February 2009 Medicaid Bulletin

Visit DMA on the Web at: http://www.ncdhhs.gov/dma

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

Common National Provider Identifier Errors on Claims

The following list contains common National Provider Identifier (NPI) claim submission errors identified on dental claims:

1. The billing NPI in field 49 is less than 10 digits long (all NPIs contain10 digits).
2. Dental group providers are not submitting the attending NPI in field 54.
3. The billing address in field 48 does not match the billing address in the MMIS system. Addresses can be verified on the DMA NPI and Address Database at http://www.ncdhhs.gov/dma/WebNPI/default.htm.
4. Sole proprietors who are incorporated and have two different NPIs (one for the incorporated practice and one for the dentist as an individual) are reporting inconsistent NPIs. N.C. Medicaid can list only one NPI on the Medicaid file. NPIs can be verified on the DMA NPI and Address Database at http://www.ncdhhs.gov/dma/WebNPI/default.htm. Report to Medicaid the NPI that you intend to use for billing in field 49 (billing NPI).

Beginning May 1, 2009, N.C. Medicaid will process claims with the NPIs and taxonomy only and will no longer accept Medicaid Provider Numbers on claims. Review all information submitted on your claims to ensure that you are filing claims correctly. Call EDS Provider Services at 919-851-8888 or 1-800-688-6696 (option 3) if you have questions regarding NPI billing.

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 Implementation Announcement

Full implementation of National Provider Identifiers (NPIs) will take place on May 1, 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

N.C. Medicaid will hold National Provider Identifier (NPI) seminars during the month of March 2009. Seminars are intended for providers who would like detailed information on how N.C. Medicaid will be implementing NPI. Full implementation of NPI will take place on May 1, 2009. Upon full implementation, the Medicaid Provider Number (MPN) will no longer be allowed on paper or electronic claims.

The seminars are scheduled at the locations listed below. **Pre-registration is required.** Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

Providers may register for the NPI seminars online at http://www.ncdhhs.gov/dma/prov.htm. Sessions will begin at 9:00 a.m. and end at 12:00 noon. Providers are encouraged to arrive by 8:45 a.m. to complete registration. Lunch will not be provided at the seminars. **Because meeting room temperatures vary, dressing in layers is strongly advised.**

Candler **March 17, 2009** Asheville-Buncombe Tech Community College Enka Campus Harvey L. Haynes Corporate Technology Training and Conference Center 1465 Sand Hill Road Candler NC 28715	**Greensboro** **March 26, 2009** Clarion Hotel Airport 415 Swing Road Greensboro NC 27409
New Bern **March 24, 2009** New Bern Convention Center 203 South Front Street New Bern NC 28563	**Raleigh** **March 30, 2009** Wake Technical Community College 9101 Fayetteville Road Raleigh NC 27603

Directions to the NPI Seminars

CANDLER
Asheville Buncombe Tech Community College, Enka Campus
From I-40: Take Exit 44. At the traffic light at the end of the exit ramp, turn right. Go about 1.4 miles and turn left onto Sand Hill Road. Go to the second entrance on the left and turn into the campus. The Haynes Conference Center is on the right. You may park on the left or in the lot straight ahead of you.

GREENSBORO
Clarion Hotel Airport
Traveling West/North on I-40/I-85: Take I-40 West/I-85 South to Exit 131 (I-40 West/Business I-85 South). Follow I-40 Business West through Greensboro to Exit 213 (Guilford College Road). At the bottom of the exit ramp, take a slight left onto Swing Road. The hotel is located on the right.

From Charlotte/I-85 North: Take I-85 North to Exit 120B (PTI Airport/I-40 West/Winston Salem). Take Exit 212B for I-40 East. Take Exit 213 (Guilford College Road). At the bottom of the exit ramp, take a slight left onto Swing Road. The hotel is located on the right.

From the Piedmont Triad International Airport: Turn right onto Bryan Boulevard. Take the second exit to I-40 (towards Winston Salem). Take Exit 1 (Greensboro/421 South). Stay in the left-hand lane to avoid going west on I-40. Take Exit 213 (Guilford College Road). At the bottom of the exit ramp, take a slight left onto Swing Road. The hotel is located on the right.

From the South/Asheboro Hwy 220/I-73: Take Exit 81 (PTI Airport/ 421 North). Stay in the left-hand lane of the exit to avoid going east on I-40. Take Exit 213 (Guilford College Road). At the bottom of the exit ramp, take a slight left onto Swing Road. The hotel is located on the right.

NEW BERN

New Bern Convention Center

From Raleigh/I-40 East: Take exit 309 for US 70 East towards Goldsboro/Smithfield. Continue on US-70 East towards Goldsboro/US 70 East. Merge onto US 117 North/US 13North/US 70 East via the ramp to US 117 Bypass/Kinston/US 70 Bypass/Wilson. Take the US 70/US 17 exit toward Jacksonville/New Bern. Turn left at US 70/Dr. Martin Luther King Jr. Boulevard/US 17 and continue to follow US 70/US 17. Turn right at Craven Street. Turn right at S. Front Street. The Convention Center is on the left.

From Wilmington/US 17: Follow US 17 North through Jacksonville. Continue to follow US 17/NC 58. Continue on Main Street/US 17. Turn right on Craven Street. Turn right at S. Front Street. The Convention Center is on the left.

RALEIGH

Wake Technical Community College

Take I-440 to US 401 South/S. Saunders Street (exit 298). Stay to the right to continue on US 401 South/Fayetteville Road. Continue to travel on US 401 South/Fayetteville Street towards Fuquay-Varina. The college is located on the left approximately one mile from the intersection with NC 1010. Turn left onto Chandler Ridge Circle. Visitor parking is on the left.

