January *Revised* *2007*

North Carolina Medicaid Bulletin

Visit DMA on the Web at: *http://www.dhhs.state.nc.us/dma/*

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

National Provider Identifier

Attention: Orthotic and Prosthetic Providers

Billing (Supplier) and Attending (Fitting) (NPI) National Provider Identification Information

When applying for a National Provider Identification (NPI) number, orthotic and prosthetic providers should note that the Centers for Medicare and Medicaid Services (CMS) requests different information from individual providers and organizations. Providers should go to the CMS Web site at https://nppes.cms.hhs.gov for clarification of the rules regarding their NPIs.

The N.C. Medicaid Web site contains links to important information regarding NPI at http://www.ncdhhs.gov/dma/NPI.htm. Included in these references is how individuals' and organizations' NPIs will be collected by N.C. Medicaid.

The CMS NPI fact sheet gives further clarification of who should apply for an NPI and other important information.

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

National Provider Identifier (NPI) Seminar

National Provider Identifier (NPI) seminars are being held during the month of January 2007. Seminars are intended for providers that would like more detailed information on how N.C. Medicaid will be implementing NPI. Please go to http://www.dhhs.state.nc.us/dma/NPI/NPI%20Agenda.pdf to access the agenda to see specific topics that will be discussed.

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 online at http://www.dhhs.state.nc.us/dma/semreg/seminar_npi.aspx. If you are planning on attending the Raleigh location that has two sessions, please indicate the session you plan to attend on the registration form.

Morning sessions of the seminars will begin at 9:30 a.m. and end at 11:30 a.m. Providers are encouraged to arrive by 9:15 a.m. to complete registration. Afternoon sessions will begin at 1:30 p.m. and end at 3:30 p.m. Providers are encouraged to arrive by 1:15 to complete registration.

Providers may access the Special December 2006 Bulletin, New Claim Form Instructions using the following link: http://www.dhhs.state.nc.us/dma/bulletin/NewClaimFormInstructions.pdf. Providers should contact EDS with any billing questions.

The seminar dates, registration form and directions are on the next 2 pages of this bulletin.

Monday, Jan. 8, 2007 Jane S. McKimmon Center 1101 Gorman St. Raleigh, NC 27606	**Tuesday, Jan. 9, 2007** Coastline Convention Center 501 Nutt St. Wilmington, NC 28401
Tuesday, Jan. 16, 2007 Matthews Community Center 100 McDowell St. E. Matthews, NC 28105	**Wednesday, Jan. 24, 2007** Crown Plaza Hotel and Resort One Holiday Inn Drive Asheville, NC 28806

Directions to the NPI Seminars

Jane S. McKimmon Center – Raleigh

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.

Coastline Convention Center – Wilmington

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.

Matthews Community Center – Matthews

From the North from I-77: From I-77 South, take the I-277/BROOKSHIRE FRWY/NC-16 exit- exit number 11. Merge onto I-277 S/W BROOKSHIRE FRWY/NC-16 S via exit number 11A- on the left. Merge onto US-74 E via exit number 2B- on the left- toward NC-27 E/INDEPENDENCE BLVD. Go about 9.3 miles on E. Independence Boulevard/74-East. At the light turn RIGHT onto SAM NEWELL RD (NTB and Boston Market are on the right at the corner). Go through the light at Sam Newell and 51/Matthews Township Parkway. SAM NEWELL RD becomes N TRADE ST. Go through the light, over the train tracks, then through another light at John Street. Go about two blocks and turn LEFT onto MCDOWELL ST. We are between the Matthews Elementary School and the First Baptist Church. It is a brick building with white pillars that says "Community Center" on the front. The main entrance is on the left side with the parking lot.

From the North from I-85: From I-85 South, take the I-485 exit (it is a brand new exit so I don't know the exit # and it only goes one way and that is east). Take EXIT 52 for MATTHEWS and make a RIGHT at the light at the bottom of the ramp onto West John Street. You will go about 2 miles to the stoplight at JOHN AND TRADE STREETS. Make a LEFT onto South Trade street. Go about two blocks and turn left onto Mc Dowell street We are between the Matthews Elementary School and the First Baptist Church. Arrive at 100 Mc Dowell street. It is a brick building with white pillars that says "Community Center" on the front. The main entrance is on the left side with the parking lot.

From the West: From Billy Graham Parkway go South to I-77 junction. Take I-77 South to I-485 East EXIT 2 toward PINEVILLE. Take EXIT 52 for MATTHEWS and make a LEFT at the light at the bottom of the ramp onto WEST JOHN STREET. You will go about 2 miles to the stoplight at JOHN AND TRADE STREETS. Make a LEFT onto SOUTH TRADE STREET. Go about two blocks and turn LEFT onto MCDOWELL ST. We are between the Matthews Elementary School and the First Baptist Church. It is a brick building with white pillars that says "Community Center" on the front. The main entrance is on the left side with the parking lot.

If you are coming from the South: Take I-77 North to I-485 East EXIT 2 toward PINEVILLE. Take EXIT 52 for MATTHEWS and make a LEFT at the light at the bottom of the ramp onto WEST JOHN STREET. You will go about 2 miles to the stoplight at JOHN AND TRADE STREETS. Make a LEFT onto SOUTH TRADE STREET. Go about two blocks and turn LEFT onto MCDOWELL ST. We are between the Matthews Elementary School and the First Baptist Church. Arrive at 100 MCDOWELL STREET. It is a brick building with white pillars that says "Community Center" on the front. The main entrance is on the left side with the parking lot.

From the East: From 74-WEST merge onto HIGHWAY 51 via the ramp on the RIGHT. At the end of the ramp, make a LEFT onto HIGHWAY 51 towards Matthews. At the next light, make a LEFT onto SAM NEWELL ROAD. SAM NEWELL ROAD turns into TRADE STREET. Go through the light, over the train tracks, then through another light at JOHN STREET. Go about two blocks and turn LEFT onto MCDOWELL ST. We are between the Matthews Elementary School and the First Baptist Church. Arrive at 100 MCDOWELL STREET. It is a brick building with white pillars that says "Community Center" on the front. The main entrance is on the left side with the parking lot.

Crown Plaza and Resort – Asheville

Traveling from South or West: Travel west on I-26. Follow signs for I-240 to Asheville. Stay in the left lane and take Exit 3A. Circle around right and exit onto Patton Avenue. Turn right at the second light into Regents Business Park (between Denny's and Pizza Hut). It will turn to the right; our entrance sign is on the immediate left. Follow our road (Holiday Inn Drive) past our golf course to the main entrance.

Traveling from North or East: Travel west on I-40. Take Exit 53 to I-240 West. Pass downtown Asheville. As you cross the French Broad River Bridge, stay in the right lane and take Exit 3B (Westgate and Holiday Inn Drive). Pass the Westgate Shopping Center on your right. After passing Mr. Transmission, you will see our entrance sign. Turn right onto Holiday Inn Drive and proceed to the main entrance.

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

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)

For Raleigh location ONLY: 9:30-11:30_____ 1:30-3:30_____

Please fax completed form to: 919-851-4014

Please mail completed form to:
EDS Provider Services
P.O. Box 300009
Raleigh, NC 27622

National Provider Identifier

Attention: All Providers

National Provider Identifier (NPI) Collection Form Now Available in Spreadsheet Format

N.C. Medicaid is actively collecting NPI numbers from providers. Providers are required to report NPI numbers to Medicaid no later than March 31, 2007. To accommodate organizations with large numbers of providers, an NPI spreadsheet is now available on the DMA Web site. The spreadsheet and its instructions can be found here: http://www.dhhs.state.nc.us/dma/NPI.htm. The spreadsheet can be completed for both group and individual provider numbers. Required fields for the spreadsheet are similar to the NPI Collection Form. Blocks A through L on the spreadsheet must be completed.

Printed Name/Title/Date, Phone Number, Fax Number and Email Address — List the person completing this information and the contact information for questions.

• **A. Group (G)/Individual (I) —** You may submit both group and individual information on the same spreadsheet. Enter the group information first by putting a "G" in column A. The indicator G is for the Group NPI. Next, enter an "I" for each individual in the group. Please complete a separate line to report the NPI for each Medicaid Provider Number.

• **B. Carolina ACCESS Provider — P**lace a "Y" or "N" in column B for each Medicaid Provider Number to indicate whether the group or the individual is a Carolina ACCESS provider.

• **C. Medicaid Provider Number — E**nter the seven- or eight-digit numeric or alphanumeric Medicaid Provider Number. Please check the most recent remittance advice (RA) to make sure the provider number is accurately recorded. Complete a separate line to report the NPI for each Medicaid Provider Number.

