North Carolina Medicaid Bulletin

Published as an Informational Service to Medicaid Providers by the Division of Medical Assistance and EDS, Fiscal Agent for the N.C. Medicaid Program

Number 3 **March 2004**

In This Issue . . .

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

Attention: All Providers

Hepatitis A and Hepatitis B Vaccine, Adult Dosage, for Intramuscular Use (CPT Code 90636, 1 ml, Twinrix) Coverage Criteria

Effective with date of service January 1, 2004, the N.C. Medicaid program covers Twinrix, the combination hepatitis A and hepatitis B vaccine. Twinrix is FDA approved for persons 18 years of age and older who are at risk of both hepatitis A and hepatitis B infection. Twinrix is normally given as a series of three 1.0 ml injections over a six-month period of time at intervals of 0, 1, and 6 months. CPT code 90636 must be billed for Twinrix.

The N.C. Medicaid program reimburses for vaccines in accordance with guidelines from the Advisory Committee on Immunization Practices (ACIP). Information regarding the risk categories pertinent to hepatitis vaccines may be found at http://www.cdc.gov/nip/publications/ACIP/default.htm.

The North Carolina Immunization Branch distributes Twinrix vaccine at no charge to **health departments only**. It is to be administered to those persons 18 years of age and older who present to the local health department for any reason with any of the following risk criteria:

- men who have sex with men
- IV drug users
- persons with multiple sex partners
- any person who has been incarcerated
- persons who are hepatitis C or are HIV positive
- persons with chronic liver disease, including persons with chronic HBV/HCV infection who have evidence of chronic liver disease
- persons seeking treatment for a sexually transmitted disease (STD)

Reimbursement Guidelines

1. Medicaid does not reimburse **local health departments** for the cost of Twinrix vaccine supplied by the North Carolina Immunization Branch. Medicaid only reimburses local health departments for the **administration** of Twinrix vaccine.

   Local health departments must bill CPT code 90471 for the administration of Twinrix vaccine. When billing for Health Check recipients aged 18 through 20, refer to Special Bulletin I, April 2003, *Health Check Billing Guide 2003.*

2. Because Twinrix can only be supplied at no cost from the North Carolina Immunization Branch to local health departments, **private providers** may bill Medicaid for the cost of Twinrix vaccine for high-risk adults aged 18 years and over using CPT code 90636.

   Private providers may bill for the administration of Twinrix vaccine using CPT code 90471. When billing for Health Check recipients aged 18 through 20, refer to Special Bulletin I, April 2003, *Health Check Billing Guide 2003.*

3. For recipients aged 21 years and over, an Evaluation and Management (E/M) code cannot be reimbursed on the same day that injection administration fee code 90471 is reimbursed unless the provider bills an E/M code for a separately identifiable service by appending modifier 25 to the E/M code.

4. For recipients aged 21 years and older, diagnosis code V05.3 must be billed. When billing for Health Check recipients aged 18 through 20, refer to Special Bulletin I, April 2003, *Health Check Billing Guide 2003* for diagnosis code billing guidelines.

For Medicaid billing, one unit of coverage is 1 ml. Providers must indicate the number of units given in block 24G on the CMS-1500 claim form. The maximum reimbursement rate for Twinrix is $85.04 per unit. Providers must bill their usual and customary charges.

Claims that were denied for dates of service January 1, 2004 and after may be refiled as new claims.

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

Attention: All Providers

Claim Adjustments for Physician, Laboratory, and Independent Mental Health Procedure Codes

N.C. Medicaid will be adjusting claims for physician procedure codes, laboratory procedure codes, and independent mental health procedure codes that had a rate change in 2003. These adjustments will begin on the March 2, 2004 checkwrite and will continue for at least three of the following checkwrites. Should you have any questions, please contact EDS Provider Services at 1-800-688-6696.

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

Attention: All Providers

Optional Sixth Dose of Synagis for the 2003-04 RSV Season for Previously Approved Infants

In September 2003, the criteria for prescribing Synagis for the 2003-04 respiratory syncytial virus (RSV) season was posted on ACS State Healthcare's website at http://www.ncmedicaidpbm.com. The criteria calls for up to five total doses of Synagis during the 2003-04 RSV season. This decision is supported both in the literature and in the American Association of Pediatrics' Redbook guidelines.

