Number 3 *March 2003*

North Carolina Medicaid Bulletin

An Information Service of the Division of Medical Assistance
Published by EDS, fiscal agent for the North Carolina Medicaid Program

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

In This Issue…… *Page #*

In This Issue…… *Page #*

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

Attention: All Providers

Proposed Medical Coverage Policies

In accordance with Session Law 2001-424, Senate Bill 1005, proposed new or amended Medicaid medical 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.

Darlene Creech
Medical Policy Section
Division of Medical Assistance
2511 Mail Service Center
Raleigh, NC 27699-2511

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.

Darlene Creech, Medical Policy Section
DMA, 919-857-4020

Attention: All Providers

Medical Coverage Policies

Updated policies for the following programs are now located on the Division of Medical Assistance's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm:

1A Physicians
- **1A-4** Cochlear Implantation
- **1A-8** Hyperbaric Oxygen (HBO) Therapy
- **1A-9** Blepharoplasty/Blepharoptosis Eyelid Repair
- **1A-10** Panniculectomy
- **1A-11** Extracorporeal Shock Wave Lithotripsy

5 Durable Medical Equipment

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

Darlene Creech, Medical Policy Section
DMA, 919-857-4020

Attention: All Providers

Provider Information Update

The N.C. Medicaid program is updating provider files to include a fax number and an e-mail address. These two methods of communication will complement the already existing methods of communication and provide a quick avenue for providers to receive information. Because only one e-mail address and one fax number can be entered for a provider number, please submit the most appropriate information for the provider number given. Please complete and return the following form to EDS Provider Enrollment at the address listed below.

To report a change of ownership, name, address, tax identification number changes, group member, or licensure status, please use the Notification of Change in Provider Status form. Managed Care providers (Carolina ACCESS, ACCESS II, and ACCESS III) must also report changes, including changes in daytime or after-hours phone numbers, using the Carolina ACCESS Provider Information Change form.

Date _____

Provider Number: _____

Provider Name: _____

Site Address: Street _____

City _____

State _____ Zip Code _____

Contact Person: _____

Phone Number: ( ) _____

Fax Number: ( ) _____

E-Mail Address: _____

Return completed form to:

EDS Provider Enrollment
PO Box 300009
Raleigh, NC 27622

Fax: 919-851-4014

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

Attention: All Providers

Unidentifiable Provider Numbers

The Medicaid Management Information System (MMIS) identifies claims, whether the claim is submitted on paper or electronically, by using the billing provider's Medicaid number. Leaving the billing provider number off of the claim or billing with an incorrect or invalid billing provider number delays claims processing or prevents a claim from being processed and reported on the provider's Remittance and Status Report (RA). Transposition of numbers or keying errors may cause a claim to be reported on another provider's RA.

In order for EDS to ensure that each provider is notified of the claims that have processed, it is essential that the correct **billing provider** number is entered on every claim that is submitted for processing. When claims are received, the billing provider number is verified to ensure that it is a valid number. The type of provider number error on a claim determines the final disposition of that claim. The chart below lists common provider number errors, the steps taken by EDS to process the claims, final disposition of the claims, and instructions for the provider.

Type of Error	Paper Claims	Electronic Claims
Billing Provider Number Is Missing	EDS conducts a provider file search using the provider name and address listed on the claim. If the search returns an exact match, the provider number is inserted and the claim is processed for payment. If an exact match is not found, the claim is returned to the provider at the address listed on the claim along with a letter explaining that the claim cannot be processed because the provider number is missing from the claim. Providers must correct and resubmit a new claim.	An **audit trail provider number** is assigned to the claim for tracking purposes only, which allows the MMIS to store identifiable claim data in a special account. Electronic transmissions do not contain provider addresses. When the billing provider number is missing, a provider file search cannot be conducted nor can providers be notified of unprocessed electronic claims. Providers submitting claims electronically must monitor their RAs to ensure that the claims they have submitted have been processed. If a claim is not reported on your RA, please call the ECS unit at EDS to verify that the transmission was received before correcting and resubmitting electronic claims.

