



## January 2009 Medicaid Bulletin

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***Providers are responsible for informing their billing agency of information in this bulletin.  
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**Attention: All Providers**  
**National Provider Identifier**  
**Implementation Announcement**

Full implementation of National Provider Identifiers (NPIs) will take place in May 2009. Upon full implementation, the Medicaid Provider Number (MPN) will no longer be allowed on paper or electronic claims. Claims submitted with the MPN will be denied unless the provider is atypical. In preparation for this transition, N.C. Medicaid encourages providers to begin submitting a small number of claims with NPI and taxonomy only, even if you have not received a ready letter.

Please contact the EDS NPI helpdesk at 1-800-688-6696 (option 3 and then option 1) with any questions regarding NPI or taxonomy.

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

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



**Attention: All Providers**  
**National Provider Identifier Seminars**

National Provider Identifier (NPI) seminars are scheduled for the month of March 2009. These seminars are intended to prepare providers for full NPI implementation in May 2009. The seminar sites and dates will be announced in the February 2009 general Medicaid bulletin.

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

***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****Clinical Coverage Policies**

The following new or amended clinical coverage policies are now available on DMA's website at <http://www.ncdhhs.gov/dma/mp/mpindex.htm>:

- 2B, *Nursing Facilities*
- 4A, *Dental Services*
- 5A, *Durable Medical Equipment*
- 10B, *Independent Practitioners*
- 10C, *Local Education Agencies*

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

**Clinical Policy and Programs****DMA, 919-855-4260****Attention: All Providers****Updated EOB Code Crosswalk to HIPAA Standard Codes**

The list of standard national codes used on the Electronic Remittance Advice (ERA) has been cross-walked to EOB codes as an informational aid to adjudicated claims listed on the Remittance and Status Report (RA). An updated version of the list is available on DMA's website at <http://www.ncdhhs.gov/dma/hipaa.htm>.

With the implementation of standards for electronic transactions mandated by HIPAA, providers now have the option to receive an ERA in addition to the paper version of the RA.

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

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

**Attention: All Providers****DMA Website Redesign**

Beginning in January 2009, the look of DMA's website and many of the features on the website will change. These changes are part of the N.C. Department of Health and Human Services Website Redesign Project, which was implemented to improve the appearance and functionality of the 124 websites that operate within DHHS.

Some features of the redesigned websites include

- smart printing of content (not the navigation)
- accessible code and design, including-high contrast colors, scalable fonts, tabbed browsing, and an uncluttered page design
- expanded contact information

To assist with the redesign project, the DHHS Website Project Manager and the DMA Web Content Manager surveyed visitors to the website, analyzed statistics, and performed usability testing with providers. As a result of this research, the following web pages are now available on DMA's website:

- A to Z Provider Topics page – An index of topics of interest to providers with links to web pages within DMA's website and to the websites of our vendors.
- A to Z Provider Contacts List – A quick reference list of phone numbers and contact information frequently used by our providers.
- Claims – A brief overview of claims filing information from the latest version of the *Basic Medicaid Billing Guide*.

In addition to these new pages, DMA is working to improve the website's search engine function and to refine the results.

Questions or comments related to the DMA website may be sent by e-mail to the DMA Webmaster at [dma.webmasters@ncmail.net](mailto:dma.webmasters@ncmail.net). For more information about the DHHS Website Redesign Project, visit <http://www.ncdhhs.gov/redesignproject/>.

**DMA Director's Office, 919-855-4100**

**Attention: All Providers****Corrected 1099 Requests for Tax Years 2006, 2007, and 2008 – Action Required by March 1, 2009**

Each provider number receiving Medicaid payments of more than \$600 annually receives a 1099 MISC tax form from EDS. The 1099 MISC tax form is generated as required by IRS guidelines. It will be mailed to each provider no later than January 31, 2009. The 1099 MISC tax form will reflect the tax information on file with NC Medicaid as of the last Medicaid checkwrite cycle date, December 29, 2008.

If the tax name or tax identification number on the annual 1099 MISC you receive is **incorrect**, a correction to the 1099 MISC must be requested. This ensures that accurate tax information is on file for each provider number with Medicaid and sent to the IRS annually. When the IRS receives incorrect information on your 1099 MISC, it may require backup withholding in the amount of **28 percent of future Medicaid payments**. The IRS could require EDS to initiate and continue this withholding to obtain correct tax data. Please note that only the provider name and tax identification number can be changed and must match the W-9 form submitted.

A correction to the original 1099 MISC must be **submitted to EDS by March 1, 2009**, and must be accompanied by the following documentation:

- Cover page stating instructions of what information needs to be changed and for which year(s).
- A copy of the original 1099 MISC form(s) or the last page of the last Remittance and Status Reports showing the total YTD for that specific year(s).
- A current signed and completed IRS W-9 form (<http://www.ncdhhs.gov.dma/formsprov.html#admin>) clearly indicating the correct tax identification number and tax name. (Additional instructions for completing the W-9 form can be obtained at <http://www.irs.gov> under the link “Forms and Pubs.”) The W-9 form cannot be dated prior to a year before submission.

