



April 2016 Medicaid Bulletin

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Attention: All Providers**NCTracks Updates****Reminder – Prior Approval Required for Chiropractic and Podiatry Services for Medicaid for Pregnant Women Recipients**

As previously announced [Dec. 3, 2015 in NCTracks](#), prior approval (PA) is required for Medicaid for Pregnant Women (MPW) recipients to validate the medical necessity for chiropractic and podiatry services.

Effective with date of service March 1, 2016, MPW claims for chiropractic or podiatry services will deny if PA is not on file for the recipient.

PA requests for chiropractic and podiatry services must be submitted via the NCTracks Provider Portal. NCTracks will not accept paper versions of the request (mail or fax).

A recipient's primary obstetric provider must make the referral (e.g., family practice physician, OB/GYN, nurse midwife, nurse practitioner, health department, etc.). The referral must document the condition that makes it medically necessary for the recipient to see a chiropractor or podiatrist. It must be specific as to how the condition is complicating the pregnancy and include the number of requested visits. The referral need not be to a particular chiropractor or podiatrist.

PA is **not** required for the initial visit. Providers may bill for an evaluation using the appropriate procedure codes. PA is required for subsequent visits/treatment. The referral may be submitted as an attachment to the PA request or it may be mailed or faxed to CSRA. No medical records, plans of care or other documentation are required to be submitted with the request.

The chiropractic or podiatry provider is responsible for entering and submitting the PA request through the NCTracks Provider Portal. The provider must indicate the service requested (chiropractic or podiatry) and the requested begin and end dates. For chiropractic services, a primary diagnosis must be selected from a drop-down list of diagnosis codes and a secondary diagnosis must be manually entered. For podiatry services, a valid diagnosis code per policy must be entered on the PA request.

PA cannot exceed 60 calendar days. Requests cannot be submitted retroactively (unless the recipient is approved for Medicaid retroactively).

If services must continue after the initially approved procedure limits or time period, providers must submit new PA requests. A new referral from the recipient's primary obstetric caregiver also must be submitted indicating the medical need for the new time period being requested.

Issue Resolved with Manage Change Request for Re-Verification

When providers fill out the re-verification application, they may receive the message "Please complete a Manage Change Request to update your record." Some providers reported an issue

that when the Manage Change Request (MCR) was completed and submitted, the address for the individual provider was not saved. This issue was resolved Feb. 7, 2016.

Clarification on Sterilization Consent Form

On Feb. 1, 2016, two new versions of the sterilization consent form were posted to the Division of Medical Assistance (DMA) website prior to their actual implementation date. Providers must have the beneficiary sign one of the old forms (consisting of two columns on one page) which can be found in [Clinical Coverage Policy](#) 1E-3, *Sterilization Procedures*, Attachment C.

System changes will be made to accommodate the newer forms. Until that time, use of the new forms will result in a delay or denial of the claim. Providers must use the [old form](#) until they are notified to use the new form and are provided instructions for the new form in the Sterilization Procedures policy.

Reminder: Call Center Cannot Disclose PA Information to Recipients

Some providers have suggested recipients contact the NCTracks Call Center regarding prior approval (PA) requests not yet approved. The Call Center is not allowed to discuss information regarding PA with a recipient. The only information that the Call Center may disclose to recipients pertains to their own eligibility, as reflected in NCTracks. PA information may only be discussed with the provider who submitted the PA request.

Reminder: Change in Long Term Care Nursing Facility FL2 PA Submission

As of Jan. 27, 2016, long term care (LTC) nursing facility providers are required to enter FL2 PA requests through the NCTracks Provider Portal. Fax and mail are no longer options.

If an FL2 form is submitted by fax or mail, a rejection letter will be posted to the Message Center Inbox of the Office Administrator for the NPI, and no PA will be created in the system.

Providers must include a recipient's address, and required demographic information, when using the NCTracks Provider Portal to submit an LTC nursing facility PA request for a recipient who is pending eligibility. This is a required field when keying the FL2 PA request into the Provider Portal.

For more information on PA, see the PA page of the [NCTracks website](#).

There is a Computer-based Training Course (CBT) – *Long Term Care Services Prior Approval Request* – which covers submitting FL2 requests through the Provider NCTracks Provider Portal. To register, logon to the NCTracks Provider Portal and click Provider Training to access SkillPort. Open the folder labeled Provider Computer-Based Training (CBT) and Instructor Led Training (ILT). The CBT course can be found in the Prior Approval folder under CBTs. Refer to the [Provider Training page](#) of the public Provider Portal for specific instructions on how to use SkillPort. The Provider Training page also includes a quick reference regarding Java, which is required for the use of SkillPort.