• **D. National Provider Number (NPI) —** Enter the 10-digit number assigned by NPPES for each Medicaid Provider Number. In addition to submitting the spreadsheet, providers must submit a copy of their NPPES certification letter for each NPI reported. If you do not submit this letter, your NPI will not be accepted. If you need to apply for an NPI, go to https://nppes.cms.hhs.gov/NPPES/Welcome.do and click on the link to *National Provider Identifier*. Follow the instructions for applying.

If you need a copy of your NPPES Certification letter, contact the NPI Enumerator at 1-800-465-3203, or go to http://questions.cms.hhs.gov/copy_of_your_NPPES_letter to have another NPI notification generated. If the provider was enumerated via EFI, the health care provider must contact the EFI organization (EFIO) for a copy of the EFIO's notification. Notifications generated by the NPPES are created in the same manner in which they were originally issued (i.e., NPI notification letter for paper applicants or an e-mail notification for Web-based applicants).

E. Taxonomy — Enter the 10 digit code ending in X. You may submit up to 15 taxonomies. If you need to report additional taxonomy codes, please complete the "Additional Taxonomy Form" located at http://www.ncdhhs.gov/dma/npi/taxonomy.htm. For a listing of taxonomy codes, go to http://www.wpc-edi.com/taxonomy. You will need this taxonomy information when applying for an NPI.

• F. Organization/Individual Name

o *Organization Name* — The name of the group or business. Please check the most recent RA to verify how your organization is listed in our provider system. If the name on the spreadsheet does not match the name listed in the provider system, the updates will not be made.

o *Individual Name* — The name of the provider as listed in our system or on the NPPES certification. If the name on the spreadsheet does not match the name listed in the provider system the updates will not be made.

• G-L. Physical/Accounting Address — Must be completed even if the addresses are the same.

o *Physical Address* — The location where services are performed or care is coordinated. Please be sure to include the ZIP Code+4 number.

o *Accounting Address* — The address where payments, remittance advices and correspondence are sent. Please be sure to include the ZIP Code+4 number. Please check the most recent RA to determine the accounting address listed in our provider system. If the accounting address is the same as the physical address, please indicate "SAME" in this block.

NOTE: If the address on this spreadsheet does not match what is currently in our provider system, we will automatically update our records with the address provided on the NPI spreadsheet. For reporting changes other than address, complete the Provider Change Form which is located here: www.ncdhhs.gov/dma/forms.html.

Upon completion, choose one of the options below to send the spreadsheet to DMA:

Please **Mail** to:	Please **Fax** to:	Please **E-mail** to:
DMA Provider Services Attention: NPI Form 2501 Mail Service Center Raleigh, NC 27699-2501	(919) 715-7140	npi.dma@ncmail.net

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

March 2007 National Provider Identifier (NPI) Seminars

Informational seminars regarding National Provider Identifier (NPI) are scheduled for March 2007. Registration information and a complete list of dates and site locations for the seminars will be published in the February 2007 general Medicaid bulletin and published on DMA's Web site at http://www.ncdhhs.gov/dma/NPI.htm.

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

National Provider Identifier

Attention: All Providers

Required Fields on New Provider Enrollment Applications and Provider Change Form

Effective Jan. 1, 2007, to facilitate National Provider Identifier (NPI) implementation, the Division of Medical Assistance (DMA) will no longer accept enrollment applications or change forms without the following information:

- National Provider Identifier (NPI)
- Zip Code plus Four
- Taxonomies

Federally mandated requirements for NPI implementation is May 23, 2007. This information is required. If this information is not provided, your new application or change forms will be returned.

If you have not enumerated, please check our Web site at http://www.dhhs.state.nc.us/dma/NPI.htm for information or enumerate at NPI at https://nppes.cms.hhs.gov/NPPES/Welcome.do.

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Providers Services
DMA, 919-855-4050

National Provider Identifier

Attention: All Providers

Submitting Both National Provider Identifier (NPI) and Provider Number on Claims

N.C. Medicaid would like to encourage providers to begin submitting both the National Provider Identifier (NPI) and the Medicaid provider number on electronic claims no later than Jan. 1, 2007. If your software is not updated to submit the NPI number, please contact your clearinghouse or software vendor as soon as possible to obtain the appropriate updates. Please ensure that you keep the capability to submit the Medicaid provider number along with the NPI. N.C. Medicaid will continue to process claims using the Medicaid provider number until NPI is implemented in May 2007.

The NCECS Webtool already contains a field for submitting the NPI, so providers can begin to populate that field. For providers who bill on paper, the new paper claim forms will be available in 2007. We plan to begin testing changes to the MMIS in January 2007, and at that time we will need both the NPI and Medicaid provider numbers.

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

National Provider Identifier

Attention: All Providers

Updated National Provider Identifier (NPI) Collection Forms

The Division of Medical Assistance (DMA) is currently collecting National Provider Identifier (NPI) numbers from Medicaid providers. Health care providers are required to complete one NPI collection form for each Medicaid provider number to ensure that North Carolina Medicaid captures the NPIs, which will be used for claims processing. There are now two different collection forms on the DMA Web site: one for individual provider numbers and one for group provider numbers. Providers who have obtained an organizational or group NPI must complete an NPI collection form for the group provider number. In addition, an individual NPI collection form must be completed for each individual provider number within the group.

The required fields for completing the NPI collection form are: Medicaid Provider Number, NPI, Physical and Billing address including Zip+4 and taxonomy code(s). If more than three taxonomy codes need to be linked to one NPI number, an additional taxonomy page has been provided on the Web site. Providers can link up to 15 taxonomies to one NPI. Also, providers need to include a copy of the notification letter from the National Plan and Provider Enumeration System (NPPES). The address information provided will overlay the information currently in the system. Any other change request will require a separate change request form.

The collection forms and instructions are located on the following Web site: http://www.dhhs.state.nc.us/dma/NPI.htm. Forms must be typed and returned no later than March 15, 2007. The form can be returned by the mail, fax or e-mail addresses listed on the form. Providers will receive a confirmation notice once the NPIs have been added.

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

Corrected 2007 Checkwrite Schedule

This article from the December General Medicaid bulletin is being re-run with corrections. Corrections have also been made to the Checkwrite schedule on DMA's Web site.

Beginning February 2007, the cutoff day for electronic claims submission will change from Friday to Thursday due to anticipated increased processing time for the National Provider Identifier (NPI) implementation. It is important that you make any required system changes to accommodate this cutoff day. The following is the 2007 checkwrite schedule:

Month	Electronic Cut-Off	Checkwrite Date
January	01/05/07	01/09/07
	01/12/07	01/17/07
	01/19/07	01/25/07
February	02/02/07	02/06/07
	02/08/07	02/13/07
	02/15/07	02/20/07
	02/22/07	02/28/07
March	03/01/07	03/06/07
	03/08/07	03/13/07
	03/15/07	03/20/07
	03/22/07	03/29/07
April	04/05/07	04/10/07
	04/12/07	04/17/07
	04/19/07	04/26/07
May	05/03/07	05/08/07
	05/10/07	05/15/07
	05/17/07	05/22/07
	05/24/07	05/31/07
June	05/31/07	06/05/07
	06/07/07	06/12/07
	06/14/07	06/21/07

Month	Electronic Cut-Off	Checkwrite Date
July	06/28/07	07/03/07
	07/05/07	07/10/07
	07/12/07	07/17/07
	07/19/07	07/26/07
August	08/02/07	08/07/07
	08/09/07	08/14/07
	08/16/07	08/23/07
September	08/30/07	09/05/07
	09/06/07	09/11/07
	09/13/07	09/18/07
	09/20/07	09/27/07
October	10/04/07	10/09/07
	10/11/07	10/16/07
	10/18/07	10/23/07
	10/25/07	10/31/07
November	11/01/07	11/06/07
	11/08/07	11/14/07
	11/15/07	11/21/07
December	11/29/07	12/04/07
	12/06/07	12/11/07
	12/13/06	12/20/07

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:

General Clinical Coverage Policy A3, Prior Authorization for Outpatient Pharmacy Point of Sale Medications
Clinical Coverage Policy 4A, Dental Services
Clinical Coverage Policy 5A, Durable Medical Equipment
Clinical Coverage Policy 5B, Orthotics and Prosthetics
Clinical Coverage Policy 10B, Independent Practitioners

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
DMA, 919-855-4260

Attention: All Providers

CPT Code Update 2007

Effective with date of service Jan. 1, 2007, the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA) have added some new CPT codes, deleted others and changed the descriptions of some existing codes. (For complete information regarding all CPT codes and descriptions, refer to the 2007 edition of *Current Procedural Terminology*, published by the American Medical Association.) New CPT codes are covered by the N.C. Medicaid Program effective with date of service Jan. 1, 2007. Claims submitted with deleted codes will be denied for dates of service on or after Jan. 1, 2007. Previous policy restrictions continue in effect unless otherwise noted.

