Number 3 *March 2006*

North Carolina Medicaid Bulletin

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

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

Attention: All Providers

Carolina ACCESS Override Requests

The fax number for submitting Carolina ACCESS Override Requests has been changed to 919-816-4420.

This fax line is dedicated to **Carolina ACCESS Override Requests only.** Override requests for current or future dates of service can be made via telephone, 919-816-4321.

Override requests for past dates of service must be submitted in writing via fax or mail. Referrals faxed to the old number do not need to be sent a second time.

EDS, 1-919-816-4321

Attention: All Providers

Clinical Coverage Policies

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

1A-19 – Transcranial Doppler Studies
1C-1 – Podiatry Services
1C-2 – Medically Necessary Routine Foot Care

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

Contacting EDS – Automated Attendant Telephone Line Instructions

The Automated Attendant Telephone Line (1-800-688-6696 or 919-851-8888) has been revised to include more options for providers when calling EDS. Calls made from a touch-tone telephone can be routed to the appropriate units by an automated attendant as follows:

For IPRS Provider Relations	Dial 5-3355
For NC PASARR	Dial 5-3505
Press 1 for Electronic Commerce Services	Press 1 to reach an ECS Analyst
Press 2 for Prior Approval	Press 802 - Optical or Hearing Aid
	Press 803 - Long Term Care, Surgery or Out of State
	Press 804 – Dental
	Press 805 - Durable Medical Equipment
	Press 809 – Enhanced Care, Therapeutic Leave or Hospice
	Press 819 - Prior Approval Denial Notices
Press 3 for Provider Services	Press 806 – Physician's Offices
	Press 806 – County Health Department
	Press 806 - Independent Practitioner
	Press 806 - Local Education Agency
	Press 807 – Hospitals
	Press 807 – Long-Term Care Facility
	Press 807 – Community Intervention Service Agencies
	Press 807 – Residential Child Care Facility (Level II-IV)
	Press 807 - Hearing Aid
	Press 807 - Dialysis
	Press 807 - Area Mental Health
	Press 808 – Dental
	Press 808 – Home Health Care Agency
	Press 808 – Personal Care Services
	Press 808 – Private Duty Nursing
	Press 808 – Durable Medical Equipment
	Press 808 – Ambulance
	Press 808 – RHC/FQHC
	Press 808 – Adult Care Homes
	Press 808 – Community Alternative Programs
	Press 808 – Home Infusion Therapy
	Press 808 – Hospice
	Press 808 – At-Risk Case Management
	Press 817 - Pharmacy

Medicaid recipients are instructed to press 6 which will direct recipients to call the Care Line Information and Referral Service at 1-800-662-7030. To speak with the receptionist providers are instructed to press 0.

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

Attention: All Providers

Corrected 1099 Requests – Action Required by March 1, 2006

Providers receiving Medicaid payments of more than $600 annually have been sent a 1099 MISC tax form from EDS. The 1099 MISC tax form is generated as required by IRS guidelines. They were mailed to individual providers and groups on January 24, 2006. The 1099 MISC tax form reflects the tax information on file with Medicaid as of the last Medicaid checkwrite cycle date, December 22, 2005.

If the tax name or tax identification number on the annual 1099 MISC you receive is **incorrect (for example, misspelled or transposed)**, a correction to the 1099 MISC must be requested. This ensures that accurate tax information is on file 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: If claims were billed under an individual provider number rather then a group number, the individual is considered to have received the income and the 1099 will reflect the individual's tax ID associated with the individual provider number rather than a Federal ID number, which is associated with a group number. This is not the type of change that corrected 1099's address. If that is your situation, please bill under your group number as soon as you identify the issue.

A correction to the original 1099 MISC must be **submitted to EDS by March 1, 2006** and must be accompanied by the following documentation:

- A copy of the original 1099 MISC
- A signed and completed IRS W-9 form clearly indicating the correct tax identification number and tax name. (Additional instructions for completing the W-9 form can be obtained at www.irs.gov under the link "Forms and Pubs.")

