March 2008 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: All Providers

Keeping Medicare Crossover Information Current

To ensure that claims continue to process correctly after the implementation of the National Provider Identifier (NPI), providers should verify that their Medicaid-to-Medicare crosswalk information is accurate. The NPI associated with the Medicaid and the Medicare number in the crosswalk must be the same. This can be verified by reviewing the crossover claims section of your Remittance and Status Advice (RA) or by calling EDS Provider Services.

Submit updates using the Medicare Crossover Reference Request form located on the DMA website at http://www.ncdhhs.gov/dma/formsprov.html. (The form is located under the heading Claim and Claim Adjustment.)

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 Identifiers for End-dated Providers

DMA continues to adjudicate claims for providers who have been end-dated when the claims are for dates of service prior to the provider's end-date. To date, more than 6,000 providers who were end-dated during the past 12 months have not reported their National Provider Identifier (NPI) to DMA. After May 23, 2008, claims will be denied for end-dated providers who have not reported their NPI to DMA.

To report your NPI or to verify that your NPI has been received, please access the NPI and Address Information database at http://www.ncdhhs.gov/dma/WebNPI/default.htm.

If all information is correct, no action is necessary. If the NPI column is blank, your NPI has not been reported. Print the form and submit your NPI with a copy of the National Plan and Provider Enumeration System (NPPES) certification.

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

Referring Provider Numbers for Atypical Providers

As defined in the National Provider Identifier (NPI) final rule, an "atypical" provider is an individual or business that does not meet the traditional definition of a health care provider, but is eligible to bill for health-related services covered by some health plans.

Because some types of Medicaid-enrolled providers may be atypical, after the implementation of NPIs, a legacy Medicaid provider number may still be acceptable as the referring provider number entered on a claim. However, it is the billing provider's responsibility to verify that the referring provider is atypical and that a legacy Medicaid provider number is acceptable.

The atypical status of a provider may be verified by visiting the NPI and Address Information database at http://www.ncdhhs.gov/dma/WebNPI/default.htm. The database may be searched by the legacy Medicaid provider number. When a result is returned, the word "atypical" will be displayed under the legacy Medicaid provider number located in the "Provider No." column if DMA recognizes the provider as atypical. If the "NPI" column is blank or an NPI is displayed, this means that DMA does not recognize this provider as atypical. Providers must contact the referring source to obtain the NPI.

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

Additional CMS Guidance on Tamper-resistant Prescription Pads

CMS has reviewed its policy regarding tamper-resistant prescriptions and has provided two updates to that policy.

Provider Additions to Otherwise Non-tamper-resistant Paper

Several states have questioned whether a provider can add a feature to a prescription to make it compliant with the tamper-resistant prescription pad requirements. States have proposed various features, including particular kinds of ink to write the prescription (gel or indelible); writing out drug quantities rather than just the number ("thirty" vs. "30"); and embossed logos. The tamper-resistant prescription pad statute states that all written prescriptions must be "executed on a tamper-resistant pad." As a result, features added to the prescription after the pads are printed do not meet the requirement of the statute. Features that would make the prescription tamper-resistant include certain types of paper as well as certain items that can be pre-printed on the paper.

Computer-generated Prescriptions

CMS has further clarified that during the period between April 1, 2008 and October 1, 2008, computer-generated prescriptions printed by a provider on plain paper, including electronic medical record computer-generated prescriptions, may meet CMS guidance by containing one or more industry-recognized features designed either to prevent the erasure or modification of information contained on the prescription, or to prevent the use of counterfeit prescription forms. However, based on its understanding of current prescription security technology, CMS does not believe that computer-generated prescriptions printed by a prescriber on plain paper will be able to meet the first baseline requirement that prescriptions contain one or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form. In other words, prescriptions printed on plain paper will not be able to meet all three baseline characteristics outlined by CMS. Therefore, beginning October 1, 2008, computer-generated prescriptions must be printed on paper that meets that requirement.

Please refer to the DMA guidance document dated September 6, 2007 for a list of acceptable features for N.C. Medicaid prescriptions. This guidance document may be found at http://www.ncdhhs.gov/dma/pharmacy/president_delay_pad_requirement.html.