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

NPI Workshops
March 2009 Seminar Registration Form
(No Fee)

Provider Name _____

Medicaid Provider Number _____ NPI Number _____

Mailing Address _____

City, Zip Code _____ County _____

Contact Person _____ E-mail _____

Telephone Number (____) _____ Fax Number _____

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

Please fax completed form to: 919-851-4014
Please mail completed form to:
EDS Provider Services
P.O. Box 300009
Raleigh, NC 27622

Attention: All Providers

DHHS Awards Contract for Replacement MMIS

The N.C. Department of Health and Human Services (DHHS) has awarded a contract to Computer Sciences Corporation (CSC) to develop and implement a Replacement Medicaid Management Information System (MMIS) in support of healthcare administration for multiple DHHS agencies.

Initially, the Replacement MMIS will be used by DMA; the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH); the Division of Public Health (DPH); the Migrant Program for the Office of Rural Health and Community Care (ORHCC); and the Division of Health Service Regulation (DHSR). DMA will assume the administration of the N.C. Health Choice Program in 2010, and Health Choice claims processing and operational support will be part of the Replacement MMIS multi-payer environment at start-up in 2011.

CSC will run the system and serve as the fiscal agent for DHHS and its divisions, providing operational support to manage provider and recipient call centers, prior authorization reviews, claims processing, pharmacy operations, medical policy reviews, and other administrative activities. CSC will be the fiscal agent for four years with one 1-year option.

The DHHS Office of MMIS Services (OMMISS) will provide contract oversight and management for the implementation of the multi-payer Replacement MMIS. OMMISS, together with staff from other DHHS divisions, will work closely with CSC on the total overall design, development, and installation of the system.

As part of the contractual agreement, responsibilities for Medicaid provider enrollment, credentialing, and verification, along with retrospective drug utilization review (Retro-DUR) functions, will be assumed by CSC within 120 days.

DHHS and CSC recognize the importance of early and continued interaction with the provider community and are moving to facilitate that interaction as quickly as possible.

More information on early implementation activities and replacement system development will appear in future Medicaid bulletins.

Linda Pruitt
DMA, 919-855-4106

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:

- A-2, *Over-the-Counter Medications*
- 1R-4, *Electrocardiography, Echocardiography, and Intravascular Ultrasound*
- 5A, *Durable Medical Equipment*
- 5B, *Orthotics and Prosthetics*
- 9, *Outpatient Pharmacy Program*

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

Basic Medicaid Seminars

Basic Medicaid seminars are scheduled for the month of April 2009. These seminars are intended to educate all providers on the basics of billing for N.C. Medicaid. Information presented at these seminars is a general review of N.C. Medicaid and is applicable to all provider types. The seminar sites and dates will be announced in the March 2009 general Medicaid bulletin.

The April 2009 *Basic Medicaid Billing Guide* will be used as the training document for the seminars and will be available on DMA's website prior to the seminars.

The April 2009 Basic Medicaid seminars will begin with a morning session and will have break-out sessions in the afternoon to address particular claim submission types. **Pre-registration will be required** for each individual session. Due to limited seating, registration will be limited to two staff members per office, per session. Unregistered providers are welcome to attend if space is available.

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

Attention: All Providers

Billing With CPT Procedure Codes 72291 and 72292

Providers are reminded that effective with date of service January 1, 2007, CPT procedure codes 72291 (radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body; under fluoroscopic guidance) and 72292 (under CT guidance) are to be billed as the professional component with modifier 26. (See the January 2007 bulletin article titled *CPT Code Update 2007* at http://www.ncdhhs.gov/dma/bulletin/0107bulletin.htm.)

Providers billing these codes as a repeat procedure with modifier 76 (repeat procedure by the same physician) or with modifier 77 (repeat procedure by another physician) should bill with modifier 26 as the first modifier and modifier 76 or 77 as the second modifier.

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

Attention: All Providers

2009 CPT Update

Effective with date of service January 1, 2009, rates for the 2009 CPT codes were revised in accordance with the N.C. Medicaid State Plan.

Revised fee schedules are available on the DMA website at http://www.ncdhhs.gov/dma/fee/fee/htm. Providers must bill their usual and customary charges.

Financial Management
DMA, 919-855-4200

Attention: All Providers

CPT Procedure Codes 72295 and 62290

Effective with date of service November 1, 2008, CPT procedure codes 72295 (discography, lumbar, radiological supervision and interpretation) and 62290 (injection procedure for discography, each level; lumbar) are allowed up to a maximum of five units per day per procedure. CPT procedure code 62290 is a surgical procedure and subject to modifier 51 payment. When billing multiple units for CPT procedure code 62290, bill 62290 with one unit on one detail and 62290 with modifier 51 and subsequent units on the next detail.

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

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

CPT Procedure Code 99170 Diagnosis List

The following ICD-9-CM diagnoses are allowable when billing CPT procedure code 99170 (anogenital examination with colposcopic magnification in childhood for suspected trauma):

- E960.1 (rape)
- V71.5 (observation following alleged rape or seduction)
- 995.53 (child sexual abuse)
- 995.59 (child maltreatment syndrome, not elsewhere classified)
- V71.81 (observation of suspected abuse or neglect)

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

Attention: All Providers

Denials for CPT Procedure Codes 76376 and 76377

The *CPT 2008 Professional Edition* published by the American Medical Association lists procedures that cannot be billed on the same date of service with CPT procedure codes 76376 (3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality; not requiring image postprocessing on an independent workstation) and 76377 (3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality; requiring image postprocessing on an independent workstation).