Fax both documents to 919-816-3186-Attention: Corrected 1099 Request - Financial

Or

Mail both documents to:

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

A copy of the corrected 1099 MISC 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

Resubmitting Claims for Ophthalmology Procedure Codes with Modifiers 26 and TC

Medicaid's claims processing system has been updated to cover ophthalmology procedure codes billed with modifiers 26 (professional component) and TC (technical component) for dates of service **January 1, 2004** and after when billed with the following ophthalmology procedure codes: 92060, 92081, 92082, 92083, 92235, 92265, 92270, 92275, 92283, and 92284. This change is being made to comply with the Centers for Medicare and Medicaid Services (CMS).

Claims submitted for these procedure codes with modifiers 26 or TC that were denied may be resubmitted as a new claim. If the claim was initially received and processed within the 365-day time limit, providers have 18 months from the date of the Remittance Advice to refile the claim. The claim may be resubmitted electronically or on paper as a new claim. Claims that have exceeded the 365-day time limit must be submitted on paper with a Medicaid Resolution Inquiry form and documentations supporting a time limit override. For addition information on time limit overrides, refer to the Basic Medicaid billing Guide on DMA's website at http.//www.dhhs.state.nc.us/dma/medbillcaguide.htm.

When applicable, the following modifiers are also covered, effective with date of service **December 1, 2005**:

- Modifier 50 (bilateral procedure) with CPT code 92136;
- Modifier 53 (discontinued procedure) with CPT codes 92060, 92081, 92082, 92083, 92265, 92270, 92275, 92283, and 92284; and
- Modifiers 76 (repeat procedure by the same physician) and 77 (repeat procedure by another physician) with CPT codes 92060, 92135, 92235, and 92240.

For additional information on billing with modifiers, refer to the April 1999 Special Bulletin, *Modifiers*, on DMA's website at http://www.dhhs.state.nc.us/dma/bulletin.htm. The rates for 2004 and 2005 are as follows:

				2004 Rates							2005 Rates	
CPT CODE	TOS	MOD	EFF DATE	Non-facility FEE	Facility FEE		CPT CODE	TOS	MOD	EFF DATE	Non-facility FEE	Facility FEE
92060	5	26	1/1/2004	31.56	31.56		92060	5	26	1/1/2005	34.96	34.96
92060	T	TC	1/1/2004	13.88	13.88		92060	T	TC	1/1/2005	14.88	14.88
92081	5	26	1/1/2004	16.83	16.83		92081	5	26	1/1/2005	18.19	18.19
92081	T	TC	1/1/2004	22.27	22.27		92081	T	TC	1/1/2005	26.54	26.54
92082	5	26	1/1/2004	20.36	20.36		92082	5	26	1/1/2005	22.40	22.40
92082	T	TC	1/1/2004	30.04	30.04		92082	T	TC	1/1/2005	34.86	34.86
92083	5	26	1/1/2004	23.23	23.23		92083	5	26	1/1/2005	25.56	25.56
92083	T	TC	1/1/2004	35.01	35.01		92083	T	TC	1/1/2005	40.53	40.53
92265	5	26	1/1/2004	35.65	35.65		92235	5	26	1/1/2005	41.94	41.94

				2004 Rates							2005 Rates	
CPT CODE	TOS	MOD	EFF DATE	Non-facility FEE	Facility FEE		CPT CODE	TOS	MOD	EFF DATE	Non-facility FEE	Facility FEE
92265	T	TC	1/1/2004	50.44	50.44		92235	T	TC	1/1/2005	75.98	75.98
92270	5	26	1/1/2004	37.61	37.61		92265	5	26	1/1/2005	39.41	39.41
92270	T	TC	1/1/2004	38.63	38.63		92265	T	TC	1/1/2005	40.76	40.76
92275	5	26	1/1/2004	46.46	46.46		92270	5	26	1/1/2005	40.84	40.84
92275	T	TC	1/1/2004	47.96	47.96		92270	T	TC	1/1/2005	40.42	40.42
92283	5	26	1/1/2004	7.89	7.89		92275	5	26	1/1/2005	51.37	51.37
92283	T	TC	1/1/2004	24.13	24.13		92275	T	TC	1/1/2005	50.75	50.75
92284	5	26	1/1/2004	10.77	10.77		92283	5	26	1/1/2005	8.68	8.68
92284	T	TC	1/1/2004	69.81	69.81		92283	T	TC	1/1/2005	25.87	25.87
							92284	5	26	1/1/2005	11.54	11.54
Source:	DMA	Rate	Setting				92284	T	TC	1/1/2005	60.17	60.17

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

Extension of the Medicare Part D Transitional Coverage Period

The U.S. Department of Health and Human Services has notified Medicare Part D prescription drug plans (PDP's) that the 30-day transitional coverage period will be extended for an additional 60 days. This will provide more time for beneficiaries to find out if they can save money by using other drugs that work in similar ways and may cost significantly less. This action reinforces steps already taken by many PDP's to help assure a smooth transition for beneficiaries.