New Covered CPT Codes									
00625	00626	15002	15003	15004	15005	15731	15830	15847	17311
17312	17313	17314	17315	19300	19301	19302	19303	19304	19305
19306	19307	22865	25109	25606	25607	25608	25609	27325	27326
28055	33202	33203	33254	33255	33256	33265	33266	33675	33676
33677	33724	33726	35302	35303	35304	35305	35306	35537	35538
35539	35540	35637	35638	35883	35884	37210	44157	44158	47719
48105	48548	49324	49325	49326	49402	49435	49436	54865	55875
56422	57296	57558	58541	58542	58543	58544	58548	58957	58958
67346	72291	72292	76776	76813	76814	76998	77001	77002	77003
77011	77012	77013	77014	77021	77022	77031	77032	77051	77052
77053	77054	77055	77056	77057	77058	77059	77072	77073	77074
77075	77076	77077	77078	77079	77080	77081	77082	77083	77084
77371	77372	77373	77435	82107	83913	86788	86789	87305	87498
87640	87641	87653	87808	88576	92025	92640	94002	94003	94004
94610	94644	94645	94777						

End-Dated CPT Codes									
01995	15000	15001	15831	17304	17305	17306	17307	17310	19140
19160	19162	19180	19182	19200	19220	19240	21300	25611	25620
26504	27315	27320	28030	31700	31708	31710	33200	33201	33245
33246	33253	35381	35507	35541	35546	35641	44152	44153	47716
48005	48180	49085	54152	54820	55859	56720	57820	67350	75998
76003	76005	76006	76012	76013	76020	76040	76061	76062	76065
76066	76070	76071	76075	76076	76077	76078	76082	76083	76086
76088	76090	76091	76092	76093	76094	76095	76096	76355	76360
76362	76370	76393	76394	76400	76778	76986	78704	78715	78760
91060	92573	94656	94657	95078					

New CPT Codes Not Covered Pending Further Review					
22526	22527	22857	22862	32998	92640

New CPT Codes Not Covered									
19105	43647	43648	43881	43882	64910	64911	70554	70555	77071
83698	91111	94005	94774	94775	94776	95012	96020	96040	96904
99364	99636								

Billing Information

CPT CODE	BILLING INFORMATION	DIAGNOSIS EDITING	PRIOR APPROVAL
15847	N/A	N/A	Prior approval is required and allowed for the following criteria: • Medically necessary to provide additional abdominal support.
15731	N/A	N/A	Prior approval is required and allowed for the following criteria: • Medically necessary to improve/restore/correct significant deformity resulting from trauma or cancer . • Not for cosmetic reasons.
22865	N/A	N/A	Prior approval is required and allowed for the following criteria: • Medical necessity based on complications directly related to the artificial disc.
33675 33676 33677	N/A	Allowed with one of the following primary diagnoses: 745.5, 747.0	N/A
37210	N/A	Allowed with one of the following primary diagnoses: 218.0, 218.1, 218.2, 218.9	N/A
57296	N/A	N/A	Prior approval is required and allowed for the following criteria: • Medical documentation substantiates that the congenital anomaly and/or ambiguous genitalia was present prior to the age of two. • Medical documentation substantiates that the development of pronounced secondary sex characteristics occurred during puberty. • Medical documentation substantiates that certain conditions are due to pelvic malignancies, such as repair of vaginal vault prolapse, treatment of female genitourinary disease, and/or treatment of malignant cancers.

CPT CODE	• BILLING INFORMATION	DIAGNOSIS EDITING	PRIOR APPROVAL
67346	• For a single muscle biopsy, one eye, bill 67346 for one unit. • For a single muscle biopsy, both eyes, bill 67346 with modifier 50 for one unit. • For two biopsies, left eye, bill 67346, modifier LT, two units. • For two biopsies, right eye, bill 67346, modifier RT, two units.		
72291 72292	Must be billed as a professional component with modifier 26.	N/A	N/A
77371 77372 77373 77435	Refer to April 2005 Medicaid Bulletin for instructions on billing a radiation treatment delivery code.	Allowed with one of the following diagnoses: 191.0 through 191.9, 192.1, 192.2, 192.3, 194.3, 198.3, 198.4, 225.0, 225.1, 225.2, 225.3, 225.4, 225.8, 225.9, 227.3, 237.0, 237.5, 237.6, 237.70 through 237.72, 239.6, 239.7, 350.1, 377.51 through 377.54, 742.9, 747.81, 747.82, 747.89	N/A
92025	• The description includes "unilateral or bilateral," therefore limited to one unit. • Not covered for routine follow-up scans. • Routine scans of an uninvolved eye are not covered. • Repeat testing is indicated only if a change of vision is reported in connection with the allowable diagnosis code(s).	Allowed with one of the following diagnoses: V42.5, 370.00 through 370.07, 371.00, 371.23, 371.50 through 371.58, 371.60 through 371.62, 372.40 through 372.45, 372.52, 996.51	N/A

Ambulatory Surgery Centers (ASCs)

New CPT Codes Covered for ASCs (effective with date of service Jan. 1, 2007)							
Code	**ASC Payment Group**	**Code**	**ASC Payment Group**	**Code**	**ASC Payment Group**	**Code**	**ASC Payment Group**
15002	2	15003	1	15004	2	15005	1
15731	3	15847	3	19300	4	19301	3
19302	7	19303	4	19304	4	25606	3
25607	5	25608	5	25609	5	27325	2
27326	2	49402	2	54865	1	55875	9
56442	1	57558	3	67346	2		

CPT Codes End-Dated for ASCs (effective with date of service Dec. 31, 2006)										
15000	15001	19140	19160	19162	19180	19182	25611	25620	26504	27315
27320	49085	54800	56720	57820						

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

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

Corrected CPT Codes 90467, 90468, 90473 and 90474 - Coverage of Immunization Administration Codes for Oral/Intranasal Vaccines

Effective with date of service Aug. 1, 2006, the N.C. Medicaid program covers CPT codes for the intranasal and oral administration of vaccines/toxoids. Their code descriptors are as follows:

90467 — Immunization administration under 8 years of age (includes intranasal or oral routes of administration) when the physician counsels the patient/family; first administration (single or combination vaccine/toxoid) per day. (For N.C. Medicaid, do not report in addition to 90465.)

90468 — Each additional administration (single or combination vaccine/toxoid) per day (list separately in addition to code for primary procedure). (For N.C. Medicaid, use 90468 in conjunction with 90465.)

90473 — Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid). (For N.C. Medicaid, do not report in addition to 90471.)

90474 — Each additional vaccine (single or combination vaccine/toxoid). (List separately in addition to code for primary procedure.) (For N.C. Medicaid, use 90474 in conjunction with 90471.)

The current codes used for immunization administration and their descriptors are as follows:

90465 — Immunization administration under 8 years of age (includes percutaneous, intradermal, subcutaneous or intramuscular injections) when the physician counsels the patient/family; first injection (single or combination vaccine/toxoid) per day. (For N.C. Medicaid, do not report 90465 in conjunction with 90467.)

90466 — Immunization administration under 8 years of age (includes percutaneous, intradermal, subcutaneous or intramuscular injections) when the physician counsels the patient/family; each additional injection (single or combination vaccine/toxoid) per day. (List separately in addition to code for primary procedure.) (For N.C. Medicaid, use in conjunction with 90465 or 90467.)

90471 — Immunization administration (includes percutaneous, intradermal, subcutaneous or intramuscular injections); **one vaccine** (single or combination vaccine/toxoid). (For N.C. Medicaid, do not report 90471 in conjunction with 90473.)

90472 — Immunization administration (includes percutaneous, intradermal, subcutaneous or intramuscular injections); one vaccine (single or combination vaccine/toxoid) **each additional vaccine** (single or combination vaccine/toxoid). (List separately in addition to code for primary procedure.) (For N.C. Medicaid, use 90472 in conjunction with 90471.)