New DME Edit for HCPCS code E0483

HCPCS code E0483 is an airway clearance device marketed under the brand name The Vest[®] System. It is a covered benefit under Clinical Coverage Policy 5A, *Durable Medical Equipment and Supplies* (Section 5.3.18 High Frequency Chest Wall Oscillation Device). According to the Clinical Coverage Policy 5A, the "Lifetime Expectancy or Quantity Limitation" for HCPCS code E0483 is "lifetime."

The device requires PA. Once PA has been granted, claims billed with E0483 are processed and paid based on either a rental price or purchase price.

HCPCS codes A7025 and A7026 are related to E0483 and represent replacement parts for patient-owned equipment. A7025 is the replacement vest and A7026 is for hose replacement. Both of these items also are limited to once per lifetime.

As of Feb. 1, 2016, edits were implemented in NCTracks to correct a situation that has allowed for overpayment. The edits prevent accumulated payments for HCPCS codes E0483, A7025 and A7026 from exceeding the maximum allowed purchase price of the equipment. The claim that causes the purchase price to be exceeded will be cutback so that the total payment for the equipment equals the maximum allowed purchase price.

A pay and report Edit 57779 - PAYMENT CUTBACK TO MAXIMUM ALLOWED AMOUNT will be set when only a portion of the claim is approved. Once the maximum allowed purchase price has been met, subsequent claims for the item will be denied with Edit 57770 - ITEM ALLOWED ONLY ONCE IN LIFETIME.

Reprocessing of DME claims is planned to recover overpayments. More information about claims repossessing will be forthcoming in NCTracks Announcements and Medicaid Bulletins. For more information, see the [Clinical Coverage Policy](#) and [DME Fee Schedule](#) web pages on the DMA website.

New Remittance Advice Fields for Hospitals and Skilled Nursing Facilities

As of the Feb. 2, 2016, checkwrite, two new fields are displayed on the paper Remittance Advice (RA) posted to the secure NCTracks Message Center Inbox:

- Medicare Co-Insurance Amount
- Medicare Paid Amount

These fields were added to the RA to assist hospitals and skilled nursing facilities submit claims to Medicare for reimbursement of bad debt. This change only affects the "Institutional" section of the RA.

The "Medicare Co-Insurance Amount" and "Medicare Paid Amount" fields were added to the RA only for claim types 'A' (Part A Institutional claims) and 'U' (Part B claims submitted on Institution claims). For other claim types reported under the Institutional section of the RA, the

“Medicare Co-Insurance Amount” and “Medicare Paid Amount” field labels are displayed with \$0 amounts. No modifications were made to the 835 X12 transaction.

New Edit for Emergency Hemodialysis

As of Feb. 1, 2016, restrictions are in place in the NCTracks computer system to limit services for certain undocumented aliens to receive dialysis services only. Providers will see RESTRICTIVE COVERAGE, EMERGENCY HEMODIALYSIS SERVICES ONLY when inquiring about eligibility information.

Federal law restricts coverage of services for undocumented aliens to those which have been determined necessary to treat an emergency condition as defined in [42 CFR 440.255](#). Previously, providers may have been reimbursed for non-emergency services provided on the same day when eligibility was determined solely by the need for hemodialysis.

A new edit is applied to Medicaid claims for services provided which do not fit the criteria for hemodialysis. The EOB 00246 - SERVICE NOT ALLOWED FOR UNDOCUMENTED ALIENS posts to denied claims.

Medicaid claims adjudicated after February 1 are subject to the new edit, regardless of dates of service. No claims reprocessing will occur.

Claims for dialysis are still subject to Medicaid clinical policy, which can be found on the DMA website, [End-Stage Renal Disease](#) web page.

This new edit only applies to beneficiaries authorized because they need dialysis. Claims for services that are provided to undocumented aliens eligible due to conditions unrelated to dialysis will not be impacted by this edit.

