- Medicaid covers only rebatable NDCs.
- Providers must bill their usual and customary charge.

The new fee schedule for the Physician's Drug Program is available on DMA's website at http://www.ncdhhs.gov/dma/fee/.

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

Attention: Nurse Practitioners and Physicians

Telavancin Injectable (Vibativ, HCPCS Code J3490): Billing Guidelines

Effective with date of service October 22, 2009, the N.C. Medicaid Program covers telavancin injectable (Vibativ) for use in the Physician's Drug Program when billed with HCPCS code J3490 (unclassified drugs). Vibativ is available in 250-mg and 750-mg single-dose vials.

Vibativ is a semisynthetic, lipoglycopeptide antibiotic indicated for the treatment of complicated skin and skin structure infections caused by susceptible gram-positive organisms including: methicillin-susceptible or -resistant Staphylococcus aureus, vancomycin-susceptible Enterococcus faecalis, and Streptococcus pyogenes, Streptococcus agalactiae or Streptococcus anginosus group.

The recommended dose is 10 mg/kg administered over 60 minutes by intravenous (IV) infusion once every 24 hours for 7 to 14 days.

For Medicaid Billing

- Providers must bill Vibativ with HCPCS code J3490 (unclassified drugs).
- Providers must indicate the number of HCPCS units billed.
- One Medicaid unit of coverage is 250 mgs. The maximum reimbursement rate, per 250 mgs, is $52.05. An entire 250-mg or 750-mg single-use vial may be billed.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Vibativ should be reported as "UN." To bill for the entire 250-mg vial or the entire 750-mg vial, report the NDC units as "UN1." If the drug was purchased under the 340-B Drug Pricing Program, place a "UD" modifier in the modifier field for that drug detail.
- Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III,* on DMA's website (http://www.ncdhhs.gov/dma/bulletin/) for additional instructions.
- Medicaid covers only rebatable NDCs.
- Providers must bill their usual and customary charge.

The new fee schedule for the Physician's Drug Program is available on DMA's website at http://www.ncdhhs.gov/dma/fee/.

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

Attention: Nurse Practitioners and Physicians

Ofatumumab Injectable (Arzerra, HCPCS Code J9999): Billing Guidelines

Effective with date of service November 1, 2009, the N.C. Medicaid Program covers ofatumumab injectable (Arzerra) for use in the Physician's Drug Program when billed with HCPCS code J9999 (not otherwise classified, antineoplastic drugs). Arzerra is available in 100-mg/5-ml (20-mg/ml) single-use vials.

Arzerra is a cytolytic monoclonal antibody that binds specifically to the CD20 molecule expressed on the surface of normal and malignant B lymphocytes. It is indicated for the treatment of patients with chronic lymphocytic leukemia (CLL) who are refractory to fludarabine and alemtuzumab.

Arzerra should be administered by intravenous infusion in 12 doses as follows: 300 mg initial dose (dose 1), followed one week later by 2,000 mg weekly for seven doses (doses 2 to 8), followed four weeks later by 2,000 mg every four weeks for four doses (doses 9 to 12); for a total of 12 doses. Premedicate patients with acetaminophen, an antihistamine, and a corticosteroid 30 to 120 minutes prior to treatment.

For Medicaid Billing

- One of the following ICD-9-CM diagnosis codes is required when billing Arzerra: 204.10 through 204.12 (chronic lymphoid leukemia).
- Providers must bill Arzerra with HCPCS code J9999 (not otherwise classified, antineoplastic drugs).
- Providers must indicate the number of HCPCS units billed.
- One Medicaid unit of coverage is one 100 mg/5 ml vial. The maximum reimbursement rate, per one 100-mg/5-ml vial, is $458.05. The entire single-use vial may be billed.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Arzerra should be reported in "ML." To bill for the entire single-use vial, report the NDC units as "ML5." If the drug was purchased under the 340-B Drug Pricing Program, place a "UD" modifier in the modifier field for that drug detail.
- Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III,* on DMA's website (http://www.ncdhhs.gov/dma/bulletin/) for additional instructions.
- Medicaid covers only rebatable NDCs.
- Providers must bill their usual and customary charge.

The new fee schedule for the Physician's Drug Program is available on DMA's website at http://www.ncdhhs.gov/dma/fee/.