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

Attention: All Providers

Addition of OTC Cetirizine to the Over-the-Counter Medications Coverage List

Effective with date of service February 1, 2008, cetirizine is available over-the-counter (OTC) for reimbursement by N.C. Medicaid in conjunction with a prescription by the prescriber. The following list of OTC cetirizine national drug codes (NDCs) have been added to the list of covered OTC medications:

NDC	Drug Label Name	Pkg Sz
00378363501	Cetirizine HCl 5-mg tablet	100
00378363701	Cetirizine HCl 10-mg tablet	100
00378363705	Cetirizine HCl 10-mg tablet	500
00781168301	Cetirizine HCl 5-mg tablet	100
00781168401	Cetirizine HCl 10-mg tablet	100
00904582941	Cetirizine HCl 10-mg tablet	14
00904582943	Cetirizine HCl 10-mg tablet	45
00904582946	Cetirizine HCl 10-mg tablet	30
00904582989	Cetirizine HCl 10-mg tablet	90
24385017574	Cetirizine HCl 10-mg tablet	14
45802091987	Cetirizine HCl 10-mg tablet	300
50580072013	Zyrtec 5-mg chewable tablet	5
50580072219	Zyrtec 10-mg chewable tablet	12
50580072410	Zyrtec 1-mg/ml syrup	118
50580072511	Zyrtec 1-mg/ml syrup	118
50580072630	Zyrtec 10-mg tablet	5
50580072632	Zyrtec 10-mg tablet	14
50580072636	Zyrtec 10-mg tablet	30
50580072638	Zyrtec 10-mg tablet	45
50580072734	Zyrtec 10-mg tablet	14
51079059701	Cetirizine HCl 10-mg tablet	100
51660093854	Cetirizine HCl 10-mg tablet	14
57664034315	Cetirizine HCl 5-mg chewable tablet	30
57664034383	Cetirizine HCl 5-mg chewable tablet	30
57664034415	Cetirizine HCl 10-mg chewable tablet	30
57664034483	Cetirizine HCl 10-mg chewable tablet	30
60505263201	Cetirizine HCl 5-mg tablet	100
60505263301	Cetirizine HCl 10-mg tablet	100

The list of covered OTC drug codes is available in General Medical Policy #A2, *Over-the-Counter Medications*, on the DMA website at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

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

Attention: All Providers

Clinical Coverage Policies

The following new or amended clinical coverage policies are now available on the DMA website at http://www.ncdhhs.gov/dma/mp/mpindex.htm:

1K-1, Breast Imaging Procedures
1R-4, Electrocardiography, Echocardiography, and Intravascular Ultrasound
3B, Program of All-inclusive Care for the Elderly (PACE)

Additionally, the list of drugs in General Coverage Policy A2, *Over-the-Counter Medications*, has been updated effective February 1, 2008.

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

Medicaid Credit Balance Reporting

All providers participating in the Medicaid program are required to submit to DMA, Third Party Recovery Section, a quarterly **Credit Balance Report** indicating balances due to Medicaid. Providers must report any **outstanding** credits owed to Medicaid that have not been reported previously on a Medicaid Credit Balance Report. However, hospital and nursing facility providers are required to submit a report every calendar quarter even if there are no credit balances. The report must be submitted no later than 30 days following the end of the calendar quarter (March 31, June 30, September 30, and December 31).

The Medicaid Credit Balance Report is used to monitor "credit balances" owed to the Medicaid program. A credit balance results from an improper or excess payment made to a provider. For example, refunds must be made to Medicaid if a provider is paid twice for the same service (e.g., by Medicaid and a medical insurance policy, by Medicare and Medicaid, by Medicaid and a liability insurance policy), if the patient liability was not reported in the billing process or if computer or billing errors occur.

For the purpose of completing the report, a Medicaid Credit Balance is the amount determined to be refundable to the Medicaid program. When a provider receives an improper or excess payment for a claim, it is reflected in the provider's accounting records (patient accounts receivable) as a "credit." However, credit balances include money due to Medicaid regardless of its classification in a provider's accounting records. If a provider maintains a credit balance account for a stipulated period (e.g., 90 days) and then transfers the account or writes it off to a holding account, this does not relieve the provider of liability to the Medicaid program. The provider is responsible for identifying and repaying all monies owed the Medicaid program.