Third Party Liability Bypass for High-Tech Imaging (eviCore) Claims

Claims should **not** deny for lack of an eviCore high-tech imaging PA when retroactive changes occur to a recipient's Third Party Liability (TPL) information. As of Feb. 1, 2016, a bypass was applied to NCTracks which allow payments for outpatient non-emergency high-tech imaging procedures in cases where the recipient:

- Is enrolled in Insurance Type 00, 08, 10, 11, 18, 20, or,
- Is dual eligible, or,
- The other insurance has made a payment towards the service, or ,
- The other insurer has indicated that the insurance payment has gone toward the patient's insurance deductible.

This change is only applicable to DMA health plans. No reprocessing will occur. To receive payment, providers must resubmit past denied claims and provide time limit override documentation, if applicable.

Refer to [Prior Approval for Imaging Policy 1K-7](#) for the list of codes that require PA for high tech imaging.

CSRA, 1-800-688-6696

Attention: All Providers

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Change in Processing of Accounts Receivable

Recoupment of system-generated Accounts Receivable (AR) begins 30 days after the AR has been established. **Beginning May 1, 2016**, recoupment of a system-generated AR will begin with the subsequent checkwrite after the system-generated AR has been established.

An AR is created in NCTracks when a provider does not have sufficient paid claims in the current checkwrite to satisfy a recoupment of funds, often related to claims reprocessing. Waiting 30 days to begin recoupment of the AR means that the provider is then subject to penalties and interest, based on state business rules. Recoupment of the AR will start in the next checkwrite to help providers avoid incurring penalties and interest.

A new letter will be generated to inform a provider's Chief Executive Officer (CEO) that money is owed to an N.C. Department of Health and Human Services (DHHS) payer. N.C. DHHS payers are:

- Division of Medical Assistance (DMA),
- Division of Mental Health (DMH),
- Division of Public Health (DPH), and,
- Office of Rural Health (ORHCC).

The new letter will be titled "Notice of Balance Due the NC DHHS – First Demand". A separate First Demand letter will be sent for each payer that is owed money. The First Demand letter will provide information regarding the potential for assessment of penalty and interest along with instructions for repayment if the provider does not want to wait on recoupments by NCTracks.

Note: For providers who share an Internal Revenue Service (IRS) Taxpayer Identification Number (TIN), NCTracks will automatically seek to recoup the AR from other National Provider Identifiers (NPIs) with the same IRS TIN if funds are insufficient to completely collect the amount(s) due from the NPI for which the AR was generated. The First Demand Letter will be sent to all providers who share the same IRS TIN.

If the AR is not satisfied within 30 days, a 30 Days Past Due Letter will be sent to the provider. The 30 Days Past Due Letter will be sent only to the provider for whom the AR was established, not to other providers who share the same IRS TIN. The 30 Days Past Due Letter will include the penalty and interest owed on the AR.

If the AR is not satisfied within 60 days, payment to the NPI for which the AR was established, as well as all other NPIs associated with the same IRS TIN will be suspended. A 60 Days Past Due Letter will be sent only to the provider for whom the AR was established, not to other providers who share the same IRS TIN. Providers are responsible for repaying the NC DHHS payer even if they are no longer filing claims to NCTracks.

Examples of the 30 and 60 Days Past Due Letters can be found on the [Provider Policies, Manuals, Guidelines and Forms web page](#) of the NCTracks Provider Portal. (The 30 and 60 Days

Past Due Letters are not new, but the wording has changed.) A list of Frequently Asked Questions (FAQs) regarding the Accounts Receivable process can be found on the [NCTracks FAQ page](#).

CSRA, 1-800-688-6696

Attention: All Providers

Prior Authorization for Outpatient Specialized Therapies

Effective April 1, 2016, prior authorizations for outpatient specialized therapies will start no earlier than the date the request is **processed**. This is consistent with N.C. Division of Medical Assistance (DMA) “Due Process” guidelines.

Exceptions will be made for the following two circumstances:

- If a reauthorization request was submitted at least 10 calendar days **prior** to the end of the current authorization period, the prior approval may continue without interruption.
- When a beneficiary, who does not have Medicaid coverage at the time of the procedure (service), is later approved for Medicaid with a retroactive eligibility date, retroactive prior approval may be considered.

This process will maximize available visits and ensure completion of the written evaluation report and treatment plan prior to provision of treatment services.