Fax all documents to 919-816-3186, Attention: Corrected 1099 Request – Financial

**Or**

Mail all documents to:

EDS

Attention: Corrected 1099 Request - Financial  
4905 Waters Edge Drive  
Raleigh, NC 27606

A copy of the corrected 1099 MISC form(s), along with a second copy of the incorrect 1099 MISC form(s) with the “Corrected” box selected, will be mailed to you for your records. All corrected 1099 MISC requests will be reported to the IRS. In some cases, additional information may be required to ensure that the tax information on file with Medicaid is accurate. Providers will be notified by mail of any additional action that may be required to complete the correction to their tax information.

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

**Attention: All Providers****Corrected Diagnosis Code for DTaP-IPV (Kinrix, CPT Procedure Code 90696)**

This article from the December 2008 general Medicaid bulletin is being republished to correct the ICD-9-CM diagnosis code for billing DTaP-IPV (Kinrix, CPT procedure code 90696). The correct diagnosis code is **V06.3 (need for prophylactic vaccination and inoculation against combinations of diseases; DTP+polio)**.

Effective with date of service September 1, 2008, N.C. Medicaid recognized DTaP-IPV (Kinrix) as a covered vaccine in the Universal Childhood Vaccine Distribution Program (UCVDP)/Vaccines for Children (VFC) Program. All of the vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) are available through the UCVDP/VFC Program. The UCVDP/VFC program provides state-supplied Kinrix as an alternative to currently available DTaP and polio vaccines only for the 4- through 6-year booster dose of DTaP and polio vaccines. For additional information, see the Kinrix package insert at [http://us.gsk.com/products/assets/us\\_kinrix.pdf](http://us.gsk.com/products/assets/us_kinrix.pdf).

Medicaid does not reimburse for the actual vaccine because state-supplied vaccine is available to all providers enrolled in the UCVDP/VFC Program. Medicaid will reimburse for a vaccine administration fee, if applicable. When state-supplied Kinrix vaccine is administered, indicate the ICD-9-CM diagnosis code V06.8 on the claim when appropriate. Refer to the April 2008 Special Bulletin, *Health Check Billing Guide 2008* (<http://www.ncdhhs.gov/dma/healthcheck.htm>), for detailed billing guidelines.

**For Medicaid Billing:**

- Report Kinrix vaccine with CPT procedure code 90696 (diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated [DTaP-IPV], when administered to children 4 years through 6 years of age, for intramuscular use).
- The ICD-9-CM diagnosis code for billing Kinrix is **V06.3 (need for prophylactic vaccination and inoculation against combinations of diseases; DTP+polio)**.
- Providers who received claim detail denials for the administration of Kinrix for dates of service on or after September 1, 2008, may resubmit the denied charges as new claims (not as adjustment requests) for processing.
- Providers who received claim detail payments for the administration of other injections, and would like to receive additional reimbursement for the Kinrix administration for dates of service on or after September 1, 2008, may submit replacement claims for processing. If the electronic replacement claim option is not available, providers may submit adjustments.

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

**Attention: All Providers****Corrected Diagnosis Code for DTaP-Hib-IPV (Pentacel, CPT Procedure Code 90698)**

This article from the December 2008 general Medicaid bulletin is being republished to correct the ICD-9-CM diagnosis code for billing DTaP-Hib-IPV (Pentacel, CPT procedure code 90698). The correct diagnosis code is **V06.8 (need for prophylactic vaccination and inoculation against combinations of diseases; other combinations)**.

Effective with date of service September 1, 2008, N.C. Medicaid recognized DTaP-Hib-IPV (Pentacel) as a covered vaccine in the Universal Childhood Vaccine Distribution Program (UCVDP)/Vaccines for Children (VFC) Program. All of the vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) are available through the UCVDP/VFC Program. UCVDP/VFC provides Pentacel for all children as part of their primary series of DTaP, polio, and Hib vaccines.

Pentacel is licensed for a 4-dose series (three primary doses and one booster dose) of DTaP, Hib, and polio at 2, 4, 6, and 15 through 18 months of age. Due to the current reduced supply of PedvaxHIB and ActHIB, the introduction of Pentacel should allow providers to continue administering the primary series of Hib vaccine. However, the CDC continues to recommend deferral of the 12- through 15-month Hib booster dose, except for high-risk children, who should continue to receive the booster. Due to these recommendations, Pentacel may not be used for the 12- through 15-month booster in otherwise healthy children until further notice. For providers who choose to use Pentacel rather than the previously available DTaP, Hib, and polio vaccines, UCVDP recommends integrating Pentacel into your practice **for children born on or after July 1, 2008**. Children already started on Pediarix or separate DTaP, Hib, and polio vaccines should complete the series with those same products. Pentacel is not licensed for anyone over the age of 4 years.

