Number 2 *February 2006*

North Carolina Medicaid Bulletin

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

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

Attention: All Providers

Basic Medicaid Billing Seminar Schedule

Basic Medicaid Billing seminars are scheduled for March 2006. Seminars are intended for providers who are new to the NC Medicaid program. Topics to be discussed will include, but are not limited to, provider enrollment requirements, billing instructions, eligibility issues, and Managed Care. Persons inexperienced in billing N.C. Medicaid are encouraged to attend. *There will be a detailed question and answer session for Enhanced Mental Health Benefits providers at the end of these seminars.*

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 Basic Medicaid Billing seminars by completing and submitting the registration form available on the next page or by registering online at http://www.dhhs.state.nc.us/dma/prov.htm. Please indicate the session you plan to attend on the registration form. Seminars begin at 10:00 a.m. and end at 2:00 p.m. Providers are encouraged to arrive by 9:45 a.m. to complete registration.

Providers must print the PDF version of the *Basic Medicaid Billing Guide* from DMA's website at http://www.dhhs.state.nc.us/dma/medbillcaguide.htm and bring it to the seminar.

Tuesday, March 7, 2006 Blue Ridge Community College Bo Thomas Auditorium College Drive Flat Rock, North Carolina	**Tuesday, March 14, 2006** Coast Line Convention Center 501 Nutt Street Wilmington, North Carolina
Wednesday, March 22, 2006 Hilton Greenville 207 SW Greenville Blvd. Greenville, North Carolina	**Monday, March 27, 2006** Jane S. McKimmon Center 1101 Gorman Street Raleigh, North Carolina

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

Directions to the Basic Medicaid Seminars

Coast Line Convention Center – Wilmington, North Carolina (Tuesday, March 14, 2006)
Take I-40 east to Wilmington. Take the US 17 exit. Turn left onto Market Street. Travel approximately 4 or 5 miles to Water Street. Turn right onto Water Street. The Coast Line Inn is located one block from the Hilton on Nutt Street behind the Railroad Museum**.**

Jane S. McKimmon Center – Raleigh, North Carolina (Monday, March 27, 2006)
Traveling East on I-40
Take exit 295 and turn left onto Gorman Street. Travel approximately one mile. 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 one mile. The McKimmon Center is located on the right at the corner of Gorman Street and Western Boulevard.

Hilton Hotel – Greenville, North Carolina (Wednesday, March 22, 2006)
Take Highway 264 east to Greenville. Turn right onto Allen Road in Greenville. Travel approximately 2 miles. Allen Road becomes Greenville Boulevard/Alternate 264. Follow Greenville Boulevard for 21/2 miles to the Hilton Greenville, which is located on the right.

Blue Ridge Community College, Bo Thomas Auditorium – Flat Rock, North Carolina (Tuesday, March 7, 2006)
Take I-40 to Asheville. Travel east on I-26 to exit 53, Upward Rd. Turn right and end of ramp. At second light, turn right onto S. Allen Drive. Turn left at sign onto College Drive. First building on right is the Sink Building. Bo Thomas Auditorium is on the left side of the Sink Building.

(cut and return the registration form only)

Basic Medicaid Seminars
Seminar Registration
(No Fee)

Provider Name _____ Provider Number _____
Address _____
City, Zip Code _____ County_____
Contact Person _____ E-mail Address _____
Telephone Number (___)_____ Fax Number (__)_____

1 or **2** (circle one) person(s) will attend the seminar at _____on_____
(location) (date)

Return to: Provider Services
EDS
P.O. Box 300009
Raleigh, NC 27622

Attention: All Providers

Clinical Coverage Policies

The following new or amended clinical coverage policies are now available on the Division of Medical Assistance's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm:

5A – Durable Medical Equipment
9 – Outpatient Pharmacy Program
11B-1 – Lung Transplantation

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

Correction to the 2006 CPT Code Update

The list of new covered CPT codes that was published in the January 2006 general Medicaid bulletin contained an error. CPT codes **33598, 92230,** and **92235** were inadvertently added to the table. The correct codes are **36598** (new code), **92330** and **92335** (end-dated codes).

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

Attention: All Providers

Informed Decisions Beneficiary Centered Enrollment Service

The implementation of the Informed Decisions Beneficiary Centered Enrollment (BCE) project that was announced in the December 2005 General Medicaid bulletin will be delayed. More information will be published in future bulletin articles.