The following principles should guide the billing of the eight codes described above:

1. Apply the appropriate code depending on the age of the recipient and whether or not the physician has counseled the recipient and family.
2. CPT codes 90465 and 90466 are in the same code family, and 90471 and 90472 are in the same code family. A code from one injectable code family cannot be used with a code from another injectable code family.
3. CPT codes 90467 and 90468 are in one code family, and 90473 and 90474 are in another code family. A code from one intranasal/oral code family cannot be used with a code from the other intranasal/oral code family.
4. The physician counseling codes should not be used as an "add-on" counseling code to the other administration codes.
5. Physicians, nurse practitioners and physician assistants may perform these services.
6. When billing 90465, 90466, 90467 or 90468, the physician, nurse practitioner or physician assistant must perform face-to-face **vaccine counseling** associated with the administration and should document such. The physician, nurse practitioner or physician assistant is not required to administer the vaccine.
7. A "first" administration is defined as the first vaccine administered to a recipient during a single patient encounter.
8. At the present time, there should not be an occasion to bill a second intranasal/oral vaccine administration code.
9. When billing one or more injectable vaccines along with one oral/intranasal vaccine, the code for **the first injectable vaccine is the primary code**.

Vaccine: Injectable Provider Type: FQHC/RHC		
Service Type	**With Physician Counseling**	**Without Physician Counseling**
Health Check Screening with Immunization(s)	For one vaccine, bill 90465EP. For two vaccines or more, bill 90465EP and 90466EP. Report CPT vaccine code(s). Immunization diagnosis code(s) **not** required.	For one vaccine, bill 90471EP. For two vaccines or more, bill 90471EP and 90472EP. Report CPT vaccine code(s). Immunization diagnosis code(s) **not** required.
Immunization(s) Only	For one vaccine, bill 90465EP. For two vaccines or more, bill 90465EP and 90466EP. Report CPT vaccine code(s). One immunization diagnosis code **is** required.	For one vaccine, bill 90471EP. For two vaccines or more, bill 90471EP and 90472EP. Report CPT vaccine codes. One immunization diagnosis code **is** required.
Office Visit with Immunization(s)	N/A	N/A
Core Visit with Immunization(s)	Cannot bill 90465EP or 90466EP. Report CPT vaccine code(s). Immunization diagnosis code(s) are **not** required.	Cannot bill 90471EP or 90472EP. Report CPT vaccine code(s). Immunization diagnosis code(s) are **not** required.

Vaccine: Injectable Provider Type: Local Health Departments		
Service Type	**With Physician Counseling**	**Without Physician Counseling**
Health Check Screening with Immunization(s)	Cannot bill 90465EP. Report vaccine CPT code(s). Immunization diagnosis code(s) **not** required.	Cannot bill 90471EP. Report vaccine CPT code(s). Immunization diagnosis code(s) **not** required.
Immunization(s) Only	For one vaccine, bill 90465EP. For two vaccines or more, bill 90465EP. Report CPT vaccine code(s). One immunization diagnosis code **is** required.	For one vaccine, bill 90471EP. For two vaccines or more, bill 90471EP. Report CPT vaccine code(s). One immunization diagnosis code **is** required.
Office Visit with Immunization(s)	For one vaccine, bill 90465EP. For two or more vaccines, bill 90465EP. Report CPT vaccine code(s). Immunization diagnosis code(s) **not** required.	For one vaccine, bill 90471EP. For two or more vaccines, bill 90471EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required.
Core Visit with Immunization(s)	N/A	N/A

Vaccine: Intranasal/Oral Provider Type: Private Sector Providers		
Service Type	**With Physician Counseling**	**Without Physician Counseling**
Health Check Screening with Immunization(s)	For one vaccine, bill 90467EP. Report vaccine CPT code. Two or more vaccines – N/A at this time. Immunization diagnosis code is **not** required.	For one vaccine, bill 90473EP. Report vaccine CPT code. Two or more vaccines – N/A at this time. Immunization diagnosis code is **not** required.
Immunization(s) Only	For one vaccine, bill 90467EP. Report vaccine CPT code. Two or more vaccines – N/A at this time. Immunization diagnosis code **is** required.	For one vaccine, bill 90473EP. Report vaccine CPT code. Two or more vaccines – N/A at this time. Immunization diagnosis code **is** required.
Office Visit with Immunization(s)	For one vaccine, bill 90467EP. Report vaccine CPT code. Two or more vaccines – N/A at this time. Immunization diagnosis code is **not** required.	For one vaccine, bill 90473EP. Report vaccine CPT code. Two or more vaccines – N/A at this time. Immunization diagnosis code is **not** required.
Core Visit with Immunization(s)	N/A	N/A

Vaccine: Intranasal/Oral Provider Type: FQHC/RHC		
Service Type	**With Physician Counseling**	**Without Physician Counseling**
Health Check Screening with Immunization(s)	For one vaccine, bill 90467EP. Report vaccine CPT code. Two vaccines or more – N/A at this time. Immunization diagnosis code is **not** required.	For one vaccine, bill 90473EP. Report vaccine CPT code. Two vaccines or more – N/A at this time. Immunization diagnosis code is **not** required.
Immunization(s) Only	For one vaccine, bill 90467EP. Report vaccine CPT code. Two vaccines or more – N/A at this time. Immunization diagnosis code **is** required.	For one vaccine, bill 90473EP. Report vaccine CPT code. Two vaccines or more – N/A at this time. Immunization diagnosis code **is** required.
Office Visit with Immunization(s)	N/A	N/A
Core Visit with Immunization(s)	Cannot bill 90467EP. Report vaccine CPT code. Immunization diagnosis code is **not** required.	Cannot bill 90473EP. Report vaccine CPT code. Immunization diagnosis code is **not** required.

Vaccine: Intranasal/Oral Provider Type: Local Health Departments		
Service Type	**With Physician Counseling**	**Without Physician Counseling**
Health Check Screening with Immunization(s)	Cannot bill 90467EP. Report vaccine CPT code. Two vaccines or more – N/A. Immunization diagnosis code is **not** required.	Cannot bill 90473EP. Report vaccine CPT code. Two vaccines or more – N/A. Immunization diagnosis code(s) **not** required.
Immunization(s) Only	For one vaccine, bill 90467EP. Report vaccine CPT code. Two vaccines or more – N/A at this time. Immunization diagnosis code **is** required.	For one vaccine, bill 90473EP. Report vaccine CPT code. Two vaccines or more – N/A at this time. Immunization diagnosis code **is** required.
Office Visit with Immunization(s)	For one vaccine, bill 90467EP. Report vaccine CPT code. Two vaccines or more – N/A at this time. Immunization diagnosis code **not** required.	For one vaccine, bill 90473EP. Report vaccine CPT code. Two vaccines or more – N/A at this time. Immunization diagnosis code **not** required.
Core Visit With Immunization(s)	N/A	N/A

Vaccine: Injectable with Intranasal/Oral Provider Type: Private Sector Providers		
Service Type	**With Physician Counseling**	**Without Physician Counseling**
Health Check Screening with Immunization(s)	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90465EP and 90468EP. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90465EP, 90466EP and 90468EP. Report CPT vaccine code(s) Immunization diagnosis code(s) **not** required.	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90471EP and 90474EP. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90471EP, 90472EP and 90474EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required.
Immunization(s) Only	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90465EP and 90468EP. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90465EP, 90466EP and 90468EP. Report CPT vaccine codes. One immunization diagnosis code **is** required.	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90471EP and 90474EP. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90471EP, 90472EP and 90474EP. Report CPT vaccine codes. One immunization diagnosis code **is** required.
Office Visit with Immunization(s)	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90465EP and 90468EP. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90465EP, 90466EP and 90468EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required.	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90471EP and 90474EP. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90471EP, 90472EP and 90474EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required.
Core Visit With Immunization(s)	N/A	N/A

Vaccine: Injectable with Intranasal/Oral Provider Type: FQHC/RHC		
Service Type	**With Physician Counseling**	**Without Physician Counseling**
Health Check Screening with Immunization(s)	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90465EP and 90468EP. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90465EP, 90466EP and 90468EP. Report vaccine CPT codes. Immunization diagnosis code(s) **not** required.	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90471EP and 90474EP. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90471EP, 90472EP and 90474EP. Report vaccine CPT codes. Immunization diagnosis code(s) **not** required.
Immunization(s) Only	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90465EP and 90468EP. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90465EP, 90466EP and 90468EP. Report vaccine CPT codes. One immunization diagnosis code **is** required.	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90471EP and 90474EP. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90471EP, 90472EP and 90474EP. Report vaccine CPT codes. One immunization diagnosis code **is** required.
Office Visit with Immunization(s)	N/A	N/A
Core Visit with Immunization(s)	Cannot bill 90465EP, 90466EP or 90468EP. Report vaccine CPT codes. Immunization diagnosis code(s) are **not** required.	Cannot bill 90471EP, 90472EP or 90474EP. Report vaccine CPT codes. Immunization diagnosis code(s) are **not** required.