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

Attention: Nurse Practitioners and Physicians

Pralatrexate Injectable (Folotyn, HCPCS Code J9999): Billing Guidelines

Effective with date of service November 1, 2009, the N.C. Medicaid Program covers pralatrexate injectable (Folotyn) for use in the Physician's Drug Program when billed with HCPCS code J9999 (not otherwise classified, antineoplastic drugs). Folotyn is available in 20-mg/1-ml and 40-mg/2-ml single-use vials.

Folotyn is a folate analog metabolic inhibitor indicated for the treatment of patients with relapsed or refractory peripheral T-cell lymphoma.

The recommended dosage of Folotyn is administered as an intravenous (IV) push of 30mg/m^2 administered over 3 to 5 minutes via the side port of a free-flowing sodium chloride 0.9% injection IV line once weekly for six weeks in 7-week cycles.

For Medicaid Billing

- One of the following ICD-9-CM diagnosis codes is required for billing Folotyn: 202.70 through 202.78 (peripheral T-cell lymphoma).
- Providers must bill Folotyn with HCPCS code J9999 (not otherwise classified, antineoplastic drugs).
- Providers must indicate the number of HCPCS units billed.
- One Medicaid unit of coverage is 20 mg. The maximum reimbursement rate, per 20 mg, is $3,253.16. An entire single-use vial may be billed.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Folotyn should be reported in "ML." To bill for the entire 20-mg single-use vial, report the NDC units as "ML1." To bill for the entire 40-mg single-use vial, report the NDC units as "ML2." If the drug was purchased under the 340-B Drug Pricing Program, place a "UD" modifier in the modifier field for that drug detail.
- Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III,* on DMA's website (http://www.ncdhhs.gov/dma/bulletin/) for additional instructions.
- Medicaid covers only rebatable NDCs.
- Providers must bill their usual and customary charge.

The new fee schedule for the Physician's Drug Program is available on DMA's website at http://www.ncdhhs.gov/dma/fee/.

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

Attention: Nurse Practitioners and Physicians

Dexamethasone Implant, Intravitreal (Ozurdex, HCPCS Code J3490): Billing Guidelines

Effective with date of service October 1, 2009, the N.C. Medicaid Program covers dexamethasone implant, intravitreal (Ozurdex) for use in the Physician's Drug Program when billed with HCPCS code J3490 (unclassified drugs) only for the indications noted below. Ozurdex is available as a 0.7-mg pouch with a single-use, specially designed drug delivery system (DDS) applicator.

Ozurdex is a biodegradable implant indicated for the treatment of macular edema following branch retinal vein occlusion (BRVO) or central retinal vein occlusion (CRVO). Dexamethasone, a potent corticosteroid, has been shown to suppress inflammation by inhibiting multiple inflammatory cytokines resulting in decreased edema, fibrin deposition, capillary leakage, and migration of inflammatory cells.

Treatment with Ozurdex is for ophthalmic intravitreal injection only. Treatment of both eyes may be performed on the same day.

For Medicaid Billing

- One of the following ICD-9-CM diagnosis codes is required when billing Ozurdex:
  - ♦ 362.35 (central retinal vein occlusion)

  OR
  - ♦ 362.36 (venous tributary [branch] occlusion)
- One of the following codes must be billed in addition to one of the codes listed above:
  - ♦ 362.53 (cystoid macular degeneration, cystoid edema)

  OR
  - ♦ 362.83 (retinal edema)
- Providers must bill Ozurdex with HCPCS code J3490 (unclassified drugs).
- Providers must indicate the number of HCPCS units billed.
- One Medicaid unit of coverage is one pouch (0.7 mg). The maximum reimbursement rate, per one pouch, is $1,348.11.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Ozurdex should be reported as "UN." To bill for the implant, report the NDC units as "UN1." If the implant was purchased under the 340-B Drug Pricing Program, place a "UD" modifier in the modifier field for that drug detail.
- Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III,* on DMA's website (http://www.ncdhhs.gov/dma/bulletin/) for additional instructions.
- Medicaid covers only rebatable NDCs.
- Providers must bill their usual and customary charge.
- Providers may bill CPT procedure code 67028 with the appropriate modifier for the administration of the implant.

The new fee schedule for the Physician's Drug Program is available on DMA's website at http://www.ncdhhs.gov/dma/fee/.