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

Attention: All Providers

Family Planning Waiver Services

Effective October 1, 2005, the Division of Medical Assistance (DMA) implemented a 5-year demonstration waiver project for Medicaid family planning services. Eligible recipients are identified by a blue Medicaid identification card with the program class 'MAFD' and the following statement "**FAMILY PLANNING WAIVER: RECIPIENT ELIGIBLE FOR LIMITED FAMILY PLANNING SERVICES ONLY".** Recipients eligible to receive waiver services are not eligible for Medicaid benefits under any other current program.

The Automated Voice Response (AVR) system has been updated to identify recipients with the program class 'MAFD' as Medicaid Family Planning Waiver beneficiaries. As a result, the AVR system will not provide dental history, an optical confirmation number, or durable medical equipment (DME) prior approval information for recipients covered by the waiver. Instead, the AVR system will state: **"This recipient is eligible for limited Family Planning Services only. Dental, DME, and optical services are not covered by the Family Planning Waiver Program."**

For more information, refer to the January 2006 Special Bulletin, Family Planning Waiver "Be Smart" on DMA's web site at http://www.dhhs.state.nc.us/dma/bulletin.htm.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

Medicare Part D Conference Calls for Providers

The Centers for Medicare and Medicaid Services (CMS) host a weekly conference call for providers. The calls are scheduled for every Tuesday from 2:00 p.m. to 3:00 p.m. beginning January 3, 2006. These 60-minute conference calls enable discussions of issues and resolutions involving the Medicare Part D program. Providers are encouraged to use this time to ask questions and to describe problems so that CMS can continue to improve the Medicare Part D program.

To participate in this weekly conference call, dial the conference phone number **1-800-619-2457** and reference the password "**Part D**".

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

Attention: All Providers

North Carolina Behavioral Management Project

The North Carolina Department of Health and Human Services has launched an innovative educational program that strives to improve the quality of care for Medicaid patients with mental illness.

The North Carolina Behavioral Pharmacy Management Project analyzes the prescribing of mental health medications for Medicaid members and identifies prescribing patterns inconsistent with evidence-based guidelines. When needed, physicians will be provided with educational materials and client survey information as well as peer-to-peer consultation.

The project is a collaborative effort that involves the Division of Medical Assistance and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and Comprehensive NeuroScience, Inc (CNS). Eli Lilly and Company is providing funding in support of the independent program. The North Carolina Physician's Advisory Group serves as an advisor to the project.

The process begins with a review by CNS of Medicaid patient pharmacy claims data to identify prescribing and utilization trends for mental health and psychotropic medications. The researchers look at such categories as multiple medication prescribing in the same therapeutic class, prescribing above or below FDA-recommended dosing levels, failure of patients to fill their prescriptions in a timely fashion and patients with two or more physicians prescribing the same medications during the identical time period. Prescriptions that fall within these categories are then compared with best practices guidelines.

Information as to which pharmacy a prescriber's patient is having their prescriptions filled will be noted on the prescriber's Patient Detail Report. The pharmacy's phone number will also be listed. A pharmacy may therefore be contacted by a physician in regards to this project.

The State expects the CNS review of prescribing practices to identify a small group of doctors who regularly fall outside of guidelines. These physicians will receive educational materials promoting adherence to the best practices guidelines. In addition, CNS will continue to monitor physicians for the duration of the program to determine whether prescribing problems improve.

The prescription monitoring program is working in several other states, including Missouri, where an analysis from the program's first year shows a 98 percent reduction of patients who are prescribed the same mental health medications from multiple doctors; a 64 percent reduction of patients who are on two or more mental health medications of the same type; a 43 percent reduction of children on three or more psychotropic medications; and a 40 percent reduction of patients receiving an unusually high dosage of medication.

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

Attention: Ambulatory Surgical Centers

Covered Codes for Ambulatory Surgical Centers

Effective with date of service January 1, 2006, the following CPT procedure codes were added to the list of covered codes for an ambulatory surgical center. These codes are covered in addition to the updated list of CPT codes published in the January 2006 general Medicaid bulletin.

CPT Code	Payment Group
15001	1
15836	3
15839	3
19296	9
19298	1
21120	7
21125	7
28108	2
29873	3
30220	3
31545	4
31546	4
31603	1
31636	2
31637	1
31638	2
33212	3
33213	3
33233	2
36475	3
36476	3
36478	3
36479	3
36834	3
37500	3
42415	7
43237	2

CPT Code	Payment Group
43238	2
44397	1
45327	1
45341	1
45342	1
45345	1
45387	1
45391	2
45392	2
46230	1
46706	1
46947	3
52301	3
57155	2
57288	5
58346	2
58565	4
62264	1
64517	2
64561	3
64581	3
64681	2
65820	1
66711	2
67445	5
67570	4
67912	3

Effective December 31, 2005, the following codes were deleted from the list of covered codes for an ambulatory surgery center. Claims submitted with these deleted codes for dates of service January 1, 2006 and after will deny.