In February 2004, a group of pediatric and infectious disease specialists met to evaluate the current RSV season in North Carolina. They determined that in certain parts of North Carolina the RSV season may extend an additional month. Thus, depending on the prevalence of RSV in their community, N.C. Medicaid providers may choose to prescribe a 6th dose of Synagis given on or before March 31, 2004 for those infants who have already received approval for the 2003-04 season. The end date for the 6th dose is based on evidence that effectiveness of the drug extends well past 30 days.

In accordance with the American Association of Pediatrics' guidelines, children born in March should receive their March dose prior to discharge from the hospital.

If an additional dose is required due to prevalence of RSV in the community, medical providers should contact their pharmacy provider. The pharmacy provider will be able to adjudicate the prescription claim through point of sale (POS) by March 1, 2004.

Sharman Leinwand, Medical Policy Section
DMA, 919-857-4020

Attention: All Providers

Payment Accuracy Measurement Project for 2004-05

The Improper Payments Act of 2002 (HR 4878) requires federal government agencies to provide an estimate of their improper payments annually. CMS has awarded funding to 27 states to pilot and test a sampling and to review methodology in preparation for a nationwide implementation in the near future. The Division of Medical Assistance (DMA) will again be participating with this effort.

Sampling

DMA Program Integrity staff will:

- Select a statistically valid, random stratified sample for both Medicaid and the N.C. Health Choice programs. The mandatory strata will be:
  1. inpatient hospital services,
  2. long-term care services,
  3. independent practitioners and clinics,
  4. prescription drugs,
  5. home and community based services
  6. other supplies and services, and
  7. primary care case management.
- Select approximately 500 claims that paid in calendar year 2003.
- Contact each provider associated with a sampled paid claim and request specific medical documentation and records that support the services provided. (**Note:** If you are contacted, it is critical that you return this information as quickly as possible.)
- Review each claim and capitation payment in detail to determine whether or not the claim was paid accurately (there was sufficient medical documentation in the provider's medical record to support the claim, all necessary prior approvals were obtained; the provider complied with DMA policies and procedures, recipient was eligible on date of service, etc.).

Consequences of Non-response

If the medical documentation is not submitted, the claim will be coded as an error and will be recouped. Because the dollars in error are projected onto the total claims universe in North Carolina, the consequence of each error or non-response magnifies its impact. If the error rate is excessive, DMA may have to add controls or other limitations to address any problem areas that are identified. Therefore, even a small dollar claim payment can have a significant impact on how a particular service area is perceived.

Medical Record Requests

Also, please note that requests for medical records are a permitted disclosure under HIPAA privacy regulations. 45 CFR 164.512 states that " a covered entity may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits…or other activities necessary for the appropriate oversight of (1) the health care system; (2) government benefit programs for which health information is relevant to beneficiary eligibility; (3) entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards; or (4) entities subject to civil rights laws for which health information is necessary for determining compliance." In addition, Medicaid providers are required to comply with a medical records request from an authorized Medicaid employee.

We appreciate your continued cooperation. If you have any questions, please contact Chuck Brownfield, DMA Program Integrity at 919-733-6681, ext. 275. More information about the PAM project can be found at http://www.pampilot.org/tiki-custom_home.php

Chuck Brownfield, Program Integrity
DMA, 919-733-6681, ext. 275

Attention: All Providers

Influenza - New Diagnosis Code for the Need for Vaccination Against Influenza

This article was originally printed in the January 2004 general Medicaid bulletin under the title *Influenza - New Diagnosis Code V04.81*. This article is being reprinted to clarifiy that ICD-9-CM diagnosis code V04.81 is used to indicate that there is a need for a vaccination against influenza. This code is not used to indicate that the recipient has influenza.

Effective with date of service October 1, 2003, the N.C. Medicaid program covers the new diagnosis code for the need for influenza vaccination, V04.81. Diagnosis code V04.8 is no longer a valid diagnosis code. Providers who have had claims denied with V04.81 may resubmit them for payment.

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

Attention: All Providers

Updated EOB Code Crosswalk to HIPAA Standard Codes

The list of standard national codes used on the Electronic Remittance Advice (ERA) has been cross-walked to EOB codes as an informational aid to adjudicated claims listed on the RA. An updated version of the list will be available on March 10, 2004 on the Division of Medical Assistance's website at http://www.dhhs.state.nc.us/dma/prov.htm.