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

Attention: Nurse Practitioners and Physicians

Ustekinumab Injectable (Stelara, HCPCS Code J3590): Billing Guidelines

Effective with date of service October 1, 2009, the N.C. Medicaid Program covers ustekinumab injectable (Stelara) for use in the Physician's Drug Program when billed with HCPCS code J3590 (unclassified biologics). Stelara is available as a 45-mg/0.5-ml single-use vial.

Stelara is a human IgG1κ monoclonal antibody indicated for the treatment of **adult patients** with moderate-to-severe plaque psoriasis. Safety and effectiveness in pediatric patients have not been evaluated.

Patients should be brought up to date with all immunizations before initiating therapy. Live vaccines should not be given concurrently; inactivated or nonlive vaccines may be given concurrently. Bacillus Calmette-Guerin (BCG) vaccines should not be given one year prior to, during, or one year following treatment.

The recommended dose for a person weighing 100 kg (220 lbs) or less is 45 mg initially, followed four weeks later with 45 mg every 12 weeks. For a person weighing more than 100 kg (220 lbs), the recommended dose is 90 mg initially, followed four weeks later with 90 mg every 12 weeks.

For Medicaid Billing

- The ICD-9-CM diagnosis code required for billing Stelara is 696.1 (other psoriasis).
- Providers must bill Stelara with HCPCS code J3590 (unclassified biologics).
- Providers must indicate the number of HCPCS units billed.
- One Medicaid unit of coverage is one 45-mg/0.5-ml single-use vial. The maximum reimbursement rate, per 45 mg, is $4,854.24. The entire single-use vial may be billed.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Stelara should be reported as "ML." To bill for the entire 45-mg/0.5-ml single-dose vial, report the NDC units as "ML0.5." If the drug was purchased under the 340-B Drug Pricing Program, place a "UD" modifier in the modifier field for that drug detail.
- Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III,* on DMA's website (http://www.ncdhhs.gov/dma/bulletin/) for additional instructions.
- Medicaid covers only rebatable NDCs.
- Providers must bill their usual and customary charge.

The new fee schedule for the Physician's Drug Program is available on DMA's website at http://www.ncdhhs.gov/dma/fee/.

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

Attention: Nurse Practitioners and Physicians

Interferon Beta-1b Injectable (Extavia, HCPCS Code J1830): Billing Guidelines

Effective with date of service September 1, 2009, the N.C. Medicaid Program covers interferon beta-1b injectable (Extavia) for use in the Physician's Drug Program when billed with HCPCS code J1830 (injection interferon beta-1b, 0.25 mg). Extavia is available as a kit containing 15 blister units. Each blister unit contains a 0.3-mg/1.2-ml vial and diluent necessary to prepare a 0.25-mg (1-ml) dose of Extavia.

Extavia is an interferon beta-1b injection that is indicated for the treatment of relapsing forms of multiple sclerosis (MS). Patients with MS in whom efficacy has been demonstrated include patients who have experienced a first clinical episode and have magnetic resonance imaging (MRI) features consistent with MS.

Extavia is contraindicated if the patient has a history of hypersensitivity to natural or recombinant interferon beta, albumin (human), or any other component of the formulation. Safety and efficacy in children have not been established. The mechanism of action of interferon beta-1b in patients with MS is unknown. Interferon beta-1b receptor binding induces the expression of proteins that are responsible for the pleiotropic bioactivities of interferon beta-1b.

Treatment with Extavia should be through 0.25-mg (1-ml) subcutaneous injections every other day. Generally, patients should be started at 0.0625 mg (0.25 ml) subcutaneously every other day and increased over a 6-week period to 0.25 mg (1 ml) every other day.

For Medicaid Billing

- The ICD-9-CM diagnosis code required for billing Extavia is 340 (multiple sclerosis).
- Providers must bill Extavia with HCPCS code J1830 (injection interferon beta-1b, 0.25 mg).
- Providers must indicate the number of HCPCS units billed.
- One Medicaid unit of coverage is one 0.3 mg blister unit containing the drug and diluent necessary to prepare a 0.25 mg (1 ml) dosage. The maximum reimbursement rate, per 0.25-mg dose, is $170.69.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Extavia should be reported as "UN." To bill for the entire 0.3 mg kit, report the NDC units as "UN1." If the drug was purchased under the 340-B Drug Pricing Program, place a "UD" modifier in the modifier field for that drug detail.
- Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III,* on DMA's website (http://www.ncdhhs.gov/dma/bulletin/) for additional instructions.
- Medicaid covers only rebatable NDCs.
- Providers must bill their usual and customary charge.