Outpatient Specialized Therapies
DMA, 919-855-4260

Attention: All Providers

Udated Policy: Outpatient Specialized Therapies

Clinical Coverage Policy 10A has been revised and will be implemented on April 7, 2016. The policy can be viewed on the N.C. Division of Medical Assistance, [Clinical Coverage Policies, Specialized Therapies web page](#)

Outpatient Specialized Therapies
DMA, 919-855-4260

Attention: All Providers**O**ut-of-State Provider Enrollment

Notice: This article was originally published in the [January 2016 Medicaid Bulletin](#).

Out-of-state providers are required to adhere to North Carolina rules, regulations, laws and statutes governing healthcare delivery under the N.C. Medicaid and the N.C. Health Choice (NCHC) programs. They are only eligible for time-limited enrollment under the following conditions:

- Reimbursement of services rendered to N.C. Medicaid or NCHC beneficiaries in response to emergencies or if travel back to North Carolina would endanger the health of the eligible beneficiaries
- Reimbursement of a prior-approved non-emergency service, or,
- Reimbursement of medical equipment and devices that are not available through an enrolled provider located within North Carolina or in the 40-mile border area

Out-of-state providers must submit a **re-enrollment application** every 365 days in order to continue as N.C. Medicaid or NCHC providers.

Out-of-state providers must wait until the day after their current enrollment period ends – when their provider record is terminated – to begin the re-enrollment process. Many out-of-state providers are attempting to re-enroll using a Managed Change Request (MCR) prior to the end of their current enrollment period. This will not continue provider enrollment. MCRs are used to report changes to the provider record; they do **not** serve as re-enrollment applications.

Providers with questions about the NCTracks online enrollment application can contact the CSRA Call Center at 1-800-688-6696 (phone); 919-851-4014 (fax) or NCTracksprovider@nctracks.com (email).

Provider Services
DMA, 919-855-4050

Attention: All Providers**Re-credentialing Due Dates for Calendar Year 2016**

Notice: This article was originally published as a [Special Medicaid Bulletin in February 2016](#).

List of Providers Due for Re-credentialing

A list of providers scheduled for re-credentialing in calendar year 2016 is available on the [provider enrollment page](#) of the DMA website under the “Re-Credentialing” header. Providers can use this resource to determine their re-credentialing/revalidation due date, and determine which month to begin the re-credentialing process. Organizations and systems with multiple providers may download this spreadsheet, which includes NPI numbers and provider names, to compare with their provider list.

Providers will receive a notification letter 45 days before their re-credentialing due date.

Providers are required to pay a \$100 application fee for re-credentialing/ reverification. If the provider does not complete the process **within the allotted 45 days, payment will be suspended** until the process is completed. If the provider does not complete the re-credentialing process within 30 days from payment suspension and termination notice, **participation in the N.C. Medicaid and Health Choice programs will be terminated.** Providers must submit a re-enrollment application to be reinstated.

Re-credentialing is not optional. It is crucial that all providers who receive a notice promptly respond and begin the process. Providers will receive a notification letter 45 days before their re-credentialing due date. When it is necessary to submit a full MCR, the provider must submit the full MCR prior to the 45th day and the application status must be in one of these status to avoid payment suspension:

- 1) In Review,
- 2) Returned,
- 3) Approved, or,
- 4) Payment Pending.

Providers are required to complete the re-credentialing application after the full MCR is completed. If the provider does not complete the process **within the allotted 45 days, payment will be suspended.** Once payment is suspended, the provider must submit a re-credentialing application or the full MCR before payment suspension will be lifted.

When the provider does **not** submit a re-verification application by the re-verification due date **and** the provider has an MCR application in which the status is In Review, Returned, Approved or Payment Pending, the provider’s due date will be reset to the current date plus 45 calendar days.

Note: Providers must thoroughly review their electronic record in NCTracks to ensure all information is accurate and up-to-date, and take any actions necessary for corrections and updates.

Re-credentialing does not apply to time-limited enrolled providers, such as out-of-state providers. Out-of-state providers must complete the enrollment process every 365 days. Providers with questions about the re-credentialing process can contact the CSRA (formerly CSC) Call Center at 1-800-688-6696 (phone); 919-851-4014 (fax) or NCTracksprovider@nctracks.com (email).

Provider Services
DMA, 919-855-4050

Attention: All Providers**2016 CPT Update Completed**

System work has been completed for the 2016 CPT Update codes added to NCTracks on Jan. 1, 2016. All of the 2016 CPT codes have now been updated in NCTracks, along with the associated rates for codes that are covered.