21440	23600	23620	69725

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

Attention: CAP-MR/DD Providers, Local Management Entities, Targeted Case Managers for MR/DD

Billing Update and Clarification for CAP-MR/DD Services

With the implementation of the new CAP-MR/DD 1915 (c) waiver on September 1, 2005, questions have arisen about billing, service orders, and Medicaid payments.

This article addresses those questions.

1. CAP-MR/DD consumers residing in a licensed community residential setting, foster home, alternative family living home or unlicensed alternative family living home that serves one adult **may receive the Community Component of Home and Community Supports**.

The community component of Home and Community Supports does not replace the Residential Support provider's responsibility to provide support to individuals in their home and community, **but is intended to support those who choose to engage in community activities that are not provided through a licensed day program.**

Providers billing for H2015 and H2015HQ in conjunction with Residential Supports will not be reimbursed on the same day of service that a consumer receives Day Supports, code T2021.

Case Managers and local approvers are responsible for incorporating the correct use of these services into the Plan of Care for their consumers receiving Residential Supports.

2. Providers of Residential Supports: H2016, T2014, T2020, and H2016HI, (which are daily rates), can bill and be reimbursed for the Community Component of Home and Community Supports, H2015 and H2015HQ. All claim restrictions have been modified for the new waiver retroactively to September 1, 2005. Payment is allowed for either the same provider or two different providers of these services billing on the same day of service.

Note: For consumers residing in a Residential setting, the use of the Community Supports service is limited to a maximum of 6 hours (24 units) a day.

All providers who have unpaid claims due to the system not paying Residential Supports on the same day of service as Home and Community Supports may resubmit claims for payment. These codes are as follows:

Residential Supports Level I	**H2016**	**$102.33/day**
Residential Supports Level 2	**T2014**	**$125.45/day**
Residential Supports Level 3	**T2020**	**$145.17/day**
Residential Supports Level 4	**H2016HI**	**$175.35/day**
Home and Community Supports – Individual	**H2015**	**$5.65/15 minute**
Home and Community Supports – Group	**H2015HQ**	**$3.15/15 minute**

3. Providers of Day Support in an unlicensed facility are authorized to bill for their services using codes H2015 and H2015HQ until August 31, 2006 when they are required to be fully licensed. Settings that have not received their license as of August 31, 2006 will no longer be reimbursed for these services.

4. The 24 units (6 hours) of Community Services under the codes H2015 and H2015HQ will decrease to 16 units (4 hours) effective DOS (Day of Service) September 1, 2006.

Questions may be addressed to the Behavioral Health Section of Clinical Policy Division, Division of Medical Assistance.

Behavioral Health Section
DMA, 919-855-4290

Attention: Durable Medical Equipment Providers

Fee Schedule Changes for Interim Rates and Other Rate Changes

Effective February 1, 2006, rates have been changed for some Durable Medical Equipment (DME) codes previously added with interim rates. Medicare pricing has now become available for the HCPCS codes below:

A4233	Replacement battery, alkaline (other than j cell), for use with medically necessary home glucose monitor woned by patient, each
A4234	Replacement battery, alkaline, j cell, for use with medially necessary home glucose monitor owned by patient, each
A4235	Replacement battery, lithium, for use with medically necessary home glucose monitor owned by patient, each
A4236	Replacement battery, silver oxide, for use with medically necessary home glucose monitor woned by patient
E0911	Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, attached to bed, with grab bar
E0912	Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, free standing, complete with grab bar
E2222	Manual wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, each
E2223	Manual wheelchair accessory, valve, any type, replacement only, each
E2225	Manual wheelchair accessory, caster wheel excludes tire, any size, replacement only, each
E2226	Manual wheelchair accessory, caster fork, any size, replacement only, each

E2371	Power wheelchair accessory, group 27 sealed lead acid battery, (e.g.gel cell, absorbed glassmat), each
K0601	Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt
K0602	Replacement battery for external infusion pump owned by patient, silver oxide, 3 volt
K0603	Replacement battery for external infusion pump owned by patient, alkaline, 1.5 volt
K0604	Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt
K0605	Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt

In addition, fees for the following HCPCS codes were changed to the Medicare reimbursement rate:

A4614	Peak expiratory flow rate meter , hand-held
A7006	Administration set, with small volume filtered pneumatic nebulizer
E0277	Powered pressure-reducing air mattress
E0424	Stationary compressed gaseous oxygen system, rental; includes contents (per unit), regulator, flowmeter, humidifier, nebulizer, cannula or mask and tubing. 1 unit = 50 cu. ft.
E0431	Portable gaseous oxygen system, rental; includes regulator, flowmeter, humidifier, cannula or mask and tubing
E0434	Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adapter, contents gauge, cannula or mask and tubing
E0439	Stationary liquid oxygen system, rental; includes use of reservoir, contents (per unit), regulator, flowmeter, humidifier, nebulizer, cannula or mask and tubing. 1 unit = 10lbs
E0561	Humidifier, non-heated, used with positive airway pressure device
E0562	Humidifier, heated, used with positive airway pressure device
E0570	Nebulizer, with compressor
E0691	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, treatment area two square feet or less
E0951	Heel loop/holder, any type, with or without ankle strap, each
E0961	Manual wheelchair accessory, wheel lock brake extension (handle), each
E0967	Manual wheelchair accessory, hand rim with projections, any type, replacement only, each
E0974	Manual wheelchair accessory, anti-rollback device, each
E0981	Wheelchair accessory, seat upholstery, replacement only
E0982	Wheelchair accessory, back upholstery, replacement only
E1390	Oxygen concentrator, capable of delivering 85 percent or greater oxygen concentration at the the prescribed rate
K0552	supplies for external infusion pump, syringe type cartridge, steril

For current pricing on these and all DME codes, refer to DMA's web page at http://www.dhhs.state.nc.us/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. Payment will be the lesser of the billed usual and customary rate or the maximum reimbursement rate.

Rate Setting
DMA, 919-855-4200

Attention: Durable Medical Equipment Providers

Procedural Change for Durable Medical Equipment Denials

Effective January 1, 2006, denied prior approval requests for durable medical equipment may not be resubmitted to EDS for reconsideration. When prior approval requests are denied, documentation regarding the denial and appropriate appeal procedures will be sent to the provider and the recipient. Please see the January 2006 Special Bulletin Prior Approval Process and Request for Non-Covered Services for details. Clinical coverage policy 5A "Durable Medical Equipment" has been updated to reflect this change in procedure. This policy can be found on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm

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

Attention: Home Health Providers, Independent Practitioner Providers, and Physician Providers

Systematic Reprocessing of Specialized Therapy Adjustments

Specialized therapy claims that have been paid or denied incorrectly will be systematically identified and adjusted. System generated adjustments are currently scheduled for the month of February or March, but please continue to check your bulletins and remittance and status report (RA) for detailed information. Providers will initially see the system generated adjustment in a pending status located in the section of the RA titled "Claims in Process". Once the system generated adjustments are completed they will appear in the Adjusted Claims" as well as the "Financial Items" sections of the RA.

Please advised that if you do not have enough revenue to cover any outstanding monies owed to North Carolina Medicaid, the transfer of adjustment balances will apply. Transfer of adjustments or other Medicaid recovery balances will be initiated from an inactive provider (no claims payment) to an active provider (claims payment) when it has been determined that both providers are operating under the same tax entity; thus, the same tax identification number. This will ensure North Carolina Medicaid's timely recovery of monies due to the program. For additional information about transfer of adjustment balances, please refer to *Medicaid Program Implements Penalties and Interest Assessments*, Special Bulletin V, October 1999 at http://www.dhhs.state.nc.us/dma/bulletin/pdfbulletin/1099Special.pdf

If you are currently an inactive provider or do not have recent claim activity, action should be taken to pay off all balances due within 30 days. Providers should refund the monies due to North Carolina Medicaid after receiving the remittance and status report with the outstanding balance.

If effort to eliminate the adjusting of claims already identified for systematic processing, all specialized therapy adjustments and replacement claims submitted by providers will be denied until the system adjustments have been completed. If you have submitted an adjustment request or replacement claim for a specialized therapy service that has been identified for systematic adjustment it will be denied with **EOB 2046** that states: "Adj request denied. Adj/replacement claims for specialized therapy services will be adjusted systematically."

When you receive your RA, please review it for the adjusted specialized therapy claims to determine if your intial adjustment request has been addressed. If so, no further action is required. Once the systematic adjustments have been completed, the denials of manual adjustments will no longer be in effect.

Any questions about the system generated adjustments should be directed to 1-800-688-6696 ext 53120.