The new fee schedule for the Physician's Drug Program is available on DMA's website at http://www.ncdhhs.gov/dma/fee/.

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

Attention: Nurse Practitioners and Physicians

Rilonacept (Arcalyst, HCPCS Code J2793): Billing Guidelines

Effective with date of service January 1, 2010, the N.C. Medicaid Program covers rilonacept, lyophilized powder, 220-mg/20-ml single-use vials (Arcalyst) for use in the Physician's Drug Program when billed with HCPCS code J2793. Arcalyst is indicated for treatment of cryopyrin-associated periodic syndromes (CAPS) including familial cold autoinflammatory syndrome (FCAS) and Muckle-Wells syndrome (MWS) in adults and children 12 years of age and older.

Each single-use vial of Arcalyst must be reconstituted with 2.3 ml of preservative-free sterile water for injection prior to administration. The final reconstituted vial will yield 2 ml of 80 mg/ml Arcalyst solution. For adults (18 years of age and older), treatment should be initiated with a loading dose of 320 mg delivered as two, 2-ml subcutaneous injections of 160 mg each given on the same day at two different sites. Dosing should be continued with a once-weekly injection of 160 mg administered as a single, 2-ml, subcutaneous injection. For children (12 through 17 years of age), treatment should be initiated with a loading dose of 4.4 mg/kg, up to a maximum of 320 mg, delivered as one or two subcutaneous injections, with a maximum single-injection volume of 2 ml. Dosing should be continued with a once-weekly injection of 2.2 mg/kg, up to a maximum of 160 mg, administered as a single subcutaneous injection, up to 2 ml. If the initial dose is given as two injections, the injections should be given on the same day at two different sites. Arcalyst should not be given more often than once weekly.

For Medicaid Billing

- The ICD-9-CM diagnosis code required for billing Arcalyst is 279.4 (autoimmune disease, not elsewhere classified).
- Providers must bill Arcalyst with HCPCS code J2793.
- Providers must indicate the number of HCPCS units used.
- One Medicaid unit of coverage is 1 mg. Arcalyst is supplied as a single-use vial; therefore, billing of a whole vial, including wastage, is permitted. The maximum reimbursement rate, per 1 mg, is $5,205.06.
- Providers must bill with the 11-digit National Drug Code (NDC) and appropriate NDC units. When calculating the NDC units used, the drug in its original state must be considered, NOT the reconstituted amount. The NDC units for Arcalyst should be reported as "units." If billing for the entire single-dose vial of Arcalyst, report the NDC units as "UN1." If the drug was purchased under the 340-B drug pricing program, place a "UD" modifier in the modifier field for that drug detail.
- Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III*, on DMA's website (http://www.ncdhhs.gov/dma/bulletin/) for instructions.
- Providers must bill their usual and customary charge.

The new fee schedule for the Physician's Drug Program is available on DMA's website at http://www.ncdhhs.gov/dma/fee/.

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

Attention: Nurse Practitioners and Physicians

C1 Esterase Inhibitor (Human) 10 Units (Cinryze, Berinert HCPCS Code J0598): Billing Guidelines

Effective with date of service January 1, 2010, the N.C. Medicaid Program covers C1 esterase inhibitor (human) (Cinryze, Berinert), for use in the Physician's Drug Program when billed with HCPCS code J0598. Cinryze and Berinert are available as 8-ml single-use vials with approximately 500 units of lyophilized powder per vial.

Cinryze and Berinert are indicated for routine prophylaxis against angioedema attacks in adolescent and adult patients with hereditary angioedema. Cinryze and Berinert are a replacement product, working on one's own natural C1 inhibitor to regulate clotting and inflammatory reaction that, when impaired, can lead to tissue swelling.

The recommended dosage of Cinryze or Berinert is 1,000 units (2 vials) administered intravenously every 3 or 4 days. Cinryze and Berinert are administered at an injection rate of 1 ml per minute.