Medicaid does not reimburse for the actual vaccine because state-supplied vaccine is available to all providers enrolled in the UCVDP/VFC Program. Medicaid will reimburse for a vaccine administration fee, if applicable. When state-supplied Pentacel vaccine is administered, indicate the ICD-9-CM diagnosis code V06.3 on the claim when appropriate. Refer to the April 2008 Special Bulletin, *Health Check Billing Guide 2008* (<http://www.ncdhhs.gov/dma/healthcheck.htm>), for detailed billing guidelines.

**For Medicaid Billing:**

- Report Pentacel vaccine with CPT procedure code 90698 (diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated [DTaP-Hib-IPV], for intramuscular use).
- The ICD-9-CM diagnosis code for billing Pentacel is **V06.8 (need for prophylactic vaccination and inoculation against combinations of diseases; other combinations)**.
- Providers who received claim detail denials for the administration of Pentacel for dates of service on or after September 1, 2008, may resubmit the denied charges as new claims (not as adjustment requests) for processing.
- Providers who received claim detail payments for the administration of other injections, and would like to receive additional reimbursement for the Pentacel administration for dates of service on or after September 1, 2008, may submit replacement claims for processing. If the electronic replacement claim option is not available, providers may submit adjustments.

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



**Attention: All Providers**

**CPT Code Update 2009**

Effective with date of service January 1, 2009, the American Medical Association (AMA) has added 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 2009 edition of *Current Procedural Terminology*, published by the American Medical Association.) New CPT codes that are covered by the N.C. Medicaid Program are effective with date of service January 1, 2009. Claims submitted with deleted codes will be denied for dates of service on or after January 1, 2009. Previous policy restrictions continue in effect unless otherwise noted.

New Covered Codes (effective 1/1/2009)									
99460	99461	99462	99463	99464	99465	99466	99467	99468	99469
99471	99472	99475	99476	99478	99479	99480	00211	00567	20696
20697	22864	27027	27057	35535	35570	35632	35633	35634	43273
43279	46930	49652	49653	49654	49655	49656	49657	55706	61796
61797	61798	61799	61800	62267	63620	63621	64455	64632	77785
77786	77787	78808	83876	83951	85397	87905	88720	88740	88741
90681	90696	90951	90952	90953	90954	90955	90956	90957	90958
90959	90960	90961	90962	90963	90964	90965	90966	90967	90968
90969	90970	93228	93229	93279	93280	93281	93282	93283	93284
93285	93286	93287	93288	93289	93290	93291	93292	93293	93294
93295	93296	93297	93298	93299	93306	93351	93352	95992	96360
96361	96365	96366	96367	96368	96369	96370	96371	96372	96373
96374	96375	96379	G0416	G0417	G0418	G0419	Q4101	Q4106	

End-Dated Codes (effective 12/31/2008)									
20986	20987	46934	46935	46936	52606	52612	52614	52620	53853
61793	77781	77782	77783	77784	78890	78891	88400	90760	90761
90765	90766	90767	90768	90769	90770	90771	90772	90773	90774
90775	90776	90779	90918	90919	90920	90921	90922	90923	90924
90925	91100	93727	93731	93732	93733	93734	93735	93736	93741
93742	93743	93744	93760	93762	99289	99290	99293	99294	99295
99296	99298	99299	99300	99431	99432	99433	99435	99436	99440
G0308	G0309	G0310	G0311	G0312	G0313	G0314	G0315	G0316	G0317
G0318	G0319	G0320	G0321	G0322	G0323	G0324	G0325	G0326	G0327
J7340	J7342								

New CPT Codes Not Covered									
22856	22861	41512	41530	65756	65757	90650	90738	95803	96376
Category II Codes			Category III Codes						

CPT Codes From Previous CPT Updates That Are Now Covered (effective 1/1/2009)									
99406	99407	99408	99409	99420	21742	21743	27415	27416	29866
29867	50592	96150	96151						