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

Attention: Hospitals

Acute Admission versus Behavioral Health Admission

If a hospital submits an acute hospital admission with a behavioral health diagnosis, the claim will deny with EOB 213 (No Prior Approval on File. Contact Value Options at 1-888-510-1150 for confirmation). If the recipient was in a medical bed and it was **truly NOT** a behavioral health admission, hospital providers must submit the claim directly to the Division of Medical Assistance. Providers should submit a copy of the claim with the history and physical along with the discharge summary. Claims and attachments should be mailed to the:

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

In addition, providers may elect to send this information electronically via ProviderLink. For questions or information regarding ProviderLink, please contact 919-465-1855 or visit their website at www.providerlink.com.

A review of the medical records attached will be conducted, if the admission was determined to be a behavioral admission and prior approval should have been obtained from ValueOptions; a non-certification letter with a provider appeal form describing the appeals process will be enclosed and mailed to the facility.

If the admission was determined to be a medical admission, an override of the denial will be sent to EDS for claims payment.

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

Attention: Hospitals

Systematic Recoupments for DRG 521-523

DMA has been coordinating with the N.C. Hospital Association (NCHA) to resolve overpayments involving reimbursement of DRG 521-523 for dates of service and RA dates from October 1, 2001 to April 30, 2002. Overpayments occurred because claims were priced utilizing a DRG rather than correctly pricing with a per diem. Claims processed during this timeframe for DRG 521-523 which were incorrectly priced or denied will be identified and correcting adjustments will be made. Claims will be reprocessed beginning with the March 14, 2006 checkwrite.

Providers will receive a written report identifying claims that were overpaid by Medicaid. The report will note the individual accounts involved and quantify amounts owed to Medicaid. **Providers must respond to EDS by March 1, 2006, and need to include either an electronic or paper copy of the enclosed report as well as a check for amounts owed Medicaid. If a provider disagrees, the provider must submit a letter asserting that no money is owed to Medicaid. The contents of this letter are specified below**. **If providers do not notify Medicaid by the due date, EDS will recoup amounts owed to Medicaid occur on the accounts to reduce the original payment by the overpayment.**

Please note that refund amounts should be quantified by each ICN. When sending a refund, providers do not need to file adjustments. Letters indicating that no money is owed to Medicaid must include the facility name, provider number, contact name, telephone number, and a signed statement indicating that your facility was not overpaid. Providers should also submit documentation or substantiate their facility was not overpaid.

Any questions about the report or reporting requirements should be directed to Brenda Bradfield at 1-800-688-6696 or 919-851-8888.

Reports and letters should be mailed to:
EDS
Attn: James Greene/DRG 521-523 Refunds
PO Box 300011
Raleigh, NC 27622

Requests for exceptions must be sent in writing to:
Division of Medical Assistance
Finance Management
Attn: Tom Galligan
2501 Mail Service Center
Raleigh, NC 27699-2501

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

Attention: Nursing Facilities and Pharmacists

Medicare Part D - Long-Term Care Fax System

In addition to using the web-based Prescription Plan Finder tool at http://www.Medicare.gov for individual resident inquiries, nursing facilities without Internet access or those who need Medicare prescription drug plan enrollment information for multiple residents can now do so via a special fax-based procedure from the Centers for Medicare and Medicaid Services (CMS).

Nursing facilities can provide the required authentication information for each of their Medicare residents by fax to Medicare at **1-785-830-2593**. The information should be indicated on a fax cover sheet (see sample) along with the name and phone number of a voice contact at the nursing facility.

Nursing Facility Actions and Instructions:

1. Information should be for multiple beneficiaries and all the names may be included on a single request form.
2. Nursing facility representatives will supply the required authentication information for each patient they are requesting information on to 1-800-MEDICARE via fax. The required authentication information includes:
   - Beneficiary Name
   - HIC #
   - Date of Birth
   - Address
   - Entitled to Part A or B (yes or no)
3. Use a fax cover sheet to transmit the required information. CMS will fax back your fax cover Sheet with the patient Medicare prescription drug plan enrollment information. A sample fax Cover sheet is provided.
4. The fax cover sheet must contain the following attestation statement signed by a nursing facility representative:

   I attest that the Medicare prescription drug plan enrollment information to be provided by CMS about patients on the attached list will be used by the nursing home only for Medicare prescription drug coverage purposes.
5. The fax cover sheet must also contain the following:
   - a fax number for returning the requested Medicare prescription drug plan enrollment information to the nursing facility
   - the name and phone number of a nursing facility contact in case there are questions.
6. Use the following safeguards when faxing to CMS' secure site:
   - include a disclaimer on the fax cover sheet (see sample fax cover sheet)
   - get the transmission confirmation after the fax is sent

Do NOT put individually identifiable or sensitive information on the fax cover sheet.