For Medicaid Billing

- The ICD-9-CM diagnosis code required for billing Cinryze or Berinert is 277.6 (other deficiencies of circulating enzymes, hereditary angioedema).
- Providers must bill Cinryze or Berinert with HCPCS code J0598.
- Providers must indicate the number of HCPCS units.
- One Medicaid unit of coverage is 10 units. Providers may bill for an entire single-use vial. The maximum reimbursement rate, per 10 units, is $41.98.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Cinryze and Berinert should be reported as "units." The drug in its original state must be considered, NOT the reconstituted amount. If billing for the entire single-dose vial, report the NDC units as "UN1." If the drug was purchased under the 340-B drug pricing program, place a "UD" modifier in the modifier field for that drug detail.
- Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III,* on DMA's website (http://www.ncdhhs.gov/dma/bulletin/) for additional instructions.
- Providers must bill their usual and customary charge.

The new fee schedule for the Physician's Drug Program is available on DMA's website at http://www.ncdhhs.gov/dma/fee/.

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

Attention: CAP/DA Case Managers, CAP/Choice Case Managers, CAP/C Case Managers, Targeted Case Management Case Managers (Waiver and Non Waiver) for Persons with Developmental Disabilities, and Early Intervention Case Managers (Children's Developmental Services Agencies)

Policy Changes for Case Management Services

Beginning **March 1, 2010,** DMA will change the policies as described below for the following programs: CAP/DA, CAP/Choice, CAP/C, CAP/MR-DD, Targeted Case Management for Persons with Developmental Disabilities, and Early Intervention.

- The maximum number of units for case management services will be limited to no more than three hours (12 units) per calendar month for each recipient. See Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) or Medicaid for Children below. Providers should continue to use the current program case management billing codes.
- No more than six additional hours (24 units) may be available if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation.
    - ♦ It is not necessary to bill all of the additional units on the same claim. These additional units can be used cumulatively within a rolling 365 day period.
    - ♦ Any billing for assessments and crises case management above this annual limit will not be paid for adults 21 years of age and older. For children under 21 years of age, requests will be reviewed under EPSDT. (See EPSDT below.)
    - ♦ These six hours (24 units) are in addition to the three hours per calendar month.
    - ♦ When billing for these additional six hours/24 units, all programs must use the new procedure code of T1017SC.

Early Intervention (EI)

Effective March 1, 2010, any recipient receiving more than three hours (12 units) per calendar month will have his/her hours reduced to the limit of three hour (12 units). This will not affect the entitlement that is applied under the Early Intervention Program for service coordination as listed in the Individualized Family Service Plan.

Providers may request additional units (additional annual and monthly) by following the EPSDT requirements as outlined on http://www.ncdhhs.gov/dma/epsdt/. If the request exceeds the policy limits described above, the request will be reviewed under the EPSDT criteria. If the request meets all of the EPSDT criteria and the requested amount is necessary to meet the child's needs, the request will be approved. If the request does not meet all of the EPSDT criteria or the request exceeds what is necessary to meet the child's needs, the request will not be approved at the level requested.

Developmental Disability (DD) Case Management (Waiver and Non-waiver)

The following procedures apply to providers of DD case management (waiver and non-waiver):

- Current authorizations with effective dates prior to March 1, 2010, will continue as authorized until the next annual continued need review (CNR). The three hour/12 unit limit policy will be applied at the next annual review.
- Effective March 1, 2010, prior authorization of case management services for adults on the Supports and Comprehensive waivers will not be required. These adults will be eligible for up to three hours/12 units monthly as well as the additional 24 units for assessment, planning, and crisis management annually.

Non-waiver adults will continue to require prior authorization and may be authorized for up to three hours/12 units per month and no more than six additional hours/24 units if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation. Should a case manager submit a request for a non-waiver recipient that exceeds the policy limits, the case will be reviewed to determine how many hours/units are necessary to meet the recipient's needs (one, two, or three hours per calendar month and/or six or less additional hours if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation within 365 days).

- Effective March 1, 2010, prior authorization of case management services for children on the Supports and Comprehensive waivers will not be required unless the request exceeds the three hour/12 unit monthly limit or the 24 unit limit for assessment, planning and crisis situations.. Non-waiver children will continue to require prior authorization.
- Waiver and non-waiver children must be evaluated under the EPSDT requirements prior to reducing their current service level at their next annual review and for authorization requests that exceed the three hour/12 unit limit or the 24-unit limits for assessment, planning, and crisis management.. See the section below regarding EPSDT.

The case manager may request the additional six hours/24 units (T1017SC) for these current authorizations even if the current monthly authorization is in excess of the three hour/12 units per month. These requests will be reviewed under the EPSDT criteria.