## Billing Information

CPT Code	Billing Information
G0308 through G0327	HCPCS dialysis codes G0308 through G0327 have been end-dated and will be denied effective January 1, 2009. Beginning January 1, 2009, bill using the new CPT dialysis codes, 90951 through 90970.
G0416 through G0419	These codes are only to be billed by the pathologist for specimens obtained with CPT code 55706.
J7340 and J7342	HCPCS skin substitute codes J7340 and J7642 have been end-dated and will be denied effective January 1, 2009. Beginning January 1, 2009, bill using the new HCPCS codes, Q4101 and Q4106.
22864	Prior approval is required. Medical necessity is based on complications directly related to the artificial disc.
95992	This code is only for use by physical therapists in an Independent Practitioner (IP) and Local Education Agency (LEA). Refer to the article on page 13 for billing instructions. This code is considered bundled into the evaluation and management code for physician offices.
96150, 96151, 99406, 99407, 99408, 99409, and 99420	<p>In addition to physicians, nurse practitioners, and health departments, these codes can be billed "incident to" the physician by the following professional specialties: licensed psychologists, licensed psychological associates, licensed clinical social workers, licensed professional counselors, licensed marriage and family counselors, certified nurse practitioners, certified clinical nurse specialists, licensed clinical addictions specialists or certified clinical supervisors. Practitioners must continue to follow the guidelines for services provided "incident to" the physician. Refer to the article titled <i>Modification in Supervision When Practicing "Incident To" a Physician</i> in the October 2008 general Medicaid bulletin (<a href="http://www.ncdhhs.gov/dma/bulletin/1008bulletin.htm">http://www.ncdhhs.gov/dma/bulletin/1008bulletin.htm</a>) for additional information.</p> <p>CPT code 99420 is limited to 2 units per day. It cannot be used to bill for smoking and tobacco use cessation counseling visit or alcohol and/or substance abuse structured screening and brief intervention since there are other codes that exist that can be billed instead. The E/M code should incorporate the services that are provided as defined in 96150 and 96151.</p>
99460 through 99480	<p>In the CPT 2009 publication, the AMA has revised the codes used for billing services provided to the normal newborn and services for critically ill children (up to age 5). These codes are being covered by N.C. Medicaid with some limitations. Providers are <b>strongly</b> encouraged to read the introductory materials at the beginning of the <i>Newborn Care Services</i>, <i>Pediatric Critical Care Patient Transport</i>, <i>Inpatient Neonatal and Pediatric Critical Care</i>, and <i>Initial and Continuing Intensive Care Services</i> sections.</p> <p>For the normal newborn, N.C. Medicaid will pay one initial day care code per recipient per admission. This code is paid to the provider who actually admits the normal newborn to the hospital or birthing center. Since the AMA instructs, in its CPT publication, that the CPT code should be selected that accurately identifies the service performed, the new normal newborn codes should be used for the initial day care. Other hospital initial day codes are not appropriate and should not be billed.</p> <p>Due to the change of some CPT codes, Clinical Coverage Policy 1A-7, <i>Neonatal and Pediatric Critical and Intensive Care Services</i> (<a href="http://www.ncddhs.gov/dms/mp/mpindex.htm">http://www.ncddhs.gov/dms/mp/mpindex.htm</a>), will be revised. The information listed here may be revised and additional guidance may be provided when the policy is updated. Providers will be notified through the general Medicaid bulletin once the updated policy is available.</p>
93228/93229	The correct diagnosis must be listed on the claim. See the diagnosis list on the table below.

**Diagnoses Required When Billing 93228 or 93229:**

<b>ICD-9-CM Code</b>	<b>Description</b>
250.60 through 250.63	Diabetes with neurological manifestations
306.2	Cardiovascular physiological malfunction arising from mental factors
337.1	Peripheral autonomic neuropathy in disorders classified elsewhere
410.00 through 410.92	Acute myocardial infarction
411.0 through 411.89	Other acute and subacute forms of ischemic heart disease
412	Old myocardial infarction
413.0 through 413.9	Angina pectoris
414.8	Other specified forms of chronic ischemic heart disease
414.9	Chronic ischemic heart disease, unspecified
425.1	Hypertrophic obstructive cardiomyopathy
425.4	Other primary cardiomyopathies
426.0 through 426.9	Conduction disorders
427.0 through 427.9	Cardiac dysrhythmias
435.0 through 435.9	Transient cerebral ischemia
780.2	Syncope and collapse
780.4	Dizziness and giddiness
785.0	Tachycardia, unspecified

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

**Clinical Policy and Programs**  
**DMA, 910-355-1883**

**Attention: All Providers****Registration for the PASARR Segment of the Medicaid Uniform Screening Tool**

The Pre-admission Screening and Annual Resident Review (PASARR) requires all individuals admitted to a nursing facility be screened before, or at the time of, admission and annually thereafter, according to federal regulations. The PASARR segment of the Medicaid Uniform Screening Tool (MUST) was implemented on November 3, 2008.

Every provider who performs PASARR screenings or admits PASARR patients is strongly encouraged to register as a provider in the MUST application. Access to the PASARR component of the MUST requires each application administrator and user to create a user account with North Carolina Identity Management (NCID) and then use that account to register their organization and/or themselves within the PASARR component. Instructions for creating an NCID account and registering an organization are available on the MUST website at <http://www.ncmust.com>. Providers should acclimate themselves to the registration process by reviewing the “Getting Started” page (<http://www.ncmust.com/mustapp/gettingstarted.jsp>) on the MUST website.