Vaccine: Injectable with Intranasal/Oral Provider Type: Local Health Departments		
Service Type	**With Physician Counseling**	**Without Physician Counseling**
Health Check Screening with Immunization(s)	Cannot bill 90465EP and 90468EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required.	Cannot bill 90471EP and 90474EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required.
Immunization(s) Only	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90465EP and 90468EP. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90465EP and 90468EP. Report CPT vaccine codes. One immunization diagnosis code **is** required.	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90471EP and 90474EP. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90471EP and 90474EP. Report CPT vaccine codes. One immunization diagnosis code **is** required.
Office Visit with Immunization(s)	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90465EP and 90468EP. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90465EP and 90468EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required.	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90471EP and 90474EP. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90471EP and 90474EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required.
Core Visit with Immunization(s)	N/A	N/A

Billing Guidelines for Immunization Codes for Recipients Aged 21 and Above

Vaccine: Injectable Provider Type: Private Sector Providers		
Service Type	**Number of Vaccines**	
	One	**Two or More**
Immunization(s) Only	Bill 90471 administration code Bill vaccine CPT code. Report diagnosis code as appropriate.	Bill 90471 and 90472 Bill CPT vaccine codes. Report diagnosis codes as appropriate.
Office Visit with Immunization(s)	Bill 90471 administration code or E/M code. May bill E/M code with modifier 25 appended in addition to 90471 if a separately identifiable service was performed. Bill vaccine CPT code.	Bill 90471 and 90472. May bill E/M code with modifier 25 appended in addition to 90471 and 90472 if a separately identifiable service was performed. Bill CPT vaccine codes.

Vaccine: Injectable Provider Type: FQHCs and RHCs		
Service Type	**Number of Vaccines**	
	One	**Two or More**
Immunization(s) Only	Bill under the C suffix . Bill 90471 administration code. Report the vaccine CPT code if vaccine was provided at no charge from the state of North Carolina. **OR** Bill the vaccine CPT code if vaccine was purchased. Report diagnosis code as appropriate.	Bill under the C suffix. Bill 90471 and 90472 administration codes. Report the vaccine CPT codes if vaccines were provided at no charge from the state of North Carolina. **OR** Bill the CPT vaccine codes if the vaccines were purchased. Report diagnosis codes as appropriate.
Core Visit with Immunization(s)	Immunization administration fees cannot be billed with core visits.	Immunization administration fees cannot be billed with core visits.

Vaccine: Injectable Provider Type: Local Health Departments		
Service Type	**Number of Vaccines**	
	One	**Two or More**
Immunization(s) Only	Bill 90471 administration code. Bill vaccine CPT code. Report diagnosis code as appropriate.	Bill 90471 and 90472. Bill CPT vaccine codes. Report diagnosis codes as appropriate.
Office Visit with Immunization(s)	Bill 90471 administration code or E/M code. May bill E/M code with modifier 25 appended in addition to the administration code if a separately identifiable service was performed. Bill vaccine CPT code.	Bill 90471 and 90472. May bill E/M code with modifier 25 appended in addition to 90471 and 90472 if a separately identifiable service was performed. Bill vaccine CPT codes.

Currently, providers cannot bill for an intranasal or oral vaccine alone or in addition to an injectable vaccine for recipients 21 years of age and older.

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 December 31, 2006, the following HCPCS procedure code was end-dated. Claims submitted for dates of service on or after January 1, 2007, using the end-dated code will be denied.

End-Dated HCPCS Code	Description	Unit
J9212	Injection, sodium chloride, 0.9%	Per 2 ml

New HCPCS 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 January 1, 2007.

New HCPCS Code	Description	Unit	Maximum Reimbursement Rate
J1562	Immune globulin, subcutaneous	100 mg	$13.50
J3473	Hyaluronidase, recombinant	1 USP unit	$0.40

End-Dated Codes with Replacement Codes

The following HCPCS procedure codes were end-dated with date of service December 31, 2006, and replaced with a new code effective with date of service January 1, 2007. Claims submitted for dates of service on or after January 1, 2007, using the end-dated codes will be denied.

End-Dated HCPCS Code	Description	Unit	New HCPCS Code	Description	Unit	Max. Reimb. Rate
J7317	Sodium hyaluronate	20–25 mg	**J7319**	Hyaluronan (sodium hyaluronate) or derivative, intra-articular injection	Per injection	$130.50
J7320	Hylan G-F 20, for intra-articular injection	16 mg				

New Codes That Were Previously Billed with the Miscellaneous Drug Codes J3490 and J3590
Effective with date of service January 1, 2007, 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 January 1, 2007, using the unlisted drug codes J3490 or J3590 for these drugs will be denied. An invoice is not required.

Old HCPCS Code	Description	Unit	New HCPCS Code	Description	Unit	Max. Reimb. Rate
J3490	Etonogestrel contraceptive implant system (Implanon)		**S0180**	Etonogestrel contraceptive implant system, including implants and supplies (Implanon)*	each	$588.38
J3490	Ibandronate sodium (Boniva)	3 mg	**J1740**	Ibandronate sodium (Boniva)	1 mg	$138.85
J3590	Abatacept (Orencia)	250 mg	**J0129**	Abatacept (Orencia)	10 mg	$18.70

*For Implanon, please append the FP modifier to the new HCPCS procedure code **S0180.**

Radiopharmaceuticals—New Codes with and without Replacement Codes

Old			New			
HCPCS Code	**Description**	**Unit**	**HCPCS Code**	**Description**	**Unit**	**Max. Reimb. Rate**
N/A			**A9527**	Iodine I-125, sodium iodide solution, therapeutic	Per mCi	Per Invoice
A9549	Technetium TC-99M arcitumomab, diagnostic per study dose	Up to 25 mCi	**A9568**	Technetium TC-99M arcitumomab, diagnostic per study dose	Up to 45 mCi	Per Invoice

Note: Providers must attach the original invoice or copy of the original invoice to the claim form when billing for the two radiopharmaceuticals indicated above. An invoice must be submitted with each claim. The paper invoice must indicate the name of the recipient, the recipient's Medicaid identification (MID) number, the name of the agent, the dosage administered, and the cost per dose. Claims submitted without this information on the invoice will be denied. Reimbursement is based on the actual invoice price of the agent only (less the shipping and handling).

Providers are reminded to bill their usual and customary charges.

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

Attention: All Providers

New Claim Form Instructions Special Bulletin

The CMS 1500 (12/90), the UB92 and the American Dental Association (ADA) 2002 paper forms have been revised and will be replaced with the new CMS 1500 (08/05), the UB-04 and ADA 2006 claim forms, respectively.

Providers may access the Special December 2006 Bulletin, New Claim Form Instructions, using the following link: http://www.ncdhhs.gov/dma/bulletin/NewClaimFormInstructions.pdf. Providers should contact EDS with any billing questions.

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

Attention: Children's Developmental Service Agencies, Home Health Agencies, Outpatient Hospital Clinics, Independent Practitioners, Health Departments, Local Management Entities, and Physicians

Prior Authorization for Outpatient Specialized Therapies – Web Site Registration

As announced in the December 2006 bulletin, providers will have the option to submit prior authorization (PA) requests electronically beginning Feb. 5, 2007. To do so, providers must first register their provider numbers with the Carolinas Center for Medical Excellence (CCME) and obtain log-on information. Registered users will have Web site access, which offers more details about electronically submitting PAs as well as training videos demonstrating the submission process.

The registration process is as follows:

1) The facility's designated provider administrator (maximum of two per provider number) must complete the two-page Provider Registration Form (in this bulletin) and fax or mail it to CCME.
2) CCME will validate the submitted provider information and issue a provider PIN, user ID and user password.
3) Log-on information will be returned to the provider via regular mail to maintain security.
4) Provider administrators who have received the Web site log-on information can register users in their facility.
5) All users at the same facility will have the same provider number and PIN for log-on; individual users will have their own user IDs and passwords.

CCME, 1-800-682-2650

The Carolinas Center *for* Medical Excellence

100 Regency Forest Drive, Suite 200, Cary, NC 27518-8598 • 919.380.9860 • 800.682.2650 • www.thecarolinascenter.org

PRIOR AUTHORIZATION OF OUTPATIENT SPECIALIZED THERAPIES

I, _____, request to be the Provider Administrator for
Name of Requestor

_____, Medicaid Provider # _____.
Name of Organization

I understand that I will be responsible for the following:

- Determine which users at the organization should have access to the Prior Authorization Web site and grant them access to the system
- Deactivate users who no longer require access to the Web site for their job responsibilities or have left the organization
- Monitor Web site usage at the organization to maintain proper security and confidentiality measures
- Act as the point of contact at the organization for information regarding Prior Authorization.