Medicare Customer Service Representative Actions:

1. Medicare Customer Service Representatives (CSRs) will process the requests and fax them back to the nursing facility within three business days.
2. Due to privacy concerns, information faxed back to nursing facilities will include only the first initial, last name, and prescription drug plan enrollment information for each beneficiary.

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

Fax Cover Sheet

CMS Medicare Prescription Drug Plan Enrollment Information Request

Date: _____

Facility Fax Number: Area Code ( ) _____

Voice Contact Name: _____

Voice Contact Phone #: _____

Number of pages (including cover sheet): _____

Identification:

Institution Name: _____

Medicare Billing Number: _____

Comments:

Attestation:

I attest that the Medicare Prescription Drug Plan enrollment information to be provided by the Centers for Medicare & Medicaid Services (CMS) will be used by the nursing home only for Medicare prescription drug coverage purposes.

_____

Signature of Nursing Home Representative

The attached information is CONFIDENTIAL and is intended only for the use of the addressee(s) identified above. If the reader of this message is not the intended recipient(s) or the employee or agency responsible for delivering the message to the intended recipient(s), please note that any dissemination, distribution, or copying of the communication is strictly prohibited. Anyone who receives this communication in error should notify us immediately by telephone and return the original message to us at the address above via U.S. Mail. Thank you.

Fax request to Medicare at (785)-830-2593.

Attention: Optical Providers

CPT Code Changes for Dispensing Low Vision Aids

In order to comply with the Centers for Medicare and Medicaid Services (CMS) CPT code changes, CPT code 92392 was end-dated on December 31, 2005 and replaced with V2797 effective with date of service January 1, 2006. Claims submitted with end-dated codes will deny.

Discontinued Procedure Code	Description	New Procedure Code	Description
92392	Supply of low vision aids	V2797	Vision supply, accessory and/or service component of another HCPCS vision code.

The new code, V2797 must be billed with procedure codes V2600, V2610, or V2615 on the same date of service with the same billing provider. Claims that are submitted without the secondary code will deny. Denied claims may be corrected and resubmitted as a new claim.

The rate for the new code remains the same as the rate of the discontinued code.

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

Attention: Pharmacists

Administrative Update for Synagis Claims Processing

The following information clarifies the current administrative process for Synagis claims processing:

The N.C. Medicaid program should not be billed for Synagis claims unless there is an accurate and complete 2005-2006 Synagis criteria form on file in the pharmacy or a Synagis Medical Review Outside of Criteria form for season 2005-2006 that has been reviewed and approved by DMA on file in the pharmacy. Payment of Synagis claims **for dates of service** prior to October 10, 2005 and after March 15, 2006 will not be allowed and will be subject to recoupment by Program Integrity.

Claims for Synagis doses that include multiple vial strengths must be submitted as a single compound drug claim. Synagis doses that require multiple vial strengths that are submitted as individual claims will be subject to recoupment by Program Integrity.

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

Attention: Pharmacists

CMS Process to Ensure Effective Transition to Medicare Part D Prescription Drug Coverage

In spite of best efforts to identify and auto-enroll dually eligible individuals prior to the effective date of their Medicare Part D eligibility, it is possible that some individuals may show up at pharmacies before they have been auto-enrolled. For this reason, the Centers for Medicare and Medicaid Services (CMS) have developed a process for a point-of-sale (POS) solution to ensure full dual eligible individuals experience no coverage gap. When beneficiaries present at a pharmacy with evidence of both Medicaid and Medicare eligibility, but without current enrollment in a Part D plan, they can have the claim for their medication submitted to a single account for payment. The beneficiary can leave the pharmacy with a prescription, and a CMS contractor will immediately follow up to validate eligibility and facilitate enrollment into a Part D plan.

In order for this process to operate effectively, there must be a uniform and straightforward set of instructions that all pharmacists can follow no matter which prescription drug plan (PDP) networks they are in or where they are located in the country. This requires a single account administered by one payer. In addition, a national plan that offers a basic plan for a premium at or below the regional low-income premium subsidy amount in every PDP region will be able to both process the initial prescription (generally at in-network rates) and enroll the beneficiary within a matter of days, thus eliminating any gap in coverage. Therefore, CMS has contracted with Wellpoint, an approved national PDP, to manage a single national account for payment of prescription drug claims for the very limited number of dually eligible beneficiaries who have not yet been auto-enrolled into a Part D plan at the time they present a prescription to a pharmacy.