Nursing facilities currently registered in the application must admit their patients into their facility using the application. Please refer to “Chapter 10: Applicant Tracking” in the user documentation for instructions on admitting new applicants

If your organization has been registered in the application but you have not submitted any screenings, please submit any new PASARR screenings through the MUST application to obtain a quicker assignment of a PASARR number (not applicable in all situations).

For providers who were unable to attend one of the training sessions, or are in need of additional training, a one-on-one training is available to assist you in establishing your organization and navigating through the MUST application to submit a screening. To sign up for a one-on-one training session, please visit the MUST website at <http://www.ncmust.com> and click on “Sign up for one-on-one training.”

Help and support are available from the MUST website. The PASARR/Uniform Screening Helpdesk is available Monday through Friday from 8:00 a.m. to 5:00 p.m. by dialing 800-688-6696, option 7.

As we continue to make refinements to the MUST PASARR application, your feedback is valuable. You may be asked to complete a short survey. Please take a few moments to complete the survey so that we know what areas need improvement.

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

**Attention: All Providers****Rotavirus Vaccine, Human, Attenuated, 2-dose Schedule, Live, for Oral Use (Rotarix, CPT Procedure 90681) – Billing Guidelines**

Effective with date of service December 1, 2008, the N.C. Medicaid program recognized the oral rotavirus vaccine, Rotarix, as a covered vaccine in the Universal Childhood Vaccine Distribution (UCVDP)/Vaccines for Children (VFC) program. This program provides all vaccines required by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).

Rotarix is a monovalent rotavirus vaccine, licensed for a two-dose series for children 2 months through 7 months of age. Rotarix, billed with CPT procedure code 90681, is an alternative to the currently available oral rotavirus vaccine, RotaTeq, the pentavalent rotavirus vaccine licensed for a three-dose series, billed with CPT procedure code 90680.

For the ACIP provisional recommendations for the use of rotavirus vaccines, please see <http://www.cdc.gov/vaccines/recs/provisional/downloads/roto-7-1-08-508.pdf>.

Medicaid does not reimburse for the actual vaccine because state-supplied vaccine is available to all providers enrolled in the UCVDP/VFC program. Medicaid will reimburse for a vaccine administration fee, if applicable. When state-supplied Rotarix vaccine is administered, the ICD-9-CM diagnosis code V04.89 (need for prophylactic vaccination and inoculation against certain viral diseases, other viral diseases) should be indicated on the claim when appropriate. Refer to the April 2008 Special Bulletin, *Health Check Billing Guide 2008* (<http://www.ncdhhs.gov/dma/healthcheck.htm>), for detailed billing guidelines.

**For Medicaid Billing**

- Report Rotarix vaccine with CPT procedure code 90681.
- The ICD-9-CM diagnosis code for billing Rotarix is V04.89.
- Refer to the April 2008 Special Bulletin, *Health Check Billing Guide 2008* (<http://www.ncdhhs.gov/dma/healthcheck.htm>), for detailed billing guidelines for this oral vaccine.
- Providers who have had a claim detail denial related to the payment for the administration of Rotarix for dates of service on or after December 1, 2008, may file a replacement claim.

**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, 2009, the following dental procedure code has been added for the N.C. Medicaid Dental Program. This addition was a result of the Current Dental Terminology (CDT) 2009-2010 American Dental Association (ADA) code updates. Clinical Coverage Policy 4A, Dental Services has been updated to reflect these changes.

<b>CDT 2009-2010 Code</b>	<b>Description and Limitations</b>
D3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development * limited to recipients under age 21 * not allowed for the same tooth on the same date of service as D3220, D3230, D3240, D3310, D3320, or D3330 * not to be construed as the first stage of root canal therapy

The Medicaid reimbursement for this procedure code will be added to the complete Dental Fee Schedule on the DMA website located at <http://www.ncdhhs.gov/dma/fee/fee.htm> during the month of January 2009. 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 DMA's website at <http://www.ncdhhs.gov/dma/mp/mpindex.htm>.

**Deferment of Inflationary Rate Increases**

Annual rate adjustment for payment of Dental Services due per State Plan (4.19B Section 10) on January 1, 2009, will be 0.00%. Effective October 1, 2008, DMA deferred implementation of inflationary adjustments allowed by SL 2008-107 (HB 2436). This deferment applies to all providers except those exempted in the Conference Report, Section G, item 65. This deferral affects those providers having rate adjustments with an effective date of October 1, 2008, and after. The deferred adjustment is projected through June 1, 2009, at which time state funding availability will be re-evaluated.