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

Attention: All Providers

Medicare Part D Exceptions and Appeals Information from CMS

If a provider is seeking prior authorization or a formulary exception from a Medicare Part D prescription drug plan (PDP) and the plan's routine protocol fails or the contacts are being made after normal business hours, the exceptions numbers that are provided on the Centers for Medicare and Medicaid Services (CMS) website may be used. The Medicare Part D appeals telephone numbers provided on the CMS website may be used to contact the plan to appeal a determination. Exceptions and appeals information and downloads for Medicare Part D prescription drug plans may be found at http://www.cms.hhs.gov/prescriptiondrugcovgenin/04_formulary.asp.

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

Attention: All Providers

Five-Year State Plan for Developmental Disability Services

The North Carolina Council on Developmental Disabilities is a state agency that carries out a variety of activities with, and in support of, persons of any age with developmental disabilities, their family members, and other agencies and organizations involved with them. Examples of such activities include policy development and legislative advocacy at the state and federal level. The Council also funds demonstration projects to promote innovative, person-centered approaches to providing services and supports. In addition to developmental needs and community support, many of these projects address health and medical needs. They are carried out in partnership with the Division for Medical Assistance and local health related agencies and providers.

The Council has started developing its new State Plan to cover the 2006 through 2011 time period. The State Plan is an important document because it determines the types of projects the Council can fund, and the policy and legislative issues upon which they focus. As part of the process to develop the State Plan, the Council seeks input from a wide variety of sources: consumers, advocacy and professional organizations, and providers.

The Council's Five-Year State Plan can be reviewed online at the Council's website (http://www.nc-ddc.org). Comments can be submitted to the Council through the website or to Council staff person Duncan Munn (Duncan.Munn@ncmail.net or 919-420-7901 or Fax 919-420-7917). Feedback is requested prior to April 28.

Input can also be provided through a series of local public hearings to be held across the state this spring. For information on the public hearing schedule, refer to the Council's website at http://www.nc-ddc.org.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: Area Mental Health Providers

Addition of Facility-Based Crisis Intervention Services for Children

Effective with date of service October 1, 2005, through March 19, 2006, LME Providers can bill for Facility-Based Crisis Intervention Services for Children ages 00-20. The HCPC code/modifier combination to be used to bill for this service is S9485 with modifier HA. This service is to be billed on a per diem basis at a rate of $372.23 per day.

This service will no longer be a covered service once the new Enhanced Services are implemented on March 20, 2006.

Effective with date of service March 20, 2006, this service will be available for adults only and will be billed per hour at the rate of $18.78 per hour. The HCPC code used to bill the service will be S9484.

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

Attention: All Enhanced Mental Health Services Providers and Local Management Entities

Billing Codes

Effective with dates of service March 20, 2006, in accordance with mental health reform, providers will no longer be able to bill the following codes with their local management provider number:

- T1017 with modifier HE - Mental Health Case Management
- H0036 with no modifier, or with modifier HI, HM, TL or U1
- H0035 with modifier HA
- H0035 with modifier HB
- H2012 with modifier HB

Providers may continue to bill H0036 HQ with their local management entity provider number until May 31, 2006.

Note: Children's Developmental Service Agencies and Community Based Rehabilitation Services who bill for services provided for ages 0 through 3 years with the HCPCS code H0036 codes are not affected by the change.

HCPCS code H0035 billed with no modifier continues to be a covered service for all enhanced mental health services providers and local management entities.

Behavioral Health Services
DMA, 919-855-4291

Attention: Home Health, Private Duty Nursing and Community Alternative Program Case Managers

Deletion of Home Health Medical Supply Procedure Code

HCPCS procedure code J1642, Injection, Heparin Sodium (heparin lock flush), will be removed from the home health fee schedule, effective February 1, 2006. Providers can bill heparin sodium IV flush kits (Hep-Loc kits) using the home health supply miscellaneous code, T1999, on any claim submitted after this date, regardless of the date of service on the claim. This action is being taken to comply with HIPAA policy. The code did not adequately describe the supply and the corresponding Medicare allowed rate did not cover the cost. The maximum allowable for most procedure codes must be set at Medicare rates. The billed amount for this service should be the agencies usual and customary charge for the item.