All Other Programs (CAP/DA, CAP/Choice, CAP/C)

- Case management services for all other affected programs will continue as currently approved until the next CNR, or reauthorization is submitted. At that time, the case management unit limits will be applied as specified in the first paragraph of this article.
- All case management units must be documented on the cost summary. It is **important** to note that the conditions set forth in the CAP waiver concerning the recipient's budget and continued participation in the waiver apply. That is, the cost of the recipient's care, including case management services, must not exceed the waiver cost limits specified in the CAP waiver.
- Children will be evaluated under EPSDT requirements prior to taking any adverse action. See the section below regarding EPSDT.

Documentation for case management billable units is required per respective clinical coverage policies. Lack of supportive documentation for billed units will be referred to Program Integrity for possible recoupment.

EPSDT

While the new limit on case management services has been reduced to no more than three hours (12 units) per calendar month and no more than six additional hours (24 units) if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation, these limits may not apply to children under 21 years of age. Federal law, 42 U.S.C. §1396d(r)(5), requires the State Medicaid agency to provide to Medicaid recipients under 21 years of age "necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) of the [Social Security] Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State [Medicaid] Plan." For more information about EPSDT and provider documentation requirements for EPSDT requests, please visit http://www.ncdhhs.gov/dma/epsdt/.

Recipient Due Process

Children

As indicated above, all requests for recipients under the age of 21 that exceed policy limits will be reviewed against the EPSDT criteria prior to taking adverse action, and the recipient or his/her legal guardian will receive a written notice explaining the decision. The notice will state the decision and effective date of the reduction, explain the reduction is based on Session Law 2009-451, Sections 10.68A.(a)(2)(a) and 10.68A.(a)(10), DMA policy promulgated pursuant to S.L. 2009-451, Section 10.68A.(c), as well as state the EPSDT criteria not met, and an explanation about how to appeal the decision should the recipient or his/her legal guardian so desire.

Adults

If the decision authorizes case management services to the policy limit (three hours per calendar month and/or six additional hours if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation within 365 days), the recipient or his/her legal guardian will receive a written notice explaining the decision. The notice will state the decision and effective date of the reduction to the policy limit, explain the reduction is based on Session Law 2009-451, Sections 10.68A.(a)(2)(a) and 10.68A.(a)(10) as well as DMA policy promulgated pursuant to S.L. 2009-451, Section 10.68A.(c), and that pursuant to 42 CFR §431.210 and §431.220(b), the recipient is not entitled to appeal this decision.

Should less than three hours (12 units) per calendar month and/or less than six additional hours if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation within 365 days be authorized, the recipient or his/her legal guardian will receive a written notice explaining the decision, and that he/she is entitled to appeal the decision to authorize less than the policy limit. The notice will state the decision and effective date of the reduction, explain the reduction is based on Session Law 2009-451, Sections 10.68A.(a)(2)(a) and 10.68A.(a)(10), as well as DMA policy promulgated pursuant to S.L. 2009-451, Section 10.68A.(c), and an explanation about how to appeal the decision should the recipient or his/her legal guardian so desire.

Recipient Notice Regarding Reductions in Case Management Services

A notice was sent at the end of January to recipients regarding these changes in case management. See the DMA website (http://www.ncdhhs.gov/dma/pub/consumerlibrary.htm) for a copy of the notice.

Comments about the reductions in case management services may be sent to the following address:

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

Questions may also be directed to the following areas:

- CAP/DA, CAP/Choice, CAP/C: DMA Community Care Section 919-855-4260
- CAP/MR-DD, DD, EI: DMA Behavioral Health Section 919-855-4290

Community Care Section
DMA, 919-855-4260

Behavioral Health Section
DMA, 919-855-4290

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

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

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

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

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

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

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

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

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

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

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

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

Proposed Clinical Coverage Policies

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

Lorie Williams
Division of Medical Assistance
Clinical Policy Section
2501 Mail Service Center
Raleigh NC 27699-2501

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

2010 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
February	2/4/10	2/9/10
	2/11/10	2/17/10
	2/18/10	2/25/10
March	2/25/10	3/2/10
	3/4/10	3/9/10
	3/11/10	3/16/10
	3/18/10	3/25/10

Electronic claims must be transmitted and completed by 5:00 p.m. on the cut-off date to be included in the next checkwrite. Any claims transmitted after 5:00 p.m. will be processed on the second checkwrite following the transmission date.

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

Melissa Robinson
Executive Director
HP Enterprise Services