Claims submitted with 2016 CPT codes that are covered should no longer pend in NCTracks for “no rate on file.” Claims that were previously submitted with newly covered codes and pended will now recycle and be adjudicated. No additional action is required by providers. This also applies to Medicare crossover claims.

NOTE: As indicated in the [February 2016 Medicaid Bulletin](#), HCPCS G0431 and G0434 were end-dated effective Dec. 31, 2015. Providers should select the most appropriate code from the lab section of the 2016 CPT manual that describes the services performed.

**Practitioner, Clinical Services Unit
DMA, 919-855-4260**

Attention: Nurse Practitioners, Nurse Midwives, Physician Assistants and Physicians**Revised Rates for 2015 New CPT Codes effective Jan. 1, 2015**

Effective Jan. 1, 2015, new 2015 CPT Codes that were added to the Medicaid and N.C. Health Choice benefit plans were **incorrectly** reduced by 3 percent. N.C. Division of Medical Assistance (DMA) has corrected the calculations and the correct rates will be implemented into NCTracks by the end of March 2016.

A systematic reprocessing will occur at a later date. Estimated timeframes will be provided in subsequent bulletin articles.

**Provider Reimbursement,
DMA, 919-814-0048**

Attention: Adult Care Home, Family Care Home, Home Health Providers, Personal Care Service Providers and Supervised Living Homes Billing Personal Care Services

Personal Care Services Program Highlights

Note: This article does not apply to providers billing for Personal Care Services (PCS) under the Community Alternatives Program (CAP).

PCS Provider Regional Training Sessions

PCS regional training sessions will be held May 3-17, 2016. Training topics and materials will be available to registered participants prior to the training dates. Providers can register through the [Liberty Healthcare NC Medicaid PCS website](#). **There is no cost to attend the training, but registration is required.**

Providers with questions may contact Liberty Healthcare at 1-855-740-1400 or N.C. Division of Medical Assistance (DMA) at 919-855-4360.

Event Dates and Locations:

- **Tuesday, May 3, 2016 – Charlotte**
Great Wolf Lodge Convention Center, *White Pine room*
- **Wednesday, May 4, 2016 – Greensboro/Winston-Salem**
Greensboro-High Point Marriott Airport, *Grand Ballroom*
- **Thursday, May 5, 2016 – Greenville**
Holiday Inn – Greenville (former City Hotel and Bistro), *Ballroom*
- **Tuesday, May 10, 2016 – Raleigh**
Jane S McKimmon Conference and Training Center – NC State University
- **Wednesday, May 11, 2016 – Fayetteville**
Doubletree by Hilton Fayetteville, *Grand Ballroom*
- **Tuesday, May 17, 2016 – Asheville**
Doubletree by Hilton – Biltmore, *Burghley Room*

**Facility, Home, and Community Based Services
DMA, 919-855-4340**

Attention: Ambulatory Surgical Centers

Updated Fee Schedule for Ambulatory Surgical Centers

In adherence to Centers for Medicare & Medicaid Services (CMS) guidance, the N.C. Division of Medical Assistance (DMA) has updated the Medicaid ambulatory surgical centers fee schedule.

The updated ambulatory surgical centers fee schedule includes the rates for 41 CPT codes with an **effective date of Jan. 1, 2014**.

Note: The format of the updated ambulatory surgical centers fee schedule has been changed. Each code and corresponding rate now reflects its respective effective date.

The updated ASC fee schedule can be found on the DMA [Ambulatory Surgical Centers \(CPT/HCPCS\) web page](#).

Provider Reimbursement
DMA, 919-814-0060

Attention: Community Care of N.C./Carolina Access (CCNC/CA) Providers

CCNC/CA Providers Who are Changing a National Provider Identifier (NPI)

Notice: This article was previously published in the [August 2015 Medicaid Bulletin](#).

Community Care of North Carolina/Carolina ACCESS (CCNC/CA) providers may change National Provider Identifiers (NPIs) due to a Change of Ownership (CHOW) or situations where beneficiaries were linked to an individual NPI when they should have been linked to a group NPI. To ensure the change is as smooth as possible, providers must adhere to the following:

- When there is an NPI change for a CCNC/CA provider, the new NPI must be credentialed for both N.C. Medicaid and CCNC/CA for continued participation.
- A Managed Change Request (MCR) must be submitted through NCTracks to end-date the old NPI for CCNC/CA participation.
- Primary Care Providers (PCPs) are encouraged to wait until after the new NPI is effective for CCNC/CA participation **before** end-dating the old NPI.
- NPI transfer always will be effective the first day of an ongoing month. Claims with dates of service prior to beneficiaries being assigned to the new NPI will require the use of the old NPI as the CCNC/CA referral authorization.
- End-dating CCNC/CA participation under the old NPI will allow Division of Medical Assistance (DMA) regional consultants to request a transfer of beneficiaries to the new NPI.
- Providers affiliated with a CCNC network must [contact their network](#) to amend or sign a new CCNC agreement under the new NPI.