There are times when the 3D rendering would be billed with an appropriate code on the same date of service as a code that does not allow 3D rendering, causing 76376 or 76377 to be incorrectly denied. For example, a recipient receives a CT scan of the brain, procedure code 70450, and a CT angiography of the abdomen, procedure code 74175. Procedure code 70450 is allowed with 76376 or 76377; procedure code 74175 is not. Because all of the procedures were performed on the same date of service, either 76376 or 76377 will be denied.

Providers receiving a denial with EOB 3772 (3D rendering with interpretation not allowed same date of service with related services) when billing CPT procedure code 76376 or 76377 with an allowable imaging procedure code may file an adjustment to EDS using the Medicaid Claim Adjustment Form (http://www.ncdhhs.gov/dma/formsprov.html) with medical records attached to the form.

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

Attention: All Providers

Medically Necessary Oral Nutrition Products for Recipients Under the Age of 21

Effective with date of service February 1, 2009, DMA has added clinical coverage criteria for medically necessary oral nutrition products for recipients under the age of 21. The detailed criteria are available in Clinical Coverage Policy 5A, *Durable Medical Equipment*.

Also, beginning February 1, 2009, DME providers may submit their claims for these products and supplies for recipients under the age of 21 (who meet the clinical coverage criteria) through EDS. All recipients who are receiving Women, Infants, and Children Special Supplemental Nutrition Program (WIC) assistance or who are WIC eligible must continue to obtain their oral nutritional products from WIC first.

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

Attention: All Providers

Provider Enrollment Packet Updates

DMA's provider enrollment packets have been updated to reflect current requirements for participation with the N.C. Medicaid Program. Applicants should obtain the January 2009 version of the provider enrollment packets from DMA's website at http://www.ncdhhs.gov/dma/provenroll.htm.

The Provider Services Unit will accept either the December 2007 version or the January 2009 version of the enrollment packets until March 1, 2009. Previous versions of the enrollment packets submitted to the Provider Services Unit on or after March 1, 2009, will not be processed and will be returned to the provider.

If an applicant submits the December 2007 version of an enrollment packet prior to March 1, 2009, and it is returned to the applicant because it is incomplete or invalid, the applicant will be required to resubmit the corrected enrollment packet using the January 2009 version.

The new version of the provider enrollment packets should also be used when re-enrolling for participation with N.C. Medicaid Program and to report

- changes of ownership
- tax number changes
- group name changes
- tax name changes

Refer to DMA's website at http://www.ncdhhs.gov/dma/provider/changematrix.htm for additional information on the types of changes that must be reported to DMA using the provider enrollment packet.

Provider Services
DMA, 919-855-4050

Attention: All Providers

Upcoming Medicaid Integrity Program – CMS Provider Audits

The Medicaid Integrity Program has announced that it will be contacting Medicaid providers in North Carolina in early February 2009 regarding provider audits. The following audit fact sheet is provided for your information.

Medicaid Integrity Program Provider Audit Fact Sheet
November 2008

Background

The Deficit Reduction Act of 2005 (DRA) created the Medicaid Integrity Program (MIP) and directed the Centers for Medicare & Medicaid Services (CMS) to enter into contracts to review Medicaid provider actions, audit claims, identify overpayments, and educate providers and others on Medicaid program integrity issues.

Who are the "Audit MICs?"

Audit Medicaid Integrity Contractors (Audit MICs) are entities with which CMS has contracted to perform audits of Medicaid providers. The overall goal of the provider audits is to identify overpayments and to ultimately decrease the payment of inappropriate Medicaid claims. At the direction of CMS, the Audit MICs will audit Medicaid providers throughout the country. The audits will ensure that Medicaid payments are for covered services that were actually provided and properly billed and documented. Audit MICs will perform field audits and desk audits. Audits have begun in CMS Regions III & IV and will be expanded to all States and Territories. The audits are being conducted under Generally Accepted Government Auditing Standards.

Which providers will be subject to audit?

Any Medicaid provider may be audited, including, but not limited to, fee-for-service providers, institutional and non-institutional, as well as managed care entities.

How are providers selected?

Providers usually will be selected for audits based on data analysis by other CMS contractors. They also will be referred by State agencies. CMS will ensure that its audits neither duplicate State audits of the same providers nor interfere with potential law enforcement investigations.

What should a provider do if it receives a Notification Letter that it has been selected for audit?

Gather the requested documents as instructed in the letter. CMS contractors have the authority to request and review copies of provider records, interview providers and office personnel, and have access to provider facilities. Requested records must be made available to the Audit MICs within the requested timeframes. Generally, providers will have at least two weeks before the start of an audit to make their initial production of documents to the Audit MICs. In obtaining documents, Audit MICs will be mindful of state-imposed requirements concerning record production. Moreover, Audit MICs may accommodate reasonable requests for extensions on document production so long as neither the integrity nor the timeliness of the audit is compromised. The Audit MICs will also contact the provider to schedule an entrance conference. Notification Letters will identify a primary point of contact at the Audit MIC if there are specific questions about the Notification Letter or the audit process.

What process will follow the completion of the audit?

The Audit MIC will prepare a draft audit report, which will first be shared with the State and thereafter with the provider. The State and the provider each will have an opportunity to review and comment on the draft report's findings. CMS will consider these comments and prepare a revised draft report. CMS will allow the State to review the revised draft report and make additional comments. Thereafter, CMS will finalize the audit report, specify any identified overpayment, and send the final report to the State. The State will pursue the collection of any overpayment in accordance with State law. Providers have full appeal rights under State law. The Audit

MICs will be available to provide support and assistance to the States throughout the State adjudication of the audit.

Who are the Audit MICs?
Umbrella contracts have been awarded to: Booz Allen Hamilton, Fox & Associates, IPRO, Health Management Solutions (HMS), and Health Integrity, LLC. Booz Allen Hamilton was awarded the task order to conduct audits in CMS Regions III & IV. HMS was recently awarded a task order for CMS Regions VI & VIII.