I understand that as a security measure, CCME may contact me on a future date to verify my position and those individuals I have registered as users under the organization's provider number.

_____
Name

_____
Title

_____
Date

Complete the Provider Administrator Registration Form and mail or fax both documents to:

The Carolinas Center for Medical Excellence
ATTN: Prior Authorization Web site
100 Regency Forest Drive, Suite 200
Cary, NC 27518
FAX: 800-228-1437

Please allow five (5) business days to process. Registration confirmation and Web site log on information will be returned via mail.

The Carolinas Center *for* Medical Excellence

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PRIOR AUTHORIZATION OF OUTPATIENT SPECIALIZED THERAPIES

Registration Form for Website Access
Provider Administrator

*** All fields marked with an asterisk are required and must be completed to obtain access**

*Date of Request:			
*First Name:	Middle Initial:	*Last Name:	
*Job Title:			
*Provider Name:		*Medicaid Billing Provider #:	
National Provider Identifier (NPI):			
*Provider Address:			
Street		City	State Zip
* E-Mail Address:			
*Phone#: ( )	Extension:	*Fax #: ( )	
*Security Question (answer all three):	Mother's Maiden Name: _____ City of Birth: _____ Name of High School: _____		

Contact Information for Prior Approval Outcomes/Questions

Contact information can be the same or different from above information, but all communication from CCME will be via the e-mail address, fax and/or phone # listed below

* E-Mail Address:		
*Phone#: ( )	Extension:	*Fax #: ( )

Attention: Durable Medical Equipment Providers

2007 HCPCS Code Changes: Discontinued Codes, Description Changes and Code Additions for Durable Medical Equipment

Effective with date of service December 31, 2006, 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:

E0164	E0166	E0180	E2320	K0090	K0091
K0092	K0093	K0094	K0095	K0096	K0097
K0098	W4704	W4705	W4706	K0010	K0011

Effective with date of service January 1, 2007, the following code description changes were made:

Code	New Description
E0163	Commode chair, mobile or stationary, with fixed arms
E0165	Commode chair, mobile or stationary, with detachable arms
E0167	Pail or pan for use with commode chair, replacement only
E0181	Powered pressure-reducing mattress overlay/pad, alternating, with pump, includes heavy duty
E0182	Pump for alternating pressure pad, for replacement only
E0720	Transcutaneous electrical nerve stimulation (TENS) device, two lead, localized stimulation
E0730	Transcutaneous electrical nerve stimulation (TENS) device, four or more leads, multiple nerve stimulation
E0967	Manual wheelchair accessory, hand rim with projections, any type, each
E2209	Arm trough, with or without hand support, each

Effective with date of service January 1, 2007, the following codes were added to the DME fee schedule:

New Code	Description	Lifetime Expectancy/Quantity Limitations
E2373*	Power wheelchair accessory, hand or chin control interface, mini-proportional, compact, or short throw remote joystick or touchpad, proportional, including all related electronics and fixed mounting hardware	4 yrs/ 2yrs 00 thru 20
E2374*	Power wheelchair accessory, hand or chin control interface, standard remote joystick (not including controller), proportional, including all related electronics and fixed mounting hardware, replacement only	4 yrs/ 2yrs 00 thru 20
E2375*	Power wheelchair accessory, non-expandable controller, including all related electronics and mounting hardware, replacement only	4 yrs/ 2yrs 00 thru 20
E2376*	Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, replacement only	4 yrs/ 2yrs 00 thru 20
E2377*	Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, upgrade provided at initial issue	4 yrs/ 2yrs 00 thru 20
E2381	Power wheelchair accessory, pneumatic drive wheel tire, any size, replacement only, each	1 year
E2382	Power wheelchair accessory, tube for pneumatic drive tire, any size replacement only, each	1 year
E2383	Power wheelchair accessory, insert for pneumatic drive wheel tire (removable), any type, any size, replacement only, each	1 year
E2384	Power wheelchair accessory, pneumatic caster tire, any size, replacement only, each	1 year
E2385	Power wheelchair accessory, tube for pneumatic caster tire, any size, replacement only, each	1 year
E2386	Power wheelchair accessory, foam-filled drive wheel tire, any size, replacement only, each	1 year
E2387	Power wheelchair accessory, foam-filled caster tire, any size, replacement only, each	1 year
E2388	Power wheelchair accessory, foam drive wheel tire, any size, replacement only, each	1 year
E2389	Power wheelchair accessory, foam caster tire, any size, replacement only, each	1 year
E2390	Power wheelchair accessory, solid (rubber/plastic}drive wheel tire, any size, replacement only, each	1 year
E2391	Power wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, replacement only, each	1 year
E2392	Power wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, replacement only, each	1 year

New Code	Description	Lifetime Expectancy/Quantity Limitations
E2393	Power wheelchair accessory, valve for pneumatic tire tube, any type, replacement only, each	1 year
E2394	Power wheelchair accessory, drive wheel excludes tire, any size, replacement only, each	1 year
E2395	Power wheelchair accessory, caster wheel excludes tire, any size, replacement only, each	1 year
E2396	Power wheelchair accessory, caster fork, any size, replacement only, each	1 year
K0733*	Power wheelchair accessory, 12 to 24 AMP hour sealed lead acid battery, each (e.g., gel cell, absorbed glassmat)	1 year
K0813*	Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds	4 years
K0814*	Power wheelchair, group 1 standard, portable, captains chair, patient weight capacity up to and including 300 pounds	4 years
K0815*	Power wheelchair, group 1 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds	4 years
K0816*	Power wheelchair, group 1 standard, captains chair, patient weight capacity up to and including 300 pounds	4 years
K0820*	Power wheelchair, group 2, standard, portable, sling/solid seat/back, patient weight capacity up to and including 300 pounds	4 years
K0821*	Power wheelchair, group 2 standard, portable, captain's chair, patient weight capacity up to and including 300 pounds	4 years
K0822*	Power wheelchair, group 2 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds	4 years
K0823*	Power wheelchair, group 2 standard, captains seat, patient weight capacity up to and including 300 pounds	4 years
K0824*	Power wheelchair, group 2 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds	4 years
K0825*	Power wheelchair, group 2 heavy duty, captains chair, patient weight capacity 301 to 450 pounds	4 years
K0826*	Power wheelchair, group 2 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds	4 years
K0827*	Power wheelchair, group 2 very heavy duty, captains chair, patient weight capacity 451 to 600 pounds	4 years
K0828*	Power wheelchair, group 2 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more	4 years

New Code	Description	Lifetime Expectancy/Quantity Limitations
K0829*	Power wheelchair, group 2 extra heavy duty, captains chair, patient weight capacity 601 pounds or more	4 years
K0830*	Power wheelchair, group 2, seat elevator, sling/solid seat/back, patient capacity up to and including 300 pounds	4 years
K0831*	Power wheelchair, group 2, seat elevator, captains chair, patient capacity up to and including 300 pounds	4 years
K0835*	Power wheelchair, group 2 standard, single power option, sling/solid seat back, patient weight capacity up to and including 300 pounds	4 years
K0836*	Power wheelchair, group 2 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds	4 years
K0837*	Power wheelchair, group 2 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	4 years
K0838*	Power wheelchair, group 2 heavy duty, single power option, captains chair, patient weight capacity 301 to 450 pounds	4 years
K0839*	Power wheelchair, group 2 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds	4 years
K0840*	Power wheelchair, group 2 extra heavy duty, single power option, sling/solid seat/back, patient weight capacity 601 pounds or more	4 years
K0841*	Power wheelchair, group 2 standard, multiple power options, sling/solid seat/back, patient weight capacity up to and including 300 pounds	4 years
K0842*	Power wheelchair, group 2 standard, multiple power options, captains chair, patient weight capacity up to and including 300 pounds	4 years
K0843*	Power wheelchair, group 2 heavy duty, multiple power options, sling/solid seat/back, patient weight capacity 301 to 450 pounds	4 years
K0848*	Power wheelchair, group 3 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds	4 years
K0849*	Power wheelchair, group 3 standard, captains chair, patient weight capacity up to and including 300 pounds	4 years
K0850*	Power wheelchair, group 3 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds	4 years
K0851*	Power wheelchair, group 3 heavy duty, captains chair, patient weight capacity 301 to 450 pounds	4 years
K0852*	Power wheelchair, group 3 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds	4 years