**Dental Program**  
**DMA, 919-855-4280**

**Attention: Independent Practitioners and Local Education Agencies****C**ode Addition

Effective with date of service January 1, 2009, the following new CPT procedure code has been added to the list of appropriate codes that Independent Practitioner and Local Education Agency physical therapists may now bill. **This code may not be billed for the same recipient on the same day by the same provider as any other physical therapy code. It is the only physical therapy service allowed by that provider for the day.**

New CPT Code	Description
95992	Standard Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day

Clinical Coverage Policies 10B, *Independent Practitioners*, and 10C, *Local Education Agencies*, have been updated to reflect this code addition and are available on DMA's website at <http://www.ncdhhs.gov/dma/mp/mpindex.htm>.

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

**Attention: N.C. Health Choice Providers****C**hanges to N.C. Health Choice Claims Processing System and N.C. Health Choice Benefit Cards

The N.C. Health Choice (NCHC) claims processor, Blue Cross Blue Shield of North Carolina, is moving to a new PowerMhs claims system in January 2009. Starting January 17, 2009, NCHC providers will receive checks from the PowerMhs system for dates of service January 1, 2009, and forward. Claim payments for dates prior to January 1, 2009, will continue to be paid using the current processing system.

Also, members are receiving new benefit cards with January 1, 2009, effective dates. Depending on when a member's eligibility is renewed, the member may receive two new NCHC benefit cards during the last few weeks of December 2008. Providers will need to continue to verify eligibility before providing services and be sure to request the member's correct benefit card. These cards have different identification numbers. Use the NCHC benefit card with the 2008 start date through December 31, 2008, for dates of service through December 31, 2008. For dates of service January 1, 2009, and forward, request the NCHC benefit card with the January 1, 2009, start date.

**Cinnamon Narron, NCHC Coordinator**  
**NCHC, 919-284-0373**

**Attention: Nurse Practitioners and Physicians****Bendamustine (Treanda, HCPCS Procedure Code J9999) – Additional Diagnosis Codes**

The N.C. Medicaid Program covers bendamustine (Treanda) for the treatment of patients with chronic lymphocytic leukemia. Effective with date of service November 1, 2008, DMA is changing the coverage of Treanda to include the treatment of indolent B-cell non-Hodgkin's lymphoma, to align with the new Food and Drug Administration (FDA) approval.

**For Medicaid Billing:**

The ICD-9-CM diagnosis codes required for billing Treanda are

- V58.11 (encounter for antineoplastic chemotherapy)  
AND one of the following:
- 204.10 (lymphoid leukemia, chronic, without mention of remission)  
OR
- 204.11 (lymphoid leukemia, chronic, in remission)  
OR
- 202.8 (Other lymphomas)

Providers who received a claim detail denial related to the diagnosis of non-Hodgkin's lymphoma for dates of service November 1, 2008, and after, may resubmit the denied charges as a new claim (not as an adjustment request) for processing.

Providers must bill National Drug Codes (NDCs); a paper invoice is not required.

Refer to the October 2008 Special Bulletin, *National Drug Code Implementation Phase III* (<http://www.ncdhhs.gov/dma/bulletinspecial.htm>), for instructions.

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



**Attention: Nurse Practitioners and Physicians****Oxaliplatin (Eloxatin, HCPCS Procedure Code J9263) – Additional Diagnosis Codes**

The N.C. Medicaid Program covers oxaliplatin (Eloxatin) for the treatment of patients with metastatic carcinoma of the colon or rectum whose disease has recurred or progressed during, or within six months of, completion of first-line therapy with the combination regimen of 5-fluorouracil, leucovorin, and irinotecan. DMA also covers Eloxatin for carcinoma of the pancreas.

Effective with date of service September 1, 2008, DMA is changing the coverage of Eloxatin to include malignant neoplasm of the esophagus and gastric carcinoma.

**For Medicaid Billing**

The ICD-9-CM diagnosis codes required for billing Eloxatin are

- V58.11 (encounter for antineoplastic chemotherapy)  
**AND** one of the following
- 153.0 through 153.9 (malignant neoplasm of colon)  
**OR**
- 154.0 through 154.8 (malignant neoplasm of rectum, rectosigmoid junction, and anus)  
**OR**
- 157.0 through 157.9 (malignant neoplasm of pancreas)  
**OR**
- 150.0 through 150.9 (malignant neoplasm of the esophagus)  
**OR**
- 151.0 through 151.9 (malignant neoplasm of the stomach)

Providers who received a claim detail denial related to the diagnosis of malignant neoplasm of the stomach or esophagus for dates of service September 1, 2008, and after, may resubmit the denied charges as a new claim (not as an adjustment request) for processing.

Providers must bill National Drug Codes (NDCs). Refer to the October 2008 Special Bulletin, *National Drug Code Implementation Phase III* (<http://www.ncdhhs.gov/dma/bulletinspecial.htm>), for instructions.