For information on the Medicaid Integrity Program, please e-mail Medicaid_Integrity_Program@cms.hhs.gov.

Program Integrity
DMA, 919-647-8000

Attention: Chiropractors, Dentists, Medical Doctors, Optometrists, Osteopaths, and Podiatrists

Clarification on Individual and Group Enrollment and Reporting Changes to Medicaid

Individual physician providers (chiropractors, dentists, medical doctors, optometrists, osteopaths, and podiatrists) who wish to enroll with the N.C. Medicaid Program must complete and submit a Physician In-State Individual Provider Enrollment Packet. Sole proprietors or single owner LLC providers who have more than one physical service location are required to submit an application for and be issued an individual Medicaid Provider Number (MPN) for each of their physical service locations. Otherwise, only one individual MPN (attending) is required per individual physician. If a physician provider is a W-2 employee of more than one physician group practice, it is not necessary for the individual provider or the group's credentialing agent to submit duplicate or multiple Provider Enrollment Packets for the multiple locations where services are rendered by the physician.

The physician and the credentialing agent can access DMA's NPI and Address database at http://www.ncdhhs.gov/dma/WebNPI/default.htm and enter the physician's National Provider Identifier (NPI) number to verify if the individual provider has been assigned an individual MPN. If the provider is enrolled and associated with the NPI, the screen will display the provider's MPN, NPI number, provider name, site address, billing address, and initial effective date that is on record at DMA.

Physician group providers who wish to enroll with N.C. Medicaid must complete and submit a Physician In-State Group Provider Enrollment Packet. Physician group practices are responsible for notifying DMA of individual physicians who are associated (linked) with their group and for whom they will be submitting Medicaid claims. Groups may list individuals to be associated with them on the group's Provider Enrollment Packet at the time of enrollment. A minimum of one Medicaid-enrolled individual physician who is associated with the group must be listed on the application. When DMA processes the group's enrollment, the individuals listed on the packet are linked to the group's assigned MPN.

When a new individual provider joins a group practice, the group completes a Provider Change Form according to the instructions on DMA's website at http://www.ncdhhs.gov/dma/provider/changematrix.htm. Likewise, when a

provider leaves a group practice, the group notifies DMA via the Provider Change Form. DMA generally processes these Provider Change Forms within 10 days from date of receipt. The group should retain their copy of the Provider Change Form request to add or delete individual providers as their record that they notified DMA of the change.

When the group submits the request to link the individual provider to their group, it is not always necessary to also report address changes for the individual. Other than sole proprietor or single owner LLC, individual providers who are required to have a provider record reflecting each service location, the individual provider, as stated above, should have only one MPN. That provider's Medicaid provider record reflects one physical and one billing address and every group MPN to which the individual is linked per the groups' notification to DMA. The physical address and corresponding billing address reflected on that individual provider's Medicaid provider record should be a primary address at which they practice the majority of the time. The current addresses reflected on the individual provider's Medicaid provider record do not affect their ability to be linked to various groups and bill as an attending provider on behalf of various groups.

When a group practice submits a request to DMA to add (link) an individual to their group, the group is also responsible for indicating their intention to submit claims electronically on behalf of that individual by agreeing to abide by the conditions for electronic submission outlined in the Electronic Claims Submission Agreement. The group should complete and submit the ECS Agreement per the instructions on DMA's website at http://www.ncdhhs.gov/dma/formsprov.html#claims. The Electronic Claim Submission Agreement for the group must be signed by each individual provider, which authorizes the group to use the individual's MPN to bill Medicaid for services provided. Additional information regarding billing claims electronically is available in the *Basic Medicaid Billing Guide*, which is available on DMA's website at http://www.ncdhhs.gov/dma/medbillcaguide.htm.

Provider Services
DMA, 919-855-4050

Attention: Durable Medical Equipment Providers

Revised Clinical Coverage Criteria for External Insulin Infusion Pumps

Effective with date of service February 1, 2009, the clinical coverage criteria for external insulin infusion pumps were revised. There are several significant changes from the old criteria. Please refer to Clinical Coverage Policy 5A, *Durable Medical Equipment*, on DMA's website at http://www.ncdhhs.gov/dma/mp/mpindex.htm for specific coverage details.

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

Attention: Durable Medical Equipment Providers

2009 HCPCS Code Description Changes and Code Additions for Durable Medical Equipment

Effective with date of service January 1, 2009, the following HCPCS code descriptions were changed:

Code	New Description
A6257	Transparent film, sterile, 16 sq. in. or less, each dressing
A6258	Transparent film, sterile, more than 16 sq. in. but less than or equal to 48 sq. in., each dressing

Effective with date of service January 1, 2009, the following HCPCS codes were added to the DME fee schedule:

New Code	Description	Modifier	Lifetime Expectancy/ Quantity Limitations
A9284	Spirometer, non-electronic, includes all accessories	New	2/year
E1354	Oxygen accessory, wheeled cart for portable cylinder or portable concentrator, any type, replacement only, each	New Used Rental	5 years
E1355	Stand/rack	New Used Rental	5 years
E1356	Oxygen accessory, battery pack/cartridge for portable concentrator, any type, replacement only, each	New	1 year
E1357	Oxygen accessory, battery charger for portable concentrator, any type, replacement only	New	1 year
E1358	Oxygen accessory, DC power adapter for portable concentrator, any type, replacement only	New	1 year
E2231*	Manual wheelchair accessory, solid seat support base (replaces sling seat), includes any type mounting hardware	New Used Rental	1 yr/00-20 3 yrs/21-115
E2295*	Manual wheelchair accessory, for pediatric size wheelchair, dynamic seating frame allows coordinated movement of multiple positioning features	New Used Rental	2 yrs/00-20

In the table above, an asterisk (*) after the code indicates that prior approval is required; bold type indicates that the item is covered by Medicare. A Certificate of Medical Necessity and Prior Approval (CMN/PA) form must be completed for all items, regardless of the requirement for prior approval. The coverage criteria for these items have not been changed.