Adelle Kingsberry, Clinical Policy
DMA, 919-855-4380

Attention: CAP/DA Lead Agencies and AQUIP Users

Quarterly AQUIP System Training Seminar

The first quarterly AQUIP training seminar for CAP/DA Lead Agencies and other AQUIP users is scheduled for March 28, 2006 at the Days Inn Conference Center in Southern Pines. Attendance at these sessions is of the utmost importance. The seminar will focus on the items covered in the seminars that were held in December including the new AQUIP system, RUGs, Quality Measures and changes to the AQUIP User/System Manual.

Lead agencies were provided with a list of AQUIP users in their county who are required to attend the training seminar. Please contact your lead agency to determine if your attendance is required.

Pre-registration is required. CAP/DA Lead Agency staff and other AQUIP users may register online by going to the AQUIP web site at https://www2.mrnc.org/aquip and clicking on registration. A computer-generated confirmation number will confirm your registration.

This AQUIP training session is scheduled to begin at 9:30 a.m. and end at 3:30 p.m. Lunch will not be provided. Registration will be from 8:30 a.m. to 9:30 a.m.

Driving Directions to the Days Inn Conference Center 650 US Hwy 1 at Morganton Rd. Southern Pines. 910-692-8585

From North
Highway 1 South to Southern Pines, take the Morganton Rd. Exit. Make a right onto Morganton Rd. Hotel is on the right.

From South
Highway 1 North to Southern Pines, take the Morganton Rd. Exit. Make a left on Morganton Rd. Hotel is on the right.

From East
I-40 West to Exit 293 I-440/US 1/US 64 to Exit 293A Highway 1 South to Southern Pines. Take Morganton Rd. Exit. Hotel is on right.

From West
I-40 East to Hwy 220 South to Hwy 211 East to 15/501 South. Make a left onto Morganton Rd. Hotel is approximately 1.5 miles on the left.

From 15/501 South
15/501 South left onto Morganton Rd. Hotel is approximately 1.5 miles on the left.

From 15/501 North
Right at Morganton Rd.

Attention: Children Developmental Service Agencies

Case Management Code

Effective with date of service March 1, 2006, Children's Developmental Service Agencies (CDSA's) will no longer be able to bill case management with the code T1016. CDSA's should continue to use T1017 HI to bill for case management.

Carol Robertson, Behavioral Health Services
DMA, 919-855-4290

Attention: Home Infusion Therapy Providers

Billing for Services with Medicare Part D

Home Infusion Therapy (HIT) providers may bill the Medicaid program for the professional therapy component when the drug is covered under the Medicare Part D program. The HIT provider should bill Medicaid using the procedure code(s), S9325, S9329 or S9494, as applicable to the therapy provided and the procedure code for the nursing component, T1030. The appropriate modifier(s) should be used when billing multiple concurrent therapies. The drug should be billed to Medicare according to Medicare Part D following their guidelines.

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

Attention: Nursing Facility Providers

Successful MDS Validation Review Seminar

In April 2006, Myers and Stauffer is scheduled to present seminars on "Going From Better to BEST" Strategies For a Successful MDS Validation Review for nursing facility providers.

The seminar is designed and produced under contract with the Division of Medical Assistance. The latest statistics of the Medicaid MDS validation reviews will be presented, including a discussion of the most frequently unsupported MDS RUG-III items.

Special emphasis will be placed on a thorough discussion of the updated supportive documentation guidelines, restorative nursing program elements and documentation on mood, behavior and cognition MDS items. Case studies will be presented that include a RUG-III calculation and will demonstrate the financial impact of an unsupported assessment.

Training Locations and Dates:

Fayetteville – April 11th Holiday Inn I-95 1944 Cedar Creek Road Fayetteville, NC 28312 (919) 323-1600	Greenville – April 13th Hilton Greenville 207 Greenville Blvd. SW Greenville, NC 27834 (252) 355-5000
Asheville – April 18th Crowne Plaza Resort One Holiday Drive Asheville, NC 28806 (828) 254-3211	Charlotte – April 19th Marriott Executive Park 5700 Westpark Drive Charlotte, NC 28217
Raleigh – April 20th Hilton North Raleigh 3415 Wake Forest Road Raleigh, NC 27609 (919) 872-2323	

Seminar Hours

Registration begins at 8:30 a.m. The seminar begins promptly at 9:00 a.m. and concludes by 3:30 p.m. Providers may register online at http://www.mslc.com. If you have questions, please call Myers & Stauffer at 1-800-877-6927.