With the implementation of standards for electronic transactions mandated by the Health Insurance Portability and Accountability Act, providers now have the option to receive an ERA in addition to the paper version of the Remittance and Status Report (RA).

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

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

Attention: All Providers

Physician's Drug Program Changes

Effective with date of service January 1, 2004, the N.C. Medicaid program covers the new HCPCS codes listed in the table below. Effective with dates of service March 31, 2004, the old codes will be end-dated. Claims submitted for dates of service on or after April 1, 2004 with the end-dated codes will deny. Refer to the table below for the new HCPCS codes and their corresponding end-dated codes.

Note: The units of coverage on several drugs have changed and some drugs no longer require an invoice to be submitted with the claim. As a reminder, the paper invoice must include the name of the medication, the dosage given, the National Drug Code (NDC) number from the vial(s) used, the number of vials used, and the cost per dose. Where an invoice is required, one must be submitted with each claim.

New Code	Maximum Reimbursement Rate	Description	Old Code	Description
J0152	$ 68.37	Injection, adenosine, **30 mg** (not to be used to report any adenosine phosphate compounds;	J0151	Injection, adenosine, 90 mg (not to be used to report any adenosine phosphate compounds;
J0215	$ 28.19 Invoice not required	Injection, alefacept **0.5 mg** (Amevive)	J3490	Injection, alefacept, 7.5 mg or 15 mg (Amevive)
J0595	$ 3.94	Injection, butorphanol tartrate, 1 mg (Stadol)	S0009	Injection, butorphanol tartrate, 1 mg (Stadol)
J2001	$ 0.88	Injection, lidocaine HCl for intravenous infusion, **10 mg**	J2000	Injection, lidocaine HCl, 50 cc
J2354	$ 3.81	Injection, octreotide, **non-depot form** for subcutaneous or intravenous injection, **25 mcg**	S0079	Injection, octreotide acetate, 100 mcg (Sandostatin)
J2353	$ 138.19 - 10 mg $ 79.35 - 20 mg $ 71.12 - 30 mg Invoice required	Injection, octreotide, **depot form** for intramuscular injection, 1 mg (Sandostatin)	J2352	Injection, octreotide acetate, 1 mg (Sandostatin LAR depot, pricing based on 10, 20 or 30 mg)
J2505	$ 2,507.50	Injection, pegfilgrastim, 6 mg (Neulasta)	S0135	Injection, pegfilgrastim, 6 mg, (Neulasta)

New HCPCS Codes Covered for the Physician's Drug Program, continued

New Code	Maximum Reimbursement Rate	Description	Old Code	Description
J9178	$ 24.73	Injection, epirubicin HCl, **2 mg**	J9180	Injection, epirubicin hydrochloride, 50 mg
J9263	$ 8.45	Injection, oxaliplatin, **0.5 mg** (Eloxatin)	J9999	Injection, oxaliplatin, 50 mg (Eloxatin)
J9395	$ 78.37	Injection, fulvestrant, 25 mg (Faslodex)	J9999	Injection, fulvestrant, 25 mg (Faslodex)
S0107	$ 76.68 Invoice not required	Injection, omalizumab, **25 mg** (Xolair)	J3490	Injection, omalizumab, 150 mg (Xolair)
S0115	$ 930.24 Invoice not required	Injection, bortezomib, 3.5 mg	J9999	Injection, bortezomib, (Velcade) 3.5 mg
J3490	$ 6.94 Invoice is required	Injection, kutapressin, up to **1 ml**	J1910	Injection, kutapressin, up to 2ml

Providers must indicate the number of units given in block 24G on the CMS-1500 claim form. Providers must bill their usual and customary charges.

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

Attention: Nursing Facility Providers

Correction to Instructions for Obtaining Retroactive Prior Approval

A correction has been made to the February 2004 general Medicaid bulletin article titled *A Reminder about Retroactive Prior Approval*. EDS may **only** approve up to 30 days of retroactive coverage by telephone. Retroactive coverage exceeding 30 days, but less than 90 days must be made in writing and include all pertinent medical records for the dates of service requested.