Refer to Clinical Coverage Policy 5A, *Durable Medical Equipment,* on DMA's website at http://www.ncdhhs.gov/dma/mp/mpindex.htm for detailed coverage information. Please refer to the DME fee schedule on DMA's website at http://www.ncdhhs.gov/dma/fee/fee.htm for the maximum allowable rates for these new codes and for all of the codes covered by N.C. Medicaid for durable medical equipment.

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

Attention: Durable Medical Equipment Providers

Coverage for Augmentative and Alternative Communication Devices

Effective with date of service February 1, 2009, newly established coverage criteria for augmentative and alternative communication devices have been implemented. This policy revision includes the addition of 11 new codes for speech-generating devices, accessories, repairs of augmentative communication devices, and speech-generating software.

HCPCS Procedure Code	Description
E1902*	Communication board, non-electronic augmentative or alternative communication device
E2500	Speech generating device, digitized speech, using pre-recorded messages, less than or equal to eight minutes recording time
E2502	Speech generating device, digitized speech, using prerecorded messages, greater than eight minutes but less than or equal to 20 minutes recording time
E2504	Speech generating device, digitized speech, using prerecorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time
E2506	Speech generating device, digitized speech, using prerecorded messages, greater than 40 minutes recording time
E2508*	Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device
E2510*	Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access
E2511*	Speech generating software program, for personal computer or personal digital assistant
E2512*	Accessory for speech generating device, mounting system
E2599*	Accessory for speech generating device, not otherwise classified
V5336*	Repair/modification of augmentative communicative system or device (excludes adaptive hearing aid)

These devices are covered for all recipients who meet the established criteria. Prior approval guidelines for synthesized speech-generating devices have been added to Section 5.3 of Clinical Coverage Policy 5A, *Durable Medical Equipment*. Refer to the policy 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: Enhanced Behavioral Health and Substance Abuse Service Providers

Community Support Services – Tiered Rates

The General Assembly enacted Session Law 2008-107 Section 10.15A(a)(b), which changes the payment methodology of Community Support services from a blended rate to a tiered rate based upon the individual qualifications of the staff providing the service. DMA submitted a State Plan Amendment (SPA) to CMS for approval to implement these changes. **The SPA has been approved effective with date of service January 1, 2009.**

For dates of service December 1, 2007 through December 31, 2008, providers are instructed to apply secondary modifiers U3 or U4 to identify units of service provided by the Qualified Professional (QP) and Non-Qualified Professional (non-QP) staff persons. Effective with date of service January 1, 2009, these two secondary modifiers will no longer be appropriate after date of service December 31, 2008, and have been replaced by eight new secondary modifiers effective with date of service January 1, 2009 (refer to the tables below).

Community Intervention Services (CIS) providers billing for Community Support services are required to apply these new secondary modifiers on claim submissions for procedure code H0036 in addition to the required primary modifier:

- H0036 HA – Community Support Child
- H0036 HB – Community Support Adult
- H0036 HQ – Community Support Group

The rates associated with the four levels of staff credentials have been approved by the Medicaid Rate Review Committee and CMS. Please note that these final rates represent a change from the proposed rates that were posted on the DMA web site.

H0036 HA - Community Support Child

Staff Level	Code	First Modifier	Second Modifier	Unit Rate
Qualified Professional - Licensed	H0036	HA	HP	$22.04
Qualified Professional – Unlicensed	H0036	HA	HO	$18.25
Associate Professional	H0036	HA	HN	$10.29
Paraprofessional	H0036	HA	UB	$ 5.92

H0036 HB - Community Support Adult

Staff Level	Code	First Modifier	Second Modifier	Unit Rate
Qualified Professional - Licensed	H0036	HB	HP	$22.04
Qualified Professional – Unlicensed	H0036	HB	HO	$18.25
Associate Professional	H0036	HB	HN	$10.29
Paraprofessional	H0036	HB	UB	$ 5.92

For H0036 HQ – Community Support Group, a separate set of modifiers will be necessary.

Staff Level	Code	First Modifier	Second Modifier	Unit Rate
Qualified Professional - Licensed	H0036	HQ	U8	$ 7.09
Qualified Professional – Unlicensed	H0036	HQ	U7	$ 5.87
Associate Professional	H0036	HQ	U6	$ 3.31
Paraprofessional	H0036	HQ	U5	$ 1.90

Authorizations for all Community Support services will continue at the aggregate level with payment at the detail level. Providers should not resubmit previously submitted prior authorization requests for CS services. The process of submitting a prior authorization request for CS services will not change.

Previously paid claims with a U3 or U4 secondary modifier for dates of service on or after January 1, 2009, will require a replacement claim to be filed with EDS. Please refer to the June 2007 Medicaid Bulletin for details on submitting replacement claims. Providers have until April 30, 2009 to submit replacement claims. After that time, automatic recoupments will be performed on claims paid with the U3 or U4 modifier for dates of service on or after January 1, 2009. It is recommended that providers separate all claim details for Community Support services for dates of service before or after January 1, 2009, to assure efficiency in payment.

Each claim for Community Support services will require the use of the two modifiers to be processed for payment. Primary modifiers HA, HB, or HQ must be placed in the first modifier position on the corresponding claim detail line. Secondary modifiers must be placed in the second modifier position on the corresponding claim detail line. **Payment of the claim is driven by the second modifier. Errors in entering the correct second modifier could result in recoupment upon audit of medical records.**

CMS-1500 Claim Examples

These examples are for illustration purposes only. Actual codes billed should reflect who rendered the services.