Facility Services Unit
DMA, 919–855-4350

Attention: All Optical Service Providers

CPT Code Changes for Dispensing Low Vision Aids

The Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA) deleted CPT code 92392, effective with date of service December 31, 2005. The replacement HCPCS code, V2797, is covered by the N. C. Medicaid program effective with date of service January 1, 2006. Claims submitted with end-dated codes will deny.

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

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

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

Attention: Pharmacists

Medicare Part B Override Code Update

Pharmacists may continue to use the Medicare Part B override code to submit claims to Medicaid in situations where a recipient has been inaccurately identified as Medicare Part B eligible. These situations include cases where there are errors in the Medicaid eligibility file indicating that the recipient has Medicare Part B coverage when they are not eligible or when their coverage has been terminated. In these situations, enter a '1' in the PA/MC field. If the claim must be submitted on paper, enter an 'O' in the family planning field and indicate the reason the override is needed in the space at the bottom of the manual claim form.

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

Attention: Pharmacists

Recipients with Medicare Deductibles

Pharmacy providers who bill pharmacy claims for recipients who have a Medicare deductible should bill Medicaid for the portion of the pharmacy claim that is applied to the Medicare deductible on the pharmacy manual claim form. These claims will be manually reviewed for payment. An 'O' should be entered in the family planning field on the form. A copy of the Medicare explanation of benefits (EOB) must also accompany the claim.

A copy of the pharmacy manual claim form is available on DMA's website at http://www.dhhs.state.nc.us/dma/forms.html.

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

Attention: Prescribers and Pharmacists

N.C. Medicaid Upper Limits for Betaseron 0.3mg, Migranal Nasal Spray and Toradol/Ketolac 10mg Tablets

The N.C. Medicaid program will implement limits on the number of dosage units that can be dispensed each month for prescriptions for Betaseron 0.3mg vial, Migranal Nasal Spray and Toradol/Ketolac 10mg tablets. These limits are based on the Food and Drug Administration's approved dosing recommendations.

Effective with date of service March 1, 2006, the following upper limits will apply:

Drug Description	Upper Limit
Betaseron 0.3mg vial	30 mls per month
Migranal Nasal Spray 4ml	2 kits per month
Migranal Nasal Spray 6ml	1 kit per month
Toradol 10mg tablets	20 tablets per month
Ketorolac 10mg tablets	20 tablets per month

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

NCLeads Update

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

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

Proposed Clinical Coverage Policies

In accordance with Session Law 2005-276, proposed new or amended Medicaid clinical coverage policies are available for review and comment on DMA's website at http://www.dhhs.state.nc.us/dma/prov.htm. To submit a comment related to a policy, refer to the instructions on the website. Providers without Internet access can submit written comments to the address listed below.

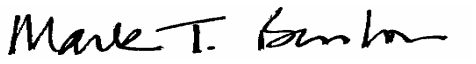
Gina Rutherford
Division of Medical Assistance
Clinical Policy Section
2501 Mail Service Center
Raleigh, NC 27699-2501

The initial comment period for each proposed policy is 45 days. An additional 15-day comment period will follow if a proposed policy is revised as a result of the initial comment period.

2006 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
March	03/03/06	03/07/06
	03/10/06	03/14/06
	03/17/06	03/21/06
	03/24/06	03/30/06
April	04/07/06	04/11/06
(c)	04/13/06	04/18/06
	04/21/06	04/27/06
May	04/28/06	05/02/06
	05/05/06	05/09/06
	05/12/06	05/16/06
	05/19/06	05/25/06

Electronic claims must be transmitted and completed by 5:00 p.m. on the cut-off date to be included in the next checkwrite. Any claims transmitted after 5:00 p.m. will be processed on the second checkwrite following the transmission date.



Mark T. Benton, Senior Deputy Director
and Chief Operating Officer
Division of Medical Assistance
Department of Health and Human Services

Cheryll Collier
Executive Director
EDS