Requests for retroactive coverage exceeding 90 days must be submitted to DMA. The request must be made in writing and include all pertinent medical records for the dates requested. DMA will not approve requests for retroactive coverage exceeding 180 days from the date of receipt of the records that document the level of care requested.

It is the responsibility of the nursing facility to ensure that the initial FL2 request for prior approval is on file with EDS when a recipient is admitted to their facility.

Linda R. Perry, R.N. Long-term Care Nurse Consultant
DMA, 919-857-4020

Attention: Durable Medical Equipment Providers

National Miscellaneous HCPCS Codes

Effective with date of service March 1, 2004, national miscellaneous HCPCS codes will replace state-created codes as indicated below. The change is being made to comply with the implementation of standard national codes mandated by the Health Insurance Portability and Accountability Act (HIPAA).

New HCPCS Code	Old State-Created Code	
A9900	W4120	Disposable bags for Inspirease inhaler system, set of 3
	W4153	Tracheostomy ties, twill
	W4651	Blood glucose test strips
	W4670	Sterile saline, 3cc vial
	W4672	Gray adapter for use w/ external insulin pump
	W4673	Piston rod for use w/ external insulin pump
	W4678	Replacement battery for portable suction pump
B9998	**Low profile gastrostomy equipment:**	
	W4210	Low profile gastrostomy kit
	W4211	Low profile gastrostomy extension/replace kit for continuous feed
	W4212	Low profile gastrostomy extension/replace kit for bolus feed
E1399	**Ambulatory devices:**	
	W4688	Single point cane for weights 251# to 600#
	W4689	Quad point cane for weights 251# to 600#
	W4690	Crutches for weights 251# to 600#
	W4691	Fixed height forearm crutches for weights to 600#
	W4695	Glides/skis for use w/ walker
	Bariatric replacement mattresses for hospital beds:	
	W4733	Replacement overszd innerspring matt for hosp bed w/ width to 39"
	W4734	Replacement overszd innerspring matt for hosp bed w/ width to 48"
	W4735	Replacement overszd innerspring matt for hosp bed w/ width to 54"
	W4736	Replacement overszd innerspring matt for hosp bed w/ width to 60"
	W4737	Trapeze bar, freestanding w/ grab bar for weights 451# to 750#
	Bariatric hospital beds:	
	W4726	Total electric hosp bed weights 351# to 450# w/ matt and side rails
	W4730	Total electric hosp bed 451# to 1000# w/ width 39"w/ matt and side rails
	W4731	Total electric hosp bed 451# to 1000# w/ width 48"w/ matt and side rails
	W4732	Total electric hosp bed 451# to 1000# w/ width 54"w/ matt and side rails
	Other equipment:	
	W4001	CO/2 saturation monitor w/ accessories, probes
	W4002	Manual ventilation bag
	W4016	Bath seat, pediatric
	W4047	Miscellaneous pediatric equipment
	W4633	Eggcrate mattress pad

National Miscellaneous HCPCS Codes for Durable Medical Equipment, continued

New HCPCS Code	Old State-Created Code	
K0009	**Manual pediatric wheelchairs:**	
	W4122	Pediatric wheelchair, lightweight manual
	W4123	Pediatric wheelchair, lightweight manual w/ growth system
	W4124	Pediatric wheelchair, ultra lightweight manual
	Manual bariatric wheelchairs:	
	W4696	Manual wheelchair for weights 451# to 600#
	W4697	Manual wheelchair for weights 651# and greater
K0014	**Power pediatric wheelchairs:**	
	W4125	Pediatric wheelchair, power, rigid frame
	W4126	Pediatric wheelchair, power, folding frame
	Power bariatric wheelchairs:	
	W4704	Power wheelchair for weights 251# to 600#
	W4705	Power wheelchair for weights 651# to 1000#
	W4706	Power wheelchair for weights 1001# and greater
K0108	W4005	Unlisted replacement or repair parts
	W4117	Wheelchair seat width, cost added option from manufacturer
	W4118	Wheelchair seat depth, cost added option from manufacturer
	W4119	Wheelchair seat height, cost added option from manufacturer
	W4128	Solid back equipment with hardware (ea)
	W4129	Solid seat equipment with hardware (ea)
	W4130	Contoured or 3-piece head/neck supports with hardware (ea)
	W4131	Basic head/neck support w/ hardware (ea)
	W4132	Contoured or 3-piece head/neck supports with adj. hardware (ea)
	W4133	Basic head/neck support w/ adj. hardware (ea)
	W4134	Shoulder stabilizers w/ hardware, including pads (pr)
	W4135	Shoulder stabilizers w/ hardware, including H-strap (ea)
	W4136	Fixed thoracic supports w/ hardware (pr)
	W4137	Adjustable thoracic supports w/ hardware (pr)
	W4138	Hip/thigh supports w/ hardware (pr)
	W4139	Sub-asis bars w/ hardware (ea)
	W4140	Abductor pads w/ hardware (pr)
	W4141	Knee blocks w/ hardware (pr)
	W4143	Shoe holders w/ hardware (pr)
	W4144	Foot/legrest cradle (ea)
	W4145	Manual tilt-in-space option (ea)
	W4146	Power tilt-in-space option (ea)