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER		E. DIAGNOSIS POINTER	F. $CHARGES	G. DAYS OR UNITS
01	**12**	**09**	**01**	**12**	**09**	**11**		**H0036**	**HA**	**HO**	**1**	**73.00**	**4**
01	**12**	**09**	**01**	**12**	**09**	**11**		**H0036**	**HA**	**UB**	**1**	**47.36**	**8**
01	**12**	**09**	**01**	**12**	**09**	**11**		**H0036**	**HA**	**HN**	**1**	**41.16**	**4**
01	**12**	**09**	**01**	**12**	**09**	**11**		**H0036**	**HQ**	**U7**	**1**	**23.48**	**4**

Below are guidelines to assist providers in accuracy of claim submission:

- Providers should bill only one line each for primary and secondary modifier combination per date of service per client. If more than one staff person with same level of credentials provides services on the same date, these staff units should be rolled into one detail line.
- It is expected that any combination of staff and associated modifiers may be billed on the same date of service.
- The determination of staff qualifications is dictated by the staff credentials providing the service; not the actual intervention.
- No rounding of time is allowed for billable services; only round down when time does not reach a complete 15 minutes per individual staff rendering the service.
- The maximum of 32 units per week per adult client (H0036 HB) is applied to the combined total of all modifiers and units of service.

Behavioral Health Services
DMA, 919-855-4290

Attention: General Hospitals with a Psychiatric Unit and Psychiatric Hospitals

Revised Pending and Retro-Eligibility Guidelines for Inpatient Services

In the July 2006 Special Bulletin, *Authorization and Utilization Review for Behavioral Health Services*, hospitals were given direction for obtaining both prior and concurrent medical necessity authorizations, depending on the status of Medicaid eligibility. In order to create a more consistent approach, DMA is revising the prior authorization review procedures for individuals who are not active Medicaid recipients at the time of admission. The new procedures are as follows:

For individuals who have active, verifiable Medicaid coverage at the time of admission for psychiatric services, concurrent medical necessity will be reviewed by contacting ValueOptions within two business days of admission. This process will continue as otherwise described in the July 2006 Special Bulletin. Note that this applies only to patients admitted with active full Medicaid coverage. Individuals with only family planning Medicaid coverage are not covered for mental health services.

For individuals who do not have verifiable, active Medicaid at the time of admission but who subsequently are approved for Medicaid covering the time of service, ValueOptions will provide a retrospective review of the service rendered. Although there is no longer a specific time limit for the submission of medical records to ValueOptions for their review, hospitals must make every effort to submit requests for retro-reviews within Medicaid's timely filing guidelines of 365 days from the date of discharge as described in 10A NCAC 22B.0104.

THESE CHANGES SHALL BE EFFECTIVE FOR ADMISSIONS OCCURRING ON OR AFTER FEBRUARY 1, 2009.

Retrospective reviews will entail the following process:

The hospital must verify that the individual has been approved for Medicaid and submit the medical record documentation to ValueOptions after verification of Medicaid eligibility. Effective on February 1, 2009, hospitals may submit medical records for retroactive Medicaid eligibility patients (including those admitted prior to February 1, 2009) to ValueOptions for review and issuance of authorization numbers. As noted above, the billing time limitations described in 10A NCAC 22B.0104 will still apply. ValueOptions will also conduct medical necessity review for patients who were approved for Medicaid during or after their admissions, and whose discharges occurred within the past year.

Regardless of the date of retroactive Medicaid approval, ValueOptions will determine whether the days were medically necessary and send notification of the review to the provider. Notification will occur within 60 days of record receipt.

For individuals subject to Certificate of Need (CON) review, DMA suggests that a CON should be performed regardless of Medicaid status on admission and retained in the medical record. Medicaid cannot accept a back dated CON.

A provider may request a reconsideration review of provider claims denials in accordance with 10A NCAC 22J.0102 and .0103.

All other requirements for prior approval of inpatient services apply for Medicaid recipients.

Behavioral Health Services
DMA, 919-855-4290

Attention: Home Infusion Therapy Providers

Prior Approval for Tocolytic Therapy

Effective January 1, 2009, all prior approval requests for subcutaneous tocolytic therapy will be approved through DMA and should not be submitted to the Carolinas Center for Medical Excellence (CCME) for approval. The change in the prior approval process includes both initial requests and any reauthorizations needed for existing cases. There are no changes to the program or the service requirements.

Requests should be submitted using the Tocolytic Prior Approval Request Form (DMA-3600) available on DMA's website at http://www.ncdhhs.gov/dma/formsprov.html#pa. Completed forms and other requested information should be faxed to DMA at 919-715-9025.

Tocolytic therapy requirements can be found in Clinical Coverage Policy 3H-2, *Home Tocolytic Infusion Therapy*, on DMA's website at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

Providers with questions on the program or the revised prior approval process should contact the DMA Home Infusion Therapy (HIT) Program Consultant at 919-855-4380.

HIT Program Consultant
DMA, 919-855-4380

Attention: Institutional (UB 04/837I) Billers

ICD-9-CM Procedure Codes

N.C. Medicaid is targeting system changes to be implemented in July 2009, in order to comply with regulations mandated by the Health Insurance Portability and Accounting Act (HIPAA) in regards to ICD-9-CM procedure codes.

According to HIPAA regulations, the use of ICD-9-CM procedure codes is restricted to the reporting of inpatient procedures by hospitals. All other institutional claims submitted with ICD-9-CM procedure codes will be denied; this includes claims submitted for outpatient, nursing home, adult care homes, home health, hospice, and/or residential child care treatment facility services.