Type of Error	Paper Claims	Electronic Claims
Billing Provider Number, Provider Name and Address are Missing	An **audit trail provider number** is assigned to the claim for tracking purposes only, which allows the MMIS to store identifiable claim data in a special account. A provider file search cannot be conducted because the claim is missing the provider number and the provider address. These claims cannot be returned nor can the provider be notified that their claim has not been processed because there is no address on the claim. Providers must monitor their RAs to ensure that the claims they have submitted have been processed. If a claim is not reported on your RA, please call EDS Provider Services to verify your billing provider number. Providers must correct and resubmit a new claim.	An **audit trail provider number** is assigned to the claim for tracking purposes only, which allows the MMIS to store identifiable claim data in a special account. Electronic transmissions do not contain provider addresses and are unidentifiable when the billing provider number is missing. Therefore, a provider file search cannot be conducted nor can providers be notified of unprocessed electronic claims. Providers who submit claims electronically must monitor their RAs to ensure that the claims they have submitted have been processed. If a claim is not reported on your RA, please call the ECS unit at EDS to verify that the transmission was received before correcting and resubmitting electronic claims.
Billing Provider Number is Invalid	EDS conducts a provider file search on the provider name and address that is listed on the claim. If the search returns an exact match, the correct provider number is inserted and the claim is processed for payment. If an exact match is not found, the claim is returned to the provider at the address listed on the claim along with a letter explaining that the claim cannot be processed because the billing provider number is invalid. Providers must correct and resubmit a new claim.	An **audit trail provider number** is assigned to the claim for tracking purposes only, which allows the MMIS to store identifiable claim data in a special account. Electronic transmissions do not contain provider addresses and are unidentifiable when the billing provider number is invalid. Therefore, a provider file search cannot be conducted nor can providers be notified of unprocessed electronic claims. Providers who submit claims electronically must monitor their RAs to ensure that the claims they have submitted have been processed. If a claim is not reported on your RA, please call the ECS unit at EDS to verify that transmission was received before correcting and resubmitting electronic claims.

Type of Error	Paper Claims	Electronic Claims
Billing Provider Number is Invalid and the Provider Address is Missing	An **audit trail provider number** is assigned to the claim for tracking purposes only, which allows the MMIS to store identifiable claim data in a special account. A provider file search cannot be conducted because the provider number is invalid and the provider address is missing from the claim. These claims cannot be returned nor can the provider be notified that their claim has not been processed because there is no address on the claim. Providers must monitor their RAs to ensure that the claims they have submitted have been processed. If a claim is not reported on your RA, please call EDS Provider Services to verify your billing provider number. Providers must correct and resubmit a new claim.	An **audit trail provider number** is assigned to the claim for tracking purposes only, which allows the MMIS to store identifiable claim data in a special account. Electronic transmissions do not contain provider addresses and are unidentifiable when the billing provider number is invalid. Therefore a provider file search cannot be conducted nor can providers be notified of unprocessed electronic claims. Providers who submit claims electronically must monitor their RAs to ensure that the claims they have submitted have been processed. If a claim is not reported on your RA, please call the ECS unit at EDS to verify that the transmission was received before correcting and resubmitting electronic claims.

Unidentifiable claims are assigned an **audit trail provider number**, which is a specific Medicaid provider number that allows the MMIS to store identifiable claim data in a special account. (This special account is sometimes referred to as the "black hole.") Claim data is retained in this special account for 18 months and establishes an audit trail should there be a need to document a time limit override for the claim.

Electronic claims refers to all claims that are submitted through a clearinghouse or by a provider using software obtained from an approved vendor or NCECS software from EDS, and claims that are crossed over from Medicare for Part A services as well as claims that are crossed over from Medicare for Part B services for dates of service prior to October 1, 2002.

If a claim cannot be processed for payment, the provider cannot verify claim status through the Automated Voice Response (AVR) system. EDS makes every effort to identify claims submitted with a missing or invalid Medicaid billing provider number. Providers should allow 45 days for paper claims to appear on their RA. Electronic claims received before the 5:00 p.m. cutoff for electronic submittals should appear on the RA the following week. Please ensure that the billing provider number entered on every claim submitted for processing is correct. Review RAs carefully to determine that all claims submitted for processing have been reported.

For paper claim submissions, providers can verify their billing provider number by calling the EDS Provider Services Unit at 1-800-688-6696 or 919-851-8888, option 3. For electronic claim submissions, call the Electronic Commerce Services unit at 1-800-688-6696 or 919-851-8888, option 1.