New Code	Description	Lifetime Expectancy/Quantity Limitations
K0853*	Power wheelchair, group 3 very heavy duty, captains chair, patient weight capacity 451 to 600 pounds	4 years
K0854*	Power wheelchair, group 3 extra heavy duty, sling/back seat/back, patient weight capacity 601 pounds or more	4 years
K0855*	Power wheelchair, group 3 extra heavy duty, captains chair, patient weight capacity 601 pounds or more	4 years
K0856*	Power wheelchair, group 3 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	4 years
K0857*	Power wheelchair, group 3 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds	4 years
K0858*	Power wheelchair, group 3 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	4 years
K0859*	Power wheelchair, group 3 heavy duty, single power option, captains chair, patient weight capacity 301 to 450 pounds	4 years
K0860*	Power wheelchair, group 3 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds	4 years
K0861*	Power wheelchair, group 3 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	4 years
K0862*	Power wheelchair, group 3 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	4 years
K0863*	Power wheelchair, group 3 very heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds	4 years
K0864*	Power wheelchair, group 3 extra heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 601 pounds or more	4 years
K0868*	Power wheelchair, group 4 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds	4 years
K0869*	Power wheelchair, group 4 standard, captains chair, patient weight capacity up to and including 300 pounds	4 years
K0870*	Power wheelchair, group 4 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds	4 years
K0871*	Power wheelchair, group 4 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds	4 years

New Code	Description	Lifetime Expectancy/Quantity Limitations
K0877*	Power wheelchair, group 4 standard, single power option, sling/solid seat back, patient weight capacity up to and including 300 pounds	4 years
K0878*	Power wheelchair, group 4 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds	4 years
K0879*	Power wheelchair, group 4 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	4 years
K0880*	Power wheelchair, group 4 very heavy duty, single power option, sling/solid seat/back, patient weight 451 to 600 pounds	4 years
K0884*	Power wheelchair, group 4 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	4 years
K0885*	Power wheelchair, group 4 standard, multiple power option, captains chair, patient weight capacity up to and including 300 pounds	4 years
K0886*	Power wheelchair, group 4 heavy duty, multiple, power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	4 years
K0890*	Power wheelchair, group 5 pediatric, single power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds	4 years
K0891*	Power wheelchair, group 5 pediatric, multiple power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds	4 years
K0898*	Power wheelchair, not otherwise classified	4 years

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 form 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 #5A, Durable Medical Equipment, on DMA's Web site at http://www.ncdhhs.gov/dma/mp/mpindex.htm for detailed coverage information.

For current pricing on these and all DME codes, refer to DMA's Web site at http://www.ncdhhs.gov/dma/fee/fee.htm. For all billings, providers are reminded to bill their usual and customary rates. Do not automatically bill the established maximum reimbursement rate.

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

Attention: Independent Practitioners

CPT Code Changes - Respiratory Therapy

Effective with date of service Jan. 1, 2007, *CPT code 94657, Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing, subsequent days,* was end-dated. Claims submitted with end-dated codes for dates of service Jan. 1, 2007 and after will be denied.

CPT code 99504, Home visit for mechanical ventilation care, has been added to the list of appropriate codes that respiratory therapists may now bill beginning with date of service Jan. 1, 2007.

Billing Guidelines for CPT Code 99504

- requires prior approval
- may be billed only once a day
- may not be billed along with any other respiratory therapy codes
- 1 unit = 1 event.

Clinical Coverage Policy 10B, Independent Practitioners, has been updated to reflect this code change and is available on DMA's Web site at http://www.ncdhhs.state.nc.usgov/dma/mp/mpindex.htm.

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

Attention: Orthotic and Prosthetic Providers

HCPCS Code Changes, Code Additions, Description Changes and Discontinued Codes for Orthotics and Prosthetics

Effective with date of service Jan. 1, 2007, the following codes will be added to the Orthotic and Prosthetic Fee Schedule.

HCPCS Code	Description	Lifetime Expectancy
***A8000**	Helmet, protective, soft, prefabricated, includes all components and accessories	6 months: ages 00-20 3 years: ages 21-115
***A8001**	Helmet, protective, hard, prefabricated, includes all components and accessories	6 months: ages 00-20 3 years: ages 21-115
***A8002**	Helmet, protective, soft, custom fabricated, includes all components and accessories	6 months: ages 00-20 3 years: ages 21-115
***A8003**	Helmet, protective, hard, custom fabricated, includes all components and accessories	6 months: ages 00-20 3 years: ages 21-115
***A8004**	Soft interface for helmet, replacement only	6 months
***L1001**	Cervical thoracic lumbar sacral orthosis, immobilizer, infant size, prefabricated, includes fitting and adjustment	6 months
***L3806**	Wrist-hand-finger orthosis, includes one or more non-torsion joint(s), elastic bands, turnbuckles, may include soft interface material, straps, custom fabricated, includes fitting and adjustment	6 months: ages 00-20 3 years: ages 21-115
***L3808**	Wrist-hand-finger orthosis, rigid without joints, may include soft interface material; straps, custom fabricated, includes fitting and adjustment	6 months: ages 00-20 3 years: ages 21-115
***L3915**	Wrist-hand orthosis, includes one or more non-torsion joint(s), elastic bands, turnbuckles, may include soft interface, straps, prefabricated, includes fitting and adjustment	6 months: ages 00-20 3 years: ages 21-115
***L5993**	Addition to lower extremity prosthesis, heavy-duty feature, foot only (for patient weight greater than 300 lbs.)	1 year: ages 00-20 3 years: ages 21-115
***L5994**	Addition to lower extremity prosthesis, heavy-duty feature, knee only (for patient weight greater than 300 lbs.)	1 year: ages 00-20 3 years: ages 21-115
***L6624**	Upper extremity addition, flexion/extension and rotation wrist unit	6 months: ages 00-20 3 years: ages 21-115
***L6639**	Upper extremity addition, heavy-duty feature, any elbow	6 months: ages 00-20 3 years: ages 21-115
***L6703**	Terminal device, passive hand/mitt, any material, any size	1 year: ages 00-20 3 years: ages 21-115
***L6704**	Terminal device, sport/recreational/work attachment, any material, any size	1 year: ages 00-20 3 years: ages 21-115

HCPCS Code	Description	Lifetime Expectancy
***L6706**	Terminal device, hook, mechanical, voluntary opening, any material, any size, lined or unlined	1 year: ages 00-20 3 years: ages 21-115
***L6707**	Terminal device, hook, mechanical, voluntary closing, any material, any size, lined or unlined	1 year: ages 00-20 3 years: ages 21-115
***L6708**	Terminal device, hand, mechanical, voluntary opening, any material, any size	1 year: ages 00-20 3 years: ages 21-115
***L6709**	Terminal device, hand, mechanical, voluntary closing, any material, any size	1 year: ages 00-20 3 years: ages 21-115

As the asterisks indicate, all codes require prior approval. Codes shown in **boldface** are covered by Medicare. The updated coverage policies are published in Clinical Coverage Policy 5B, Orthotics and Prosthetics, on DMA's Web site at http://www.ncdhhs.gov/dma/mp/mpindex.htm. All of the items will be individually priced at the time prior approval is given, based on the provider's documentation of cost.

Effective with date of service Jan. 1, 2007, the following code description changes will be made on the Orthotics and Prosthetics Fee Schedule.

HCPCS Code	Description
L0631	Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment
L5848	Addition to endoskeletal knee-shin system, fluid stance extension, dampening feature, with or without adjustability
L5995	Addition to lower extremity prosthesis, heavy-duty feature, other than foot or knee (for patient weight greater than 300 lbs.)
L6805	Addition to terminal device, modifier wrist unit
L6810	Addition to terminal device, precision pinch device
L6884	Replacement socket, above elbow/elbow disarticulation, molded to patient model, for use with or without external power

Effective with date of service Dec. 31, 2006, the following codes will be end-dated and removed from the Orthotics and Prosthetics Fee Schedule.

L0100	L0110	L3902	L3914	L6700	L6705
L6710	L6715	L6720	L6725	L6730	L6735
L6740	L6745	L6750	L6755	L6765	L6770
L6775	L6780	L6790	L6795	L6800	L6806
L6807	L6808	L6809	L6825	L6830	L6835
L6840	L6845	L6850	L6855	L6860	L6865
L6867	L6868	L6870	L6872	L6873	L6875
L6880					

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

Attention: Personal Care Service and Personal Care Service–Plus Providers

Personal Care Services Provider Training Sessions

The Carolinas Center for Medical Excellence (CCME; www.thecarolinascenter.org) announces continued provider training for Personal Care Services (PCS) as approved by the Division of Medical Assistance (DMA).