Details on the four step POS facilitated enrollment process are provided below:

1. Request the beneficiary's Medicare Part D Plan Identification (ID) card.
   Beneficiaries may have a plan enrollment "acknowledgement letter" that should contain the BIN, PCN, GROUP, and Member ID information. If the beneficiary has no proof of enrollment, their plan's billing information may be available through the new E1 query. If none of these sources of information are available and the beneficiary is dually eligible for Medicare and Medicaid, the POS facilitated enrollment process will allow the beneficiary's prescription to be filled.

2. Submit an E1 transaction to the Troop Facilitator. This ensures that the beneficiary has not already been assigned to a PDP. If the E1 transaction returns a valid BIN/PCN indicating the beneficiary has been enrolled with a PDP or Medicare Advantage Prescription Drug Plan (MA-PD), the pharmacist may not submit the claim under the POS facilitated enrollment. (If the E1 returns a help desk phone number, this means that the beneficiary has been enrolled in a PDP but the billing data is still in process.)

3. Identify a "Dually Eligible" beneficiary. The first step is to request the beneficiary's Medicare and Medicaid identification cards. If the beneficiary cannot provide clear evidence of enrollment in both programs, the claim should **not** be processed under the

POS facilitated enrollment process. Please see the options below that are available to verify a beneficiary's dual eligibility.

To verify Medicaid eligibility: Any of the following can be used to verify Medicaid eligibility:

- Medicaid ID card
- Recent history of Medicaid billing in the pharmacy patient profile
- Copy of current Medicaid award letter

In addition to these options to verify Medicaid eligibility, the North Carolina Automated Voice Response System (AVRS) is readily accessible twenty-four hours each day at 1-800-723-4337 except for 1:00 a.m.-5:00 a.m. on the first, second, fourth and fifth Sunday and 1:00 a.m.-7:00 a.m. on the third Sunday. Additional information on the N.C. AVRS is available at http://www.dhhs.state.nc.us/dma/bulletin/AppendixAAug2005.pdf.

To verify Medicare eligibility: Any of the following can be used to verify Medicare eligibility:

- Submit an expanded E1 query to determine A, B or AB eligibility
- Request to see a Medicare card
- Request to see a Medicare Summary Notice (MSN)
- Call the dedicated Medicare pharmacy eligibility line at 1-866-835-7595

4. **Bill the POS Contractor.** There is no need to call WellPoint to confirm enrollment as no enrollment pre-exists the claim submission. There are no edits for non-formulary, prior authorization or step therapy drugs. However, drugs excluded from Medicare or Part D coverage will not be paid for.

   Make sure an E1 query has first been submitted to rule out evidence of enrollment in a Part D plan before billing Wellpoint. Enter the claim into the pharmacy claims system in accordance with the Wellpoint payer sheet. This payer sheet is available at: http://www.anthem.com/jsp/antiphona/apm/nav/ilink_pop_native.do?content_id=PW_A081085.

   It is important that the payer sheet is carefully reviewed so that claims are submitted in the required format. It is critical that both the Medicaid ID number and the Medicare ID number (HICN) are submitted to validate the beneficiary's "dual eligible" status. Submission of claims without both of these numbers will be considered invalid.

   If there are problems with these submission requirements, another option is available until the pharmacy provider's software vendor can support these requirements. For systems that do not currently support two beneficiary numbers, the following alternative requirements may be used:

   - BIN: 610575 (Anthem Prescription Management, LLC)
   - PCN: CMSDUAL02 (instead of CMSDUAL01)
   - Medicaid ID number in field 301 C1 Group ID (instead of the Patient ID 332-CY and Patient ID Qualifier 331-CX)
   - Patient segment required fields are still required including date of birth, first and last name, full address, phone number and patient location code
   - Medicare ID number in field 302-C2 Cardholder ID

Beneficiary Coverage:
The days supply is limited to fourteen days. This will allow for an appropriate opportunity for beneficiaries to be enrolled in a PDP.

For Further Assistance with the POS Facilitated Enrollment Process:
Pharmacy Help Desk: (800)-662-0210
Hours of Operation: Monday - Friday, 8:30 a.m.-12:00 a.m.
Saturday and Sunday, 9:00 a.m.-7:00 p.m.

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

Attention: Pharmacists

Denial on Medicaid Covered Excluded Drugs

Pharmacy providers receiving a denial on a Medicaid covered excluded drug for a Medicaid eligible recipient after the Medicare Part D prescription drug program begins on January 1, 2006 may contact the EDS pharmacy unit to check for coverage status of the drug.