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

**Attention: Orthotics and Prosthetics Providers****Annual Rate Adjustment Effective January 1, 2009**

The orthotics and prosthetics annual rate adjustment that would normally be effective January 1, 2009, (according to 4.19B, Section 12 of the State Plan) has been deferred. Therefore, no rate adjustment will be implemented on January 1, 2009. However, there will be an updated fee schedule (<http://www.ncdhhs.gov/dma/fee/fee.htm>) that includes new services effective January 1, 2009, and removes service codes that are no longer effective.

For more information, refer to the memo on Deferral of Rate Increases on DMA's website at <http://www.ncdhhs.gov/dma/fee/fee.htm>.

**Financial Operations****DMA, 919-855-4240****Attention: Durable Medical Equipment Providers****Coverage for Canes, Crutches, Walkers, and Gait Trainers**

Effective with date of service January 1, 2009, newly established coverage criteria for canes, crutches, walkers, and gait trainers were implemented. This policy revision includes the addition of seven new codes for crutches and walkers and three new codes for coverage of gait trainers and pediatric walkers. For recipients ages 0 through 20, lifetime expectancies have been reduced for 12 of the codes currently covered by Medicaid. Prior approval guidelines for pediatric gait trainers and walkers have been added.

Refer to Section 5.3.21 of Clinical Coverage Policy 5A, *Durable Medical Equipment*, on DMA's website at <http://www.ncdhhs.gov/dma/mp/mpindex.htm> for more coverage details.

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

**Attention: Nursing Facilities**

**Ventilator Rate Hour Change**

CMS has approved a State Plan Amendment related to the Nursing Facility Policy that approves the ventilator rate be granted to providers for any patient in a vent bed, who is receiving 10 hours per day of ventilator care or more. This changes the policy which in the past granted the ventilator rate to be paid to a provider that had a patient on a ventilator for at least 16 hours per day or more. All other criteria such as rates, ventilator types and ventilator settings and patient condition requirements remain the same. The ventilator request form currently sent to the physician will need to be sent for any patient who meets the new criteria.

Providers will submit claims for these patients using their ventilator provider number as they do for the patients that currently meet the criteria. This policy is effective as of January 1, 2009.

**Margaret Comin, Facility and Community Care  
DMA, 919-855-4355**

**Attention: Nursing Facilities**

**Nursing Facility Provider Assessment Fee Increase**

Effective January 1, 2009, DMA increased the skilled nursing facility provider assessment by one dollar (\$1.00) over the assessment amount currently in effect. This assessment increase shall be consistent with federal law and regulations for provider assessments. Therefore, providers whose assessment is currently \$4.00 will be increased to \$5.00 and providers whose assessment is currently \$10.50 will be increased to \$11.50. Rates effective for January 1, 2009, will reflect this assessment fee increase.

**Rate Setting  
DMA, 919-855-4200**

**Attention: Personal Care Service Providers, CAP/DA Service Providers, and CAP/C Service Providers****Approval and Criteria for the Use of Telephony for In-home Personal Care Services Provided under the Medicaid PCS, PCS-Plus, CAP/DA, and CAP/C Programs**

Effective January 1, 2009, the use of telephony systems to document the provision of in-home personal care services under the CAP/DA and CAP/C Programs is approved. The use of telephony for in-home PCS and PCS-Plus was previously approved in December 2007 by the Division of Facility Services (now Division of Health Service Regulation), and that approval is reaffirmed through this bulletin article.

**Provider Requirements**

Provider agencies furnishing in-home personal care services under the Medicaid PCS, PCS-Plus, CAP/DA, and CAP/C programs must

- advise the Medicaid recipient (recipient) that a telephony system will be used to document the time the PCS aide spends in the recipient's home and the approved personal care services provided;
- explain to the recipient how the system works;
- inform the recipient that calls made will not be charged to his or her telephone, and there will be no cost to the recipient for use of this system;
- ensure that the recipient agrees to participate in the telephony system prior to implementation;
- ensure that the recipient understands that he or she must be present in the home and receiving approved in-home PCS in accordance with his or her plan of care between the arrival and departure times documented by the telephony system; and
- provide evidence that these requirements have been met by having the recipient sign and date a letter or form acknowledging that he or she 1) understands the telephony system and its purpose, 2) understands how it works, and 3) agrees to the use of this system to document that authorized services were provided between the time-in and time-out calls.

Providers furnishing in-home PCS aide services under the above-referenced programs are required to orient all PCS aides to program requirements for service documentation under the telephony system and the implications of submitting inaccurate or falsified records. Upon request from DMA, provider agencies must provide evidence that such an orientation has been completed for each aide.