Training sessions for the first calendar quarter, which will be conducted in March 2007, will target continued issues facing PCS providers and provide guidance in resolving them.

The training is for registered nurses (RNs), agency administrators and agency owners. All participants planning to attend should already be familiar with N.C. Medicaid's clinical coverage policies 3C (PCS; http://www.ncdhhs.gov/dma/cc/3C.pdf) and 3J (PCS–Plus; http://www.ncdhhs.gov/dma/cc/3J.pdf). RNs are required to pass the PCS certification exam before performing their first assessment; DMA and CCME recommend that RN attendees have already passed the exam before the seminar.

There is no cost for attending these sessions, but online or faxed pre-registration is required, and space is limited to 200 participants at each session. Registration details were not available at press time; please e-mail Jennifer Manning at CCME for information on how and when to register: jmanning@thecarolinascenter.org.

The dates and cities of the sessions are as follows. Specific venues will be announced in a later issue of the Bulletin.

March 2	Winston-Salem
March 6	Fayetteville
March 16	Raleigh–Durham
March 23	Greenville
March 30	Asheville

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

Attention: Physicians and Nurse Practitioners

Corrected Bevacizumab (Avastin, J9035)—Update to Billing Guidelines

This article from the December General Medicaid bulletin is being re-run with corrections.

The N.C. Medicaid program covers bevacizumab (Avastin) for use in the Physician's Drug Program for the diagnosis of malignant neoplasm of the colon, rectum, rectosigmoid junction and anus. The Food and Drug Administration has also approved Avastin for the diagnosis of non–small cell lung carcinoma. In accordance with the new FDA-approved diagnosis for Avastin, the following ICD-9-CM **diagnosis codes** are required when billing for Avastin:

•**V58.11—**admission or encounter for chemotherapy **must be billed**

and

•an **ICD-9-CM** diagnosis code in one of the following groups:

1. 153.0 through 154.8
2. 162.2 through 162.9

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

Attention: Physicians and Nurse Practitioners

Panitumumab, 20 mg/ml Injectable (Vectibix, J9999) Billing Guidelines

Effective with date of service Nov. 1, 2006, the N.C. Medicaid program covers panitumumab (Vectibix) for use in the Physician's Drug Program when billed with HCPCS procedure code J9999 (not otherwise classified, antineoplastic drug). Vectibix is indicated for treatment of epidermal growth factor receptor (EGFR) — expressing, metastatic colorectal carcinoma with disease progression on or following fluoropyrimidie-, oxaliplatin- and irinotecan-containing chemotherapy regimens. Vectibix is a monoclonal antibody that binds specifically to EGFR, which is overexpessed in certain cancers, including those of the colon and rectum. The binding of panitumumab to EGFR inhibits cell growth and survival of tumor cells that express EGFR.

The recommended dose of Vectibix is 6 mg/kg administered over 60 minutes as an intravenous infusion every 14 days.

For Medicaid Billing:

- The ICD-9-CM diagnosis codes required for billing Vectibix are V58.11 (admission or encounter for chemotherapy) **AND** one diagnosis code in one of the following ranges:
  - 153.0 through 153.9 (malignant neoplasms of colon)
  - 154.0 through 154.8 (malignant neoplasms of the rectum)
- Providers must bill Vectibix with HCPCS code J9999 (not otherwise classified, antineoplastic drug), with the original invoice or copy of the original invoice attached to the CMS-1500 claim form. **An invoice must be submitted with each claim.** The paper invoice must include the recipient's name and Medicaid identification number, the name of the medication, the dosage given, the National Drug Code (NDC) number from the vial(s) used, the number of vials used and the cost per dose.
- Providers must indicate the number of units given in block 24G on the CMS-1500 claim form.
- Providers must bill their usual and customary charge.

One unit of coverage is 100 mg (5 ml), which is equivalent to the smallest single-use vial. The maximum reimbursement rate per unit is $900.

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

Attention: All Dental Providers and Health Department Dental Centers

American Dental Association Code Updates

Effective with date of service January 1, 2007, the following dental procedure codes have been added for the N.C. Medicaid Dental Program. These additions are a result of the *Current Dental Terminology* (CDT) 2007 American Dental Association (ADA) code updates. Clinical Coverage Policy 4A, Dental Services, has been updated to reflect these changes.

CDT 2007 Code	Description and Limitations	Reimbursement Rate
D0273	Bitewings – three films * allowed one (1) time per 12 calendar month period * not allowed on the same date of service as D0270, D0272, or D0274 * not allowed within the same 12 calendar month period as D0210	$24.46
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients * limited to recipients under age 21 * allowed one time per recipient per six calendar month period for the same provider	$15.44
D2970	Temporary crown (fractured tooth) * limited to recipients under age 21	$126.91
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant * must be at least three edentulous units in a quadrant to qualify for payment for alveoloplasty * requires a quadrant indicator in the area of oral cavity or tooth number field	$82.00
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant * requires prior approval * must be at least three edentulous units in a quadrant to qualify for payment for alveoloplasty * requires a quadrant indicator in the area of oral cavity or tooth number field	$131.61

The following procedure codes were end-dated effective with date of service December 31, 2006.

End-Dated CDT Code	Description
D1201	Topical application of fluoride (including prophylaxis) - child
D1205	Topical application of fluoride (including prophylaxis) - adult

The following procedure code descriptions were revised effective with date of service January 1, 2007.

Revised CDT Code	Description and Limitations
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces per quadrant
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces per quadrant
D7944	Osteotomy – segmented or subapical
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous or nonautogenous, by report
D9610	Therapeutic parenteral drug, single administration * allowed for a single administration of antibiotics, steroids, anti-inflammatory drugs, or other therapeutic medications * not allowed for the administration of sedatives, anesthetic, or reversal agents * identify the drug, dosage, and rationale in the recipient's dental record and on the claim form if filed as a paper claim

Providers are reminded to bill their usual and customary charges rather than the Medicaid rate.
For coverage criteria and additional billing guidelines, please refer to Clinical Coverage Policy 4A, Dental Services, on the Division of Medical Assistance Web site at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

Dental Program
DMA, 919-855-4280

Attention: Physicians, Nurse Practitioners, Health Departments, Federally Qualified Health Centers and Rural Health Centers

American Dental Association Code Updates for the Physician Fluoride Varnish (Into the Mouths of Babes) Program

Effective with date of service Jan. 1, 2007, the dental procedure codes used for the Physician Fluoride Varnish (Into the Mouths of Babes) Program have been changed. These deletions and additions are a result of the *Current Dental Terminology* (CDT) 2007 American Dental Association code updates.

The following procedure codes were end-dated effective with date of service Dec. 31, 2006.

End-Dated CDT Code	Description
D0150	Comprehensive oral evaluation – new or established patient
D0120	Periodic oral evaluation – established patient
D1203	Topical application of fluoride (including prophylaxis) – child
D1330	Oral hygiene instructions

The following procedure codes were added to replace the above deleted codes effective with date of service Jan. 1, 2007.

CDT 2007 Code	Description and Limitations	Reimbursement Rate
D0145	Oral evaluation for a patient under 3 years of age and counseling with primary caregiver * **replacing procedure codes D0150, D0120, and D1330** * must be billed in conjunction with D1206 * limited to recipients under age 3 * allowed once every 90 days * limited to six times prior to the recipient's third birthday	$38.07
D1206	Topical fluoride varnish; therapeutic application for moderate to high-caries-risk patients * **replacing procedure code D1203** * must be billed in conjunction with D0145 * limited to recipients under age 3 * allowed once every 90 days * limited to six times prior to the recipient's third birthday	$15.44

For questions regarding the coverage criteria or billing guidelines, contact the Division of Medical Assistance Dental Program at 919-855-4280.

Dental Program
DMA, 919-855-4280

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.

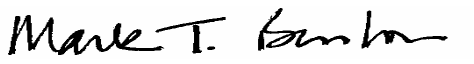
Loretta Bohn
Division of Medical Assistance
Clinical Policy Section
2501 Mail Service Center
Raleigh, NC 27699-2501

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.

2007 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
January	01/05/07	01/09/07
	01/12/07	01/17/07
	01/19/07	01/25/07
February	02/02/07	02/06/07
	02/08/07	02/13/07
	02/15/07	02/20/07
	02/22/07	02/28/07
March	03/01/07	03/06/07
	03/08/07	03/13/07
	03/15/07	03/20/07
	03/22/07	03/29/07

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.



Mark T. Benton, Senior Deputy Director
and Chief Operating Officer
Division of Medical Assistance
Department of Health and Human Services

Cheryll Collier
Executive Director
EDS