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

Attention: All Providers

Routine Newborn Circumcision Coverage Policy Clarification

Effective with date of service March 1, 2003, the following diagnosis codes are not considered medically necessary for newborn circumcisions:

- V30.0 – V39.2 Live newborn
- V50.2 Routine or ritual circumcision
- 605 Redundant prepuce and phimosis: adherent prepuce, congenital phimosis, paraphimosis, tight foreskin

Medically necessary circumcisions continue to be covered. Providers must bill the most appropriate ICD-9-CM diagnosis code that supports medical necessity. Claims without an ICD-9-CM diagnosis code supporting medical necessity will be denied. Medical documentation supporting the medical necessity for circumcision must be available to the Division of Medical Assistance or its contractual agents upon request in accordance with the Social Security Act 1902 (a) (4) and (27) and 42 CFR 431.107.

Providers may bill a patient accepted as a Medicaid patient if, as specified in the North Carolina Administrative Code 10 NCAC 26K.0106, the provider has informed the patient, before the service is provided, that the patient may be billed for a service that is not covered by Medicaid.

Claims submitted for dates of service between December 1, 2002 and February 28, 2003 with the ICD-9-CM diagnosis 605 will be accepted for processing.

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

Attention: All Providers

Sodium Hyaluronate for Intra-Articular Injection – Billing Guidelines

The N.C. Medicaid program will end-date the current code for sodium hyaluronate to align with Medicare guidelines. Effective with date of service March 31, 2003, HCPCS code Q3030 (sodium hyaluronate, per 20 to 25 mg dose, for intra-articular injection) will be end-dated. Effective with date of service April 1, 2003, providers must bill J7317 (sodium hyaluronate, per 20 to 25 mg dose, for intra-articular injection). Providers must indicate the number of units given in block 24G on the CMS-1500 claim form. The maximum reimbursement rate is $134.44 per unit. For Medicaid billing, one unit equals 20 mg to 25 mg. Providers must bill their usual and customary charge.

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

Attention: All Providers

Update on HIPAA Implementation Training Seminars

Seminars scheduled for Spring 2003 on the implementation of the Health Insurance Portability and Accountability Act (HIPAA) transaction sets have been postponed until Summer 2003. The seminars are intended for providers who currently use North Carolina Electronic Claims Submission (NCECS) software and for those providers who plan to begin using NCECS software. Dates and site locations for the seminars will be published in a future general Medicaid bulletin.

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

Attention: Carolina ACCESS Providers

Quarterly Utilization Review Report

The Quarterly Utilization Review Report is produced for Carolina ACCESS (CA) primary care providers (PCPs) and contains quarterly data on the utilization of services by the Medicaid recipients enrolled in their practice. The report allows for a comparison of utilization rates with the provider's peers in the same CA specialty. Recently, this report has been revised to improve accuracy and usefulness. The layout of the report as well as how the services are grouped together for comparison were changed. The first revised report was sent to CA providers in January 2003. The next distribution is scheduled for April 2003. Please contact the regional Managed Care Consultant for your county with questions or comments.

Angie Yow, RN, Managed Care Section
DMA, 919-857-4022

Attention: Carolina ACCESS Providers

Reduction in Management Fee

Effective April 1, 2003, the Carolina ACCESS (CA) management fee for any CA provider not linked with an ACCESS II or ACCESS III administrative entity will be reduced to $1.00 per member per month. There is no change in fees for ACCESS II and ACCESS III providers. The management fee will continue to be paid on the first checkwrite of every month for the current month.

If you have any questions or concerns, please contact the Managed Care Consultant for your county.

Managed Care Section
DMA, 919-857-4022

Attention: Durable Medical Equipment Providers, Nurse Practitioners, Physician Assistants, and Physicians

Durable Medical Equipment Prescriptions and Certificate of Medical Necessity and Prior Approval Forms

Effective with date of service March 1, 2003, nurse practitioners and physician assistants are allowed to write prescriptions and sign Certificate of Medical Necessity and Prior Approval (CMN/PA) forms for durable medical equipment for Medicaid recipients. These medical professionals must be licensed in their state of practice by their respective licensing boards and must comply with all practice guidelines. In addition, the nurse practitioner or physician assistant must be treating the recipient for a diagnosis related to the supply or equipment being prescribed. For example, the nurse practitioner or physician assistant may write a prescription for a blood glucose monitor or diabetic supplies if he or she is treating the patient for diabetes.

Melody B. Yeargan, P.T., Medical Policy
DMA, 919-857-4020

Attention: Health Check Providers

Health Check Seminars

Health Check seminars for all providers except health departments are scheduled for May 2003. The April 2003 general Medicaid bulletin will have the registration form and a list of site locations for the seminars. Attendance at these seminars is very important because some Health Check billing requirements will change effective with date of processing July 1, 2003.