To allow providers to report surgical procedures previously reported using ICD-9-CM procedure codes, DMA will be expanding the detail level information required for Revenue Codes 36X (Operating Room Services) and 76X (Specialty Room Treatment/Observation Room) to include CPT/HCPCS procedure codes.

Refer to the tables below and to future Medicaid bulletin articles for additional information.

Operating Room Services

Revenue Code	Revenue Code Description	Covered Service	Require HCPCS Code
360	Operating Room Services – General Classification	Y	Y
361	Operating Room Services – Minor Surgery	Y	Y
362	Operating Room Services – Organ Transplant – Other than Kidney	Y	N
363	Operating Room Services – Reserved	N	N
364	Operating Room Services – Reserved	N	N
365	Operating Room Services – Reserved	N	N
366	Operating Room Services – Reserved	N	N
367	Operating Room Services – Kidney Transplant	Y	N
368	Operating Room Services – Reserved	N	N
369	Operating Room Services – Other OR Services	Y	Y

Specialty Room Treatment/Observation Room

Revenue Code	Revenue Code Description	Covered Service	Require HCPCS Code
760	Specialty Room Treatment/Observation Room – General Classification	Y	Y
761	Specialty Room Treatment/Observation Room – Treatment Room	Y	Y
762	Specialty Room Treatment/Observation Room – Observation Room	Y	Y
763	Specialty Room Treatment/Observation Room – Reserved	N	N
764	Specialty Room Treatment/Observation Room – Reserved	N	N
765	Specialty Room Treatment/Observation Room – Reserved	N	N
766	Specialty Room Treatment/Observation Room – Reserved	N	N
767	Specialty Room Treatment/Observation Room – Reserved	N	N
768	Specialty Room Treatment/Observation Room – Reserved	N	N
769	Specialty Room Treatment/Observation Room – Other Specialty Rooms	Y	Y

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

Attention: Nurse Practitioners and Physicians

17 Alpha Hydroxyprogesterone Caproate (17P), Injection from Bulk Powder – Billing Guideline Update

The billing guidelines for 17 alpha hydroxyprogesterone caproate (17P) intramuscular injections published in the April 2007 general Medicaid bulletin have been updated to indicate that a copy of the pharmacy invoice is no longer necessary for dates of service on or after April 1, 2007.

The N.C. Medicaid Physician's Drug Program began covering 17P effective with date of service April 1, 2007, for use in pregnant women with a history of a preterm delivery before 37 weeks' gestation but no preterm labor in the current pregnancy. The recommended dose of 17P is a 250-mg weekly intramuscular injection administered from gestational weeks 16 through 36.

17P for intramuscular injection is not commercially available, but can be compounded by a pharmacy provider. When billed on the professional claim form, 17P must be billed with HCPCS procedure code J3490 (unclassified drugs). As explained in the section on miscellaneous codes in the October 2008 Special Bulletin, *National Drug Code Implementation Phase III* (http://www.ncdhhs.gov/dma/bulletinspecial.htm), compounds must be billed with the original invoice or copy of the original invoice. Although this is a compounded product, as indicated above, a copy of the pharmacy invoice is no longer necessary when billing for **this** drug.

Providers may obtain 17P from compounding pharmacies in multi-dose vials and may feel it necessary to utilize a multi-dose vial of medication for more than one patient. Providers should keep a list of patients who received medication from each multi-dose vial on file, should auditing be necessary.

Note: Providers must use rebatable 11-digit National Drug Codes (NDCs) and appropriate NDC units when billing for 17P.

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

Attention: Orthotics and Prosthetics Providers

2009 HCPCS Code Changes for Orthotics and Prosthetics

Effective with date of service December 31, 2008, the following codes were end-dated and removed from the Orthotics and Prosthetics (O&P) fee schedule.

L2860	L3890	L5993	L5994	L5995
L7611	L7612	L7613	L7614	L7621
L7622				

Effective with date of service January 1, 2009, the following code description was changed:

Code	New Description
L4360	Walking boot, pneumatic and/or vacuum, with or without joints, with or without interface material, prefabricated, includes fitting and adjustment.

Effective with date of service January 1, 2009, the following codes were added to the O&P fee schedule:

New Code	Description	Modifier	Lifetime Expectancy/Quantity Limitations
A6545	Gradient compression wrap, non-elastic, below knee, 30-55 mmhg each	New Left Right	4 per year
K0672	Addition to lower extremity orthosis, removable soft interface, all components, replacement only, each	New Left Right	6 months: ages 00-20; 1 year ages 21 and older
L0113*	Cranial cervical orthosis, without joint, with or without soft interface material, prefabricated, includes fitting and adjustment	New Left Right	6 months: ages 00-20; 1 year ages 21 and older
L6677	Upper extremity addition, harness, triple control, simultaneous operation of terminal device and elbow	New Left Right	1 year: ages 00-20; 3 years ages 21 and older
L6711*	Terminal device, hook, mechanical, voluntary opening, any material, any size, lined or unlined, pediatric	New Left Right	1 year: ages 00-20
L6712*	Terminal device, hook, mechanical, voluntary closing, any material, any size, lined or unlined, pediatric	New Left Right	1 year: ages 00-20
L6713*	Terminal device, hand, mechanical, voluntary opening, any material, any size, pediatric	New Left Right	1 year: ages 00-20
L6714*	Terminal device, hand, mechanical, voluntary closing, any material, any size, pediatric	New Left Right	1 year: ages 00-20

New Code	Description	Modifier	Lifetime Expectancy/Quantity Limitations
L6721*	Terminal device, hook or hand, heavy duty, mechanical, voluntary opening, any material, any size, lined or unlined	New Left Right	1 year: ages 00-20; 3 years ages 21 and older
L6722*	Terminal device, hook or hand, heavy duty, mechanical, voluntary closing, any material, any size, lined or unlined	New Left Right	1 year: ages 00-20; 3 years ages 21 and older

Note: In the tables above, an asterisk (*) after the code indicates prior approval is required; bold type indicates the item is covered by Medicare. A Certificate of Medical Necessity and Prior Approval must be completed for all items, regardless of the requirement for prior approval. The coverage criteria for these items have not changed.