[Regional consultants](#) can answer questions regarding CCNC/CA.

**CCNC/CA Managed Care
DMA, 919-855-4780**

Attention: Optical Providers**NCTracks Update: Request Begin Date on Prior Approvals for Visual Aids**

Notice: This article was previously published as part of the *NCTracks Update* which ran in February 2015.

When entering prior approval (PA) requests for visual aids, the **Request Begin Date** must be the current date (i.e. the day the request is being submitted) **and** the request must be entered under the correct health plan on the current date. PA requests with backdated and future Request Begin Dates are being received from providers. This can result in non-payment of dispensing fees. The Request Begin Date is the first line on the Detail page of the NCTracks Provider Portal submission for visual aid PA requests.

In addition, providers are reminded not to enter procedure codes when submitting PA requests for visual aids. Entering procedure codes will result in only partial payment for dispensing fees.

CSRA, 1-800-688-6696

Attention: Skilled Nursing Home and Hospice Providers**NCTracks Updates: Claims Reprocessing Due to Rate Change**

Effective Jan. 1, 2015, Session Law 2014-100, Senate Bill 744, enacted a freeze on the Case Mix Index (CMI) for skilled nursing facilities. Claims impacted by the CMI freeze with dates of service from Jan. 1, 2015 to May 31, 2015, will be systematically reprocessed. The reprocessing includes nursing home claims and hospice claims that pay as a percentage of the nursing home rate. (Hospice revenue codes 658 and 659.)

In most cases, claims will be processed as adjustments. However, claims containing Patient Monthly Liability (PML) may be voided on either March 20, 2016 or March 21, 2016 and reprocessed as original claims. In both cases, the reprocessed claims will appear in the March 29, 2016, checkwrite. No action is required on the part of providers.

The reprocessed claims will appear in a separate section of the paper Remittance Advice (RA) with a unique Explanation of Benefits (EOB) code:

EOB 06046 - CLAIM REPROCESSED FOR RATE ADJUSTMENT PAYMENT.

The 835 electronic transactions will include the reprocessed claims along with other claims submitted for the checkwrite. (There is no separate 835.)

Note: Reprocessing does not guarantee claim payment. While some edits may be bypassed as part of the claim reprocessing, changes made to the system since the claims were originally adjudicated may apply to reprocessed claims. Therefore, the reprocessed claim could deny. If the reprocessed claim denies and there are not sufficient funds in the provider's current checkwrite to satisfy the full recoupment amount, the recoupment process will continue on each checkwrite until the full amount due is recouped.

**Provider Reimbursement
DMA, 919-814-0060**

Proposed Clinical Coverage Policies

According to NCGS §108A-54.2, proposed new or amended Medicaid clinical coverage policies are available for review and comment on the DMA website. To submit a comment related to a policy, refer to the instructions on the [Proposed Clinical Coverage Policies web page](#). Providers without Internet access can submit written comments to:

Richard K. Davis
 Division of Medical Assistance
 Clinical Policy Section
 2501 Mail Service Center
 Raleigh NC 27699-2501

The initial comment period for each proposed policy is 45 days. An additional 15-day comment period will follow if a proposed policy is substantively revised as a result of the initial comment period. If the adoption of a new or amended medical coverage policy is necessitated by an act of the N.C. General Assembly or a change in federal law, then the 45- and 15-day time periods will instead be 30- and 10-day time periods.

Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
April 2016	03/31/16	04/05/16	04/06/16
	04/07/16	04/12/16	04/13/16
	04/14/16	04/19/16	04/20/16
	04/21/16	04/26/16	04/27/16
	04/28/16	05/03/16	05/04/16
May 2016	05/05/16	05/10/16	05/11/16
	05/12/16	05/17/16	05/18/16
	05/19/16	05/24/16	05/25/16
	05/26/16	06/01/16	06/02/16

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