A separate teleconference sponsored by the Division of Public Health is scheduled for health department providers. The April general bulletin will include registration information for the teleconference.

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

Attention: Dialysis Providers

Occurrence Code Change for First Date of Ongoing Dialysis Treatment

To comply with the implementation of the Health Insurance Portability and Accountability Act (HIPAA), state-created Occurrence Code 51 will be end-dated effective with date of service May 31, 2003. Effective with date of service June 1, 2003, providers must enter national Occurrence Code 11 in field 32 - 35 on the UB-92 claim form when reporting the date of the first ongoing dialysis treatment. No filing changes will be necessary for CMS-1500 claims.

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

Attention: Home Health Agencies, Private Duty Nursing Providers, and Community Alternatives Program Case Managers

HCPCS Code Changes for Home Health Supplies

The following Home Health supply codes will be end-dated effective with date of service March 31, 2003.

Home Health Supplies			
HCPCS Code	**Description**	**Billing Unit**	**Maximum Rate**
W4201	Non-sterile exam gloves	100/bx	$ 10.92
W4202	Non-sterile exam gloves	1 pair	.11
W4204	Sterile surgical gloves	1 pair	.85
W4622	Proderm	Each	25.52
W4646	Nebulizer kit, plastic or glass	Each	4.08
W4638	Disposable diapers, including pull ups (all sizes)	Each	.90
W4647	Male external catheter with or without adhesive, with or without anti-reflux device	Each	2.55
W4652	Urine test strips for multiple elements which may include glucose and/or ketones	Each	.71
W4664	Prefilled heparin/saline syringe	Each	5.71
W4669	Sterile water, 250 cc to 1000 cc	Bottle	3.27
W4671	Sterile saline, 250 cc to 1000 cc	Bottle	2.42
W4675	Urine test strips for combination ketones and glucose, e.g., keto diastix	Each	.29
W4676	Urine test strips or tablets for ketones	Each	.26
W4677	Urine test strips or tablets for glucose	Each	.20

The following codes will replace the deleted codes listed above, effective with date of service April 1, 2003.

HCPCS Code	**Description**	**Billing Unit**	**Maximum Rate**
A4250	Urine test or reagent strips or tablets	100/box	$ 25.00
A4323	Sterile saline, 1000 cc	Each	2.42
A4521	Adult-sized (*disposable)* incontinence product, diaper, small size	Each	.90
A4522	Adult-sized *(disposable)* incontinence product, diaper, medium size	Each	.90
A4523	Adult-sized *(disposable)* incontinence product, diaper, large size	Each	.90

HCPCS Code	Description	Billing Unit	Maximum Rate
A4524	Adult-sized *(disposable)* incontinence product, diaper, extra large size	Each	.90
A4525	Adult-sized *(disposable)* incontinence product, brief, small size	Each	.90
A4526	Adult-sized *(disposable)* incontinence product, brief, medium size	Each	.90
A4527	Adult-sized *(disposable)* incontinence product, brief, large size	Each	.90
A4528	Adult-sized *(disposable)* incontinence product, brief, extra-large size	Each	.90
A4529	Child-sized *(disposable)* incontinence product, diaper, small/medium size	Each	.90
A4530	Child-sized *(disposable)* incontinence product, diaper, large size	Each	.90
A4531	Child-sized *(disposable)* incontinence product, brief, small/medium	Each	.90
A4532	Child-sized *(disposable)* incontinence product, brief, large size	Each	.90
A4533	Youth-sized *(disposable)* incontinence product, diaper	Each	.90
A4534	Youth-sized *(disposable)* incontinence product, brief	Each	.90
A4927	Gloves, non-sterile	100/box	10.92
A4930	Gloves, sterile	Pair	.85
K0409	Sterile water, 1000 cc	Each	3.27
J1642	Prefilled Heparin saline syringe, per 10 units	Each	5.71
A6196	Alginate or other fiber gelling dressing, wound cover, pad size 16 sq. in. or less	Each	7.35
A6197	Alginate or other fiber gelling dressing wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in.	Each	16.44
A6198	Alginate or other fiber gelling dressing, wound cover, pad size more than 48 sq. in.	Each	19.64
A6199	Alginate or other fiber gelling dressing, wound filler, per 6 inches	Each	5.29
A6260	Wound cleansers, any type, any size	Each	25.52

Providers must bill their usual and customary charges.