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

Attention: Pharmacists

Medicare Part D Prescription Drug Plans and Temporary First Fill Policies

Medicare Part D prescription drug plans are required to establish a transition process for Medicare/Medicaid full-benefit, dually eligible enrollees who are transitioning from other prescription drug coverage. This transition process includes filling of a temporary one-time transition supply for a prescription drug that is not on the formulary of the Medicare Part D drug plan in which the beneficiary is enrolled. This accommodates the immediate need of the beneficiary and allows the beneficiary and the drug plan to work out with the prescriber an appropriate alternative medication or completion of an exception request to maintain coverage.

Temporary first fill policies can vary from plan to plan based on the drug in question, the unique needs of an individual or an individual's setting (e.g., a long term care setting).
The following information includes temporary first fill policies for Medicare Part D prescription drug plans available in North Carolina:

Organization	**Formulary ID #**	**New Enrollee General Transition Day Supply (First Fill)**	**New Enrollee Long Term Care Transition Day Supply (First Fill)**
SilverScript	619	30 days	90 days
Blue Cross Blue Shield of North Carolina	786	30 days	90-180 days
Blue Cross Blue Shield of North Carolina	787	30 days	90-180 days
SilverScript	897	30 days	90 days
Cigna Healthcare	1241	Utilization management clinical edits lifted during the 30-day transition period	Utilization management clinical edits lifted during the 90-day transition period
Pennsylvania Life Insurance Company	1446	60 days	60 days
RxAmerica	1479	30 days	30 days initially. Based on exceptions process outcome, may extend up to 90-180 days
RxAmerica	1644	30 days	30 days initially. Based on exceptions process outcome, may extend up to 90-180 days
Humana, Inc.	1863	30 days	Up to 90 days
WellCare	2003	30 days	90 days
WellCare	2129	30 days	90 days
Unicare	2493	90 days	90 days
Unicare	2546	90 days	90 days
WellCare	2629	30 days	90 days
PacifiCare Life and Health Insurance Company	2654	30 days	30 days initially, but may be extended up to 90 days if stabilized on multiple non-formulary medications
PacifiCare Life and Health Insurance Company	2656	30 days	30 days initially, but may be extended up to 90 days if stabilized on multiple non-formulary medications
Aetna Medicare	2662	Up to 30 day supply for all Part D medications and for select drugs,	90-180 days for all Part D medications or 1 plan year

Organization	Formulary ID #	New Enrollee General Transition Day Supply (First Fill)	New Enrollee Long Term Care Transition Day Supply (First Fill)
		1 plan year	coverage
Aetna Medicare	2681	Up to 30 day supply for all Part D medications and for select drugs, 1 plan year	90-180 days for all Part D medications or 1 plan year coverage
Coventry AdvantraRx	2759	30 days	Up to 90 days
Coventry AdvantraRx	2764	30 days	Up to 90 days
Coventry AdvantraRx	2766	30 days	Up to 90 days
Medco Health Solutions, Inc.	3164	30 days	Up to 90 days
Sterling Prescription Drug Plan	3245	30 days	90 days
United American Insurance Company	3296	30 days	90 days
MemberHealth	3422	30 days	90-180 days
United Healthcare	3440	30 days	Up to 90 days

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

Attention: Physicians

HCPCS Code Changes for the Physician's Drug Program

Due to recent information from the Centers for Medicare and Medicaid Services (CMS), HCPCS codes J7317 and J7320 will not be end dated effective with date of service December 31, 2005. HCPCS code J7318 will not be covered effective with date of service January 1, 2006.

This information supercedes the information published in the January 2006 general Medicaid bulletin article titled *HCPCS Changes for the Physician's Drug Program*.

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

NCLeads Update

Information related to the implementation of the new Medicaid Management Information System, *NCLeads*, can be found online at http://ncleads.dhhs.state.nc.us. Please refer to this web site for information, updates, and contact information related to the *NCLeads* system.

NCLeads Provider Relations
Office of MMIS Services
919-647-8315

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 website at http://www.dhhs.state.nc.us/dma/prov.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.

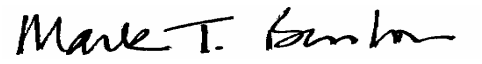
Gina Rutherford
Division of Medical Assistance
Clinical Policy Section
2501 Mail Service Center
Raleigh, NC 27699-2501

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.

2006 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
February	02/03/06	02/07/06
	02/10/06	02/14/06
	02/17/06	02/23/06
March	03/03/06	03/07/06
	03/10/06	03/14/06
	03/17/06	03/21/06
	03/24/06	03/30/06
April	040/7/06	0411/06
	04/13/06	04/18/06
	04/21/06	04/27/06

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