The provider agencies referenced above shall, whenever possible, utilize the recipient's landline to record the exact arrival and departure time of the PCS aide. The system must be capable of verifying that this is the recipient's telephone number. If the recipient does not have a telephone landline, the PCS provider may use an authorized personal or agency cell phone; however, when a cell phone is used the recipient must verbally verify over the same cell phone that approved personal care services were received between the reported arrival and departure times.

These requirements must be addressed in the provider agency's written policies and procedures and available for review upon request by DMA.

**Minimum Telephony System Requirements**

DMA will not approve or endorse specific types or brands of telephony systems. The telephony system employed must provide, at a minimum, the following functionality:

- identifies calls made from unauthorized numbers
- identifies each aide through a unique and secure identification number
- records essential recipient identification data, services provided, and medical monitoring tasks
- records date of service, day of week, time in, and time out
- automatically alerts the agency when an aide fails to clock in for a scheduled visit
- tracks aide actions and compliance with recipient's plan of care
- records deviations from approved schedule and plan of care
- maintains service schedules that can be cross-referenced by aide and recipient
- employs appropriate security to prevent unauthorized manipulation of recorded data
- stores the data in an easily retrievable format
- prints hard copies of reports
- meets HIPAA standards for privacy and electronic security

The recipient is not required to sign a service log or otherwise verify that he or she received services during the scheduled visit when a telephony system is used. If the telephony system meets the requirements of an aide signature on the service log, a printed hard copy with the aide signature on the log is not necessary.

Provider agencies employing telephony systems must take adequate precautions to prevent loss of data, such as off-site storage of backup disks or tapes, or, if necessary, backup hard copies of critical service and billing records to include service logs.

The provider agencies employing telephony must continue to comply with all applicable federal and state statutes, rules, regulations, policies, standards, and guidelines for recordkeeping under the Medicaid PCS, PCS-Plus, CAP/DA, and CAP/C programs. CAP/DA and CAP/C case managers, at their discretion, can request and review telephony records prior to submitting them for Medicaid payment.

The provider agency must maintain a hard-copy recordkeeping system for those recipients who do not agree to participate in the telephony system, or when other circumstances prevent its use.

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

**Attention: Residential Child Care Treatment Facility Providers****C**  
**Change in Re-enrollment Requirements for Residential Child Care Treatment Facility Providers**

Providers of residential child services are no longer required to submit the Residential Child Care Re-enrollment Addendum to DMA annually. Previously, providers were required to submit the Addendum along with their renewed license each year. Effective immediately, DMA will be notified by Division of Health Service Regulation (DHSR) regarding license expiration and notified by the Local Management Entity (LMEs) regarding endorsement withdrawal. Residential child care providers will still be required to submit a copy of their renewed license to DMA annually. The license, with a cover letter addressed to DMA Provider Services RCC Enrollment Specialist, must be mailed to:

DMA Provider Services  
RCC Enrollment Specialist  
2501 Mail Service Center  
Raleigh, NC 27699-2501

**Provider Services**  
**DMA, 919-855-4050**

**Attention: Enhanced Behavioral Health Services Providers****R**  
**Rate Change**

Medicaid providers enrolled to offer the services of **Child and Adolescent Day Treatment**, please note the following rate change:

<b>Service Code</b>	<b>Old Rate</b>	<b>New Rate</b>
H2012 HA	\$31.25/hour	\$34.75/hour

These rates are effective as of January 1, 2009.

Please refer to DMA's website at <http://www.ncdhhs.gov/dma/fee/mhfee.htm> for additional updates, which will be posted as changes are made.

**Rate Setting**  
**DMA, 919-855-4200**

## **Early and Periodic Screening, Diagnostic and Treatment and Applicability to Medicaid Services and Providers**

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

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

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

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

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

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

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

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

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

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

- *Basic Medicaid Billing Guide* (especially sections 2 and 6): <http://www.ncdhhs.gov/dma/medbillcaguide.htm>.
- *Health Check Billing Guide*: <http://www.ncdhhs.gov/dma/healthcheck.htm>.
- EPSDT provider information: <http://www.ncdhhs.gov/dma/EPSDTprovider.htm>.

## Proposed Clinical Coverage Policies

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

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.

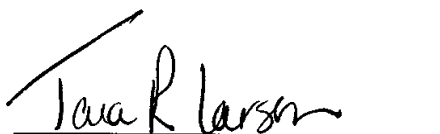
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## 2009 Checkwrite Schedule

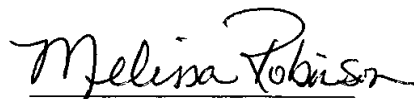
Month	Electronic Cut-Off Date	Checkwrite Date
January	01/08/09	01/13/09
	01/15/09	01/21/09
	01/22/09	01/29/09
	01/29/09	02/03/09

***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.***

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Tara Larson  
 Acting Director  
 Division of Medical Assistance  
 Department of Health and Human Services



Melissa Robinson  
 Executive Director  
 EDS, an HP Company

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