National Miscellaneous HCPCS Codes for Durable Medical Equipment, continued

New HCPCS Code	Old State-Created Code	
K0108, continued	**Bariatric wheelchair components:**	
	W4147	Power recline (ea)
	W4148	Modular back w/ hardware (ea)
	W4150	Multi-adj. tray (ea)
	W4151	Specialty controls w/ hardware (ea)
	W4152	Growth kit (ea)
	W4155	Abductor pads w/ hardware (pr)
	W4698	Seat width 21" and 22" for oversized manual wheelchair
	W4699	Seat width 23" and 24" for oversized manual wheelchair
	W4700	Seat width 25" and greater for oversized manual wheelchair
	W4701	Seat depth 19" and 20" for oversized manual wheelchair
	W4702	Seat depth 21" and 22" for oversized manual wheelchair
	W4703	Seat depth 23" and greater for oversized manual wheelchair
	W4707	Seat width 21" and 22" for oversized power wheelchair
	W4708	Seat width 23" and 24" for oversized power wheelchair
	W4709	Seat width 25" and greater for oversized power wheelchair
	W4710	Seat depth 19" and 20" for oversized power wheelchair
	W4711	Seat depth 21" and 22" for oversized manual wheelchair
	W4712	Seat depth 23"and greater for oversized power wheelchair
	W4713	Oversized footplates for weights 301#
	W4714	Swingaway special footrests for weight 401# and greater (pr)
	W4715	Swingaway reinforced legrest elevating for weight 301# to 400# (pr)
	W4716	Swingaway footrests, elevating for weight 401# and greater (pr)
	W4717	Oversized calf pads (pr)
	W4718	Oversized solid seat
	W4719	Oversized solid back
	W4720	Oversized 2" cushion
	W4721	Group 27 Gel cell battery
	W4722	Oversized full support footboard
	W4723	Oversized full support calfboard

Prior Approval

All of these national miscellaneous HCPCS codes require prior approval beginning with dates of service March 1, 2004. Both the national miscellaneous HCPCS code and the state-created code must be indicated on the Certificate of Medical Necessity and Prior Approval Form (CMN/PA). Enter the national miscellaneous HCPCS code in the "HCPCS Code" block on the CMN/PA form. The state-created code must be entered in the "Equipment Description" field.

For example, if providing a "Basic head/neck support w/ hardware (ea)" and a "Solid back equipment with hardware (ea)," indicate that you are requesting prior approval for rental of K0108 for W4131, "Basic head/neck support w/ hardware (ea)" by entering the K0108 in the "HCPCS Code" field with the state-created code W4131 entered in the "Equipment Description" field. On the next line, enter K0108 in the "HCPCS Code" field with the state-created code W4128, "Solid back equipment with hardware (ea)" entered in the Equipment Description field. Include the "from" and "to" dates for each piece of equipment that is needed. All existing documentation requirements remain the same.

Note: Prior approval will be given for a year for state-created codes listed under national miscellaneous HCPCS code A9900 and B9998 if the prescribing physician, physician's assistant or nurse practitioner deems them medically necessary for a year and writes the prescription for a year.

The EDS prior approval staff will enter an 11-digit number in the "Service Review Number" field beside each item approved with a national miscellaneous code. Providers **must** use this number when submitting claims for payment for national miscellaneous codes.