Dot Ling, Medical Policy Section
DMA, 919-857-4021

Attention: Hospitals and Area Mental Health Centers

N.C. Medicaid Criteria for Continued Acute Stay in an Inpatient Psychiatric Facility

Following is a restatement of the criteria for continued acute stay in an inpatient psychiatric facility. The following criteria apply to individuals under the age 21 in a psychiatric hospital or in a psychiatric unit of a general hospital, and to individuals aged 21 through 64 receiving treatment in a psychiatric unit of a general hospital. These criteria shall be applied after the initial admission period of up to three days. To qualify for Medicaid coverage for a continuation of an acute stay in an inpatient psychiatric facility a patient must meet each of the conditions specified in Items (1) through (4) of this Rule. To qualify for Medicaid coverage for continued post-acute stay in an inpatient psychiatric facility, a patient must meet all of the conditions specified in Item (5) of this Rule.

(1) The patient has one of the following:
  (a) A current DSM-IV, Axis I diagnosis, or
  (b) A current DSM-IV, Axis II diagnosis and current symptoms/behaviors which are characterized by all of the following:
    (i) Symptoms/behaviors are likely to respond positively to acute inpatient treatment, and
    (ii) Symptoms/behaviors are not characteristic of patient's baseline functioning, and
    (iii) Presenting problems are an acute exacerbation of dysfunctional behavior patterns, which are recurring and resistive to change.

(2) Symptoms are not due solely to mental retardation.

(3) The symptoms of the patient are characterized by:
  (a) At least one of the following:
    (i) Endangerment of self or others, or
    (ii) Behaviors which are grossly bizarre, disruptive, and provocative (e.g., feces smearing, disrobing, pulling out hair), or
    (iii) Related to repetitive behavior disorders which present at least five times in a 24 hour period, or
    (iv) Directly result in an inability to maintain age appropriate roles, and
  (b) The symptoms of the patient are characterized by a degree of intensity sufficient to require continual medical nursing response management and monitoring.

(4) The services provided in the facility can reasonably be expected to improve the patient's condition or prevent further regression so that treatment can be continued on a less intensive level of care, and proper treatment of the patient's psychiatric condition requires services on an inpatient basis under the direction of a physician.

(5) Effective July 1, 2002, hospitals providing Criterion #5 services must submit claims for reimbursement to Medicaid through EDS and not through local management entities (LMEs). Contracts between hospitals and LMEs for Criterion #5 services are no longer necessary.

Criterion #5 services can only be provided if community placement is not available at the discharge date and both the hospital and LME are actively working on discharge planning. This service requires prior approval from the Program Accountability Section in the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (919-881-2446).

Claims must be submitted on a UB-92 form (hospital outpatient claim type M) using revenue center code 902, procedure code Y2343, and bill type 141. The Medicaid rate is $248.40 per day. Only one (1) unit is allowable per date of service. Only physician visits and case management may be billed in addition to procedure code Y2343.

Carol Robertson, Behavioral Health Section
DMA, 919-857-4040

Attention: Independent Practitioners and Local Education Agencies

Speech/Language Therapy Code Changes

Effective with date of service April 1, 2003, the following speech/language codes will be end-dated and replaced with new CPT codes. Claims submitted after April 1, 2003 will deny if end-dated codes are used.

End-Dated Code(s)	New CPT Code(s)	Description
G0193	92612	***Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording***
G0195	92610	***Evaluation of oral and pharyngeal swallowing function***
G0197	92607	***Evaluation for prescription for speech-generating augmentative and alternative communication device, face to face with the patient; first hour***
G0199	92607 and 92608	***Evaluation for prescription for speech-generating augmentative and alternative communication device, face to face with the patient; first hour*** ***Each additional 30 minutes (use 92608 in conjunction with 92607)***
G0198	92609	***Therapeutic services for the use of speech-generating device, including programming and modification***

Nora Poisella, Medical Policy Section
DMA, 919-857-4020

Attention: Physicians, Nurse Practitioners, and Dialysis Providers

Darbepoetin Alfa, 5 mcg (Aranesp, J0880) – Billing Guidelines

Effective with date of service January 1, 2003, the N.C. Medicaid program covers darbepoetin alfa (Aranesp) for use in the Physician's Drug Program. Aranesp is indicated for the treatment of anemia associated with chronic renal failure and with chemotherapy for the treatment of malignancy. It is normally administered weekly or biweekly. For Medicaid billing, one unit of coverage is 5 mcg. The maximum reimbursement rate per unit is $22.50. Providers must bill their usual and customary charge. This drug should be added to the lists of injectable drugs published in the June 2002 and August 2002 general Medicaid bulletins.