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

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

Attention: Non-State-Owned ICF/MR Providers

Rate Adjustments

Effective for dates of service November 1, 2007, through June 30, 2008, DMA increased the rate for non-state-owned Intermediate Care Facilities for Mental Retardation (ICF/MR) rates by 3.91%. This is a temporary increase in the rates, with 2.73% applied to the direct component and 1.18% applied to the indirect component.

Effective for date of service July 1, 2008, and after, the rates will be adjusted by 2.61%. This is a permanent increase in the rates, with 1.82% applied to the direct component and 0.79% applied to the indirect component. Providers who are currently at or near the direct rate limit might not receive the full benefit of these rate increases.

Retroactive payment will be handled through DMA Audit's cost settlement process for claims for dates of service through June 30, 2008. DMA will recoup and repay for claims beginning July 1, 2008, for the current fiscal year. Providers may elect to submit adjusted claims to receive retroactive payment for this period.

Tabitha D. Lee, Rate Setting
DMA, 919-855-4190

Attention: Personal Care Services and Personal Care Services–Plus Personal Care Services Provider Training Sessions

The Carolinas Center for Medical Excellence (CCME; http://www2.thecarolinascenter.org/ccme/) announces continued provider training for Personal Care Services (PCS) as approved by DMA.

The 1st calendar quarter training sessions (PCS Provider Training Session XI) of 2009 are scheduled for March 2009. The training is recommended for registered nurses, agency administrators, and agency owners who have a working knowledge of the PCS Program and applicable DMA policies.

Pre-registration is required and space is limited. Registration will be provided online or by fax. Detailed information regarding times and session content will be posted on CCME's website.

To register online, visit CCME's website and click on the appropriate link in Upcoming Events. When you have completed the online registration, you will receive a computer-generated number to confirm your registration. Bring the number with you to the session.

To register by fax, complete the form following this announcement and fax it to the attention of Alisha Brister at 919-380-9457. A member of the PCS team will contact you with a registration number, which you should bring with you to the session.

If you need to **cancel** at any time, please contact Alisha Brister (919-380-9860, x2018) to allow others to register. Please e-mail Alisha Brister at CCME (abrister@thecarolinascenter.org) for further information on registering.

CCME, 919-380-9860

The Carolinas Center *for* Medical Excellence

CCME PCS Provider Training Session 11
March 2009
Registration Form

Location requested: _____ Location Date: _____

First Name: _____

Last Name: _____

Credentials: _____ First time to attend training? _____

Position: _____

Organization: _____

Facility: _____

Address: _____

City: _____, NC Zip: _____

County: _____

UPIN/Provider #: _____

Phone #: _____ Ext: _____

Fax #: _____

Email: _____

Referred by/How did you hear about this event?

_____

_____

May we send you e-mail updates on new information, features, and tools on the CCME website?
please check: ☐ Yes ☐ No

Please fax completed form to the attention of
Alisha Brister at 919-380-9457

Attention: Pharmacists

Emergency Fills for Recipients in the Focused Risk Management Program

Pharmacy providers may provide emergency fills for the Focused Risk Management (FORM) program recipients who have opted in to another pharmacy for situations in which recipients may not be able to get to their pharmacy. The emergency supply is limited to a 4-day supply. The pharmacy provider will be paid for the drug cost only and the recipient will be responsible for the appropriate copayment. Pharmacy providers should use a "03" in the level of service field (418-DI) in order to dispense an emergency supply of a medication to a FORM recipient.

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

Attention: Portable X-ray Providers

Billing for Services

Portable X-ray providers are reminded that they may bill N.C. Medicaid for only the following CPT procedure codes.

70250	70260	71010	71015	71020	71021	71022	71030	71100	71101
71110	71111	71120	71130	72010	72020	72040	72050	72052	72069
72070	72072	72074	72080	72090	72100	72110	72114	72120	72170
72190	72220	72202	72220	73000	73010	73020	73030	73060	73070
73080	73090	73092	73100	73110	73120	73130	73140	73500	73510
73520	73540	73550	73560	73562	73564	73565	73590	73592	73600
73610	73620	73630	73650	73660	74000	74010	74020	74022	

When billing for these procedure codes, portable X-ray providers must append modifier TC to the code for the technical component of the procedure.

Please refer to the May 2005 bulletin article titled *Electronic Billing for Portable X-Ray and New Level II HCPCS* (http://www.ncdhhs.gov/dma/bulletin/0505bulletin.htm) for complete billing instructions for portable X-ray providers.

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

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.

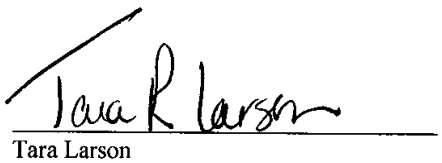
Loretta Bohn
Division of Medical Assistance
Clinical Policy Section
2501 Mail Service Center
Raleigh NC 27699-2501

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.

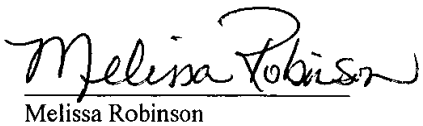
2009 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
January	01/29/09	02/03/09
February	02/05/09	02/10/09
	02/12/09	02/18/09
	02/19/09	02/26/09
	02/26/09	03/03/09

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.



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



Melissa Robinson
Executive Director
EDS, an HP Company