Claim Submission

When submitting a claim, providers must enter the 11-digit service request number (SRN) from the approved CMN/PA form in block 23 of the CMS-1500 claim form or in the "PA-Num" field if submitting electronically (EVS, NCECS, 837 or tape). **This is different from previous billing procedures.** If the SRN is not included on the claim when billing for a national miscellaneous code, the claim cannot be processed for payment and will be denied.

Providers can only submit one national miscellaneous code per claim. If a provider submits multiple national miscellaneous codes on the same claim, the claim cannot be processed for payment. Providers may submit other HCPCS codes on the claim with the national miscellaneous code as long as there is only one miscellaneous code per claim.

Note: The appropriate modifier must be included on the claim in order for the claim to process.

Example

	Type of Claim	
	Electronic	**Paper**
Dates of Service	03/01/04 – 03/31/04	03/01/04 – 03/31/04
Procedure Billed	K0108 RR	K0108 RR

Providers who have already received an approval for any of these items that crosswalked to any of the national miscellaneous codes and who have approval dates that extend into March 2004 will receive by mail the appropriate SRNs for use on those claims. For any item requested on or after March 1, 2004, providers must use the SRN entered by the EDS prior approval staff on the CMN/PA form.

The coverage criteria for these items have not changed. Refer to Medical Coverage Policy #5, Durable Medical Equipment for detailed coverage information.

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

Attention: Durable Medical Equipment Providers

Addition to Medical Coverage Policy #5, Durable Medical Equipment

A new attachment has been added to Medical Coverage Policy #5, Durable Medical Equipment, on DMA's website http://www.dhhs.dtate.nc.us/dma/mp/mpindex.htm. Attachment D, Frequently Asked Questions, has been renumbered as Attachment E. The new Attachment D is a listing of lifetime expectancies and quantity limitations for items on the DME Fee Schedule.

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

Attention: Hospitals

Medicaid Cost Reports

During the week of February 9, 2003, the Medicaid Provider Statistics and Reimbursements (PS&Rs) for the fiscal year ending June 30, 2003 were mailed to the Hospital Chief Financial Officers. The due date for the June 30, 2003 Medicaid Cost Report will be the later of 30 days after the due date of the Medicare Cost Report or March 19, 2003.

EDS is currently preparing the PS&Rs for the fiscal year ending September 30, 2003 but does not have a projected mailing date at this time. The due date for the September 30, 2003 Medicaid Cost Report will be the later of 30 days after the due date of the Medicare Cost Report or 30 days after the mailing of the Medicaid PS&Rs.

The Division of Medical Assistance's Supplemental Cost Report forms are available to download from DMA's website at http://www.dhhs.state.nc.us/dma/prov.htm under the heading "Cost Reports." When filing the Medicaid Cost Report, DMA will need a paper copy and an electronic file of the Medicare Cost Report as well as a paper copy and electronic file of the Medicaid Supplemental Forms.

DMA will update the Cost Report filing deadlines as more information becomes available from EDS and Palmetto GBA.

Roger Barnes, Financial Operations
DMA, 919-857-4015

Attention: Health Check Providers

Health Check Seminars

Health Check seminars for all providers except health departments are scheduled for May 2004. The April 2004 general Medicaid bulletin will have the registration form and a list of site locations for the seminars. Attendance at these seminars is very important due to changes in Health Check billing requirements. The seminars will also focus on vision and hearing assessments and developmental screening requirements.

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

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

Proposed Medical Coverage Policies

In accordance with Session Law 2003-284, 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
Division of Medical Assistance
Medical 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.

Checkwrite Schedule

March 2, 2004	April 6, 2004	May 4, 2004
March 9, 2004	April 13, 2004	May 11, 2004
March 16, 2004	April 20, 2004	May 18, 2004
March 25, 2004	May 5, 2004	May 27, 2004

Electronic Cut-Off Schedule

February 27, 2004	April 2, 2004	May 7, 2004
March 5, 2004	April 8, 2004	May 14, 2004
March 12, 2004	April 16, 2004	May 21, 2004
March 19, 2004	April 30, 2004	

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.

Gary H. Fuquay, Acting Director
Division of Medical Assistance
Department of Health and Human Services

Patricia MacTaggart
Executive Director
EDS