Aranesp is covered for recipients under the following conditions:

1. If the recipient has a primary diagnosis of chronic renal failure (ICD-9-CM **585**), a secondary diagnosis of 284.9, 285.21, 285.8 or 285.9 must be present.
2. If the recipient has a primary diagnosis of chemotherapy (**V58.1**), a secondary diagnosis of 285.8, or 285.9 must be present.

Billing Requirements for Physicians and Nurse Practitioners

- Use the CMS-1500 claim form.
- Enter ICD-9-CM diagnosis code **585 or V58.1, and one** of the diagnosis codes indicated above in block 21.
- Enter the date of service in block 24A.
- Enter the place of service in block 24B.
- Enter HCPCS code J0880 in block 24D.
- Enter the total charges in block 24F.
- Enter the units given in block 24G (5 mcg = 1 unit).

Example:

21 Diagnosis	**24A** **Date(s) of Service**	**24B** **Place of Service**	**24D** **Procedures, Services or Supplies**	**24F** **Charges**	**24G** **Days or Units**
585 285.8	02042003	11	J0880	$	40

Note: Physicians cannot bill an evaluation and management (E/M) code in addition to an injection administration code, CPT 90782.

Billing Requirements for Dialysis Treatment Facilities

Dialysis treatment facilities may bill for Aranesp in addition to the dialysis composite rate. Administration supply costs are included in the dialysis composite rate.

- Use the UB-92 claim form.
- Enter revenue code 250 in form locator 42.
- Enter the description of the drug in form locator 43.
- Enter HCPCS code J0880 in form locator 44.
- Enter the date of service in form locator 45.
- Enter the units given in form locator 46 (5 mcg = 1 unit).
- Enter the total charges in form locator 47.
- Enter diagnosis code **585** or **V58.1** in form locator 67, **and**
- Enter a diagnosis code as indicated above in form locators 68 through 75.

Example:

42 Rev Code	43 Description	44 HCPCS/Rate	45 Serv Date	46 Serv Units	47 Total Charges
250	Aranesp 5 mcg	J0880	02042003	40	$

67 Prin Diag Cd	68 Code	69 Code	70 Code	71 Code	72 Code	73 Code	74 Code	75 Code
585	285.8							

Physicians, nurse practitioners or dialysis facility providers who have administered this drug to recipients on dates of service June 1, 2002 through December 31, 2002 may bill Medicaid using J3490. These claims must be submitted on paper with an invoice. **An invoice must be submitted with each claim.** The paper invoice must indicate the name of the recipient, the recipient's Medicaid identification number, the name of the medication, the dosage given, the National Drug Code (NDC) number from the vial(s) used, the number of vials used of each NDC, and the cost per dose.

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

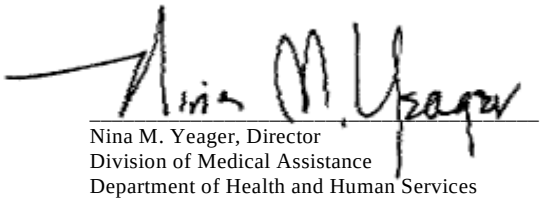
Checkwrite Schedule

March 4, 2003	April 8, 2003	May 6, 2003
March 11, 2003	April 15, 2003	May 13, 2003
March 18, 2003	April 22, 2003	May 20, 2003
March 27, 2003		May 29, 2003

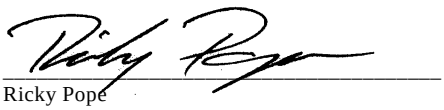
Electronic Cut-Off Schedule

March 7, 2003	April 4, 2003	May 2, 2003
March 14, 2003	April 11, 2003	May 9, 2003
March 21, 2003	April 17, 2003	May 16, 2003
		May 23, 2003

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.



Nina M. Yeager, Director
Division of Medical Assistance
Department of Health and Human Services



Ricky Pope
Executive Director
EDS

e

Presorted Standard
U.S. POSTAGE
PAID
Raleigh, N.C.
Permit No. 1087

P.O. Box 300001
Raleigh, North Carolina 27622