The Medicaid Credit Balance Report requires specific information on each credit balance on a claim-by-claim basis. The reporting form provides space for 15 claims but may be reproduced as many times as necessary to accommodate all the credit balances being reported. Specific instructions for completing the report are on the reverse side of the reporting form.

Submitting the Medicaid Credit Balance Report does not result in the credit balances automatically being reimbursed to the Medicaid program. A check is the preferred form of satisfying the credit balances; the check must be made payable to EDS and sent to EDS with the Medicaid Provider Refund Request attached for a refund. If an adjustment is to be made to satisfy the credit balance, an adjustment form must be completed and submitted to EDS with all the supporting documentation for processing.

Submit **Medicaid Credit Balance Report Form** to:	Submit **Medicaid Provider Refund Form** and **refund checks** to:	Submit **Medicaid Claim Adjustment Request Form** to:
Third Party Recovery Section Division of Medical Assistance 2508 Mail Service Center Raleigh, NC 27699-2508	EDS Refunds P.O. Box 300011 Raleigh, NC 27622-3011	EDS Adjustment Unit P.O. Box 300009 Raleigh, NC 27622-3009

Submit **only** the completed Medicaid Credit Balance Report to DMA. **Do not** send refund checks or adjustment forms to DMA. **Do not** send the Credit Balance Report to EDS. Failure to submit a Medicaid Credit Balance Report will result in the withholding of Medicaid payment until the report is received.

A copy of the Medicaid Credit Balance Report form follows this article. Both the Medicaid Claim Adjustment Request form and the Medicaid Credit Balance Report form are also available on DMA's website at http://www.ncdhhs.gov/dma/forms/html.

Third Party Recovery Section
DMA, 919-647-8100

Instructions for Completing Medicaid Credit Balance Report

Complete the "Medicaid Credit Balance Report" as follows:

- **Full name of facility as it appears on the Medicaid Records**
- **The facility's Medicaid provider number**. If **the facility has more than one provider number, use a separate sheet for each number. DO NOT MIX**
- **Circle the date quarter end**
- **Enter year**
- The name and telephone number of the person completing the report. This is needed in the event DMA has any questions regarding some item in the report

Complete the date fields for each Medicaid balance by providing the following information:

Column 1 – The last name and first name of the Medicaid recipient (e.g., Doe, Jane)

Column 2 – The individual Medicaid identification (MID) number

Column 3 – The month, day, and year of beginning service (e.g., 12/05/03)

Column 4 – The month, day, and year of ending service (e.g., 12/10/03)

Column 5 – The R/A date of Medicaid payment (not your posting date)

Column 6 – The Medicaid ICN (claim) number

Column 7 – The amount of the credit balance (not the amount your facility billed or the amount Medicaid paid)

Column 8 – The reason for the credit balance by entering: "81" if it is a result of a Medicare payment; "83" if it is the result of a health insurance payment; "84" if it is the result of a casualty insurance/attorney payment or "00" if it is for another reason. Please explain "00" credit balances on the back of the form.

After this report is completed, total column 7 and mail to **Third Party Recovery, DMA, 2508 Mail Service Center, Raleigh, NC 27699-2508.**

MEDICAID CREDIT BALANCE REPORT

PROVIDER NAME: _____ CONTACT PERSON: _____
PROVIDER NUMBER: _____ TELEPHONE NUMBER: _____
QUARTER ENDING: (Circle one) 3/31 6/30 9/30 12/31 YEAR: _____

(1) RECIPIENT'S NAME	(2) MEDICAID NUMBER	(3) FROM DATE OF SERVICE	(4) TO DATE OF SERVICE	(5) DATE MEDICAID PAID	(6) MEDICAID ICN	(7) AMOUNT OF CREDIT BALANCE	(8) REASON FOR CREDIT BALANCE
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							

Circle one: Refund Adjustment

Return form to: **Third Party Recovery**
DMA
2508 Mail Service Center
Raleigh, NC 27699-2508

Revised 10/07

Attention: All Providers

Outdated Enrollment Packets Will No Longer Be Accepted

The N.C. Medicaid Program's provider enrollment packets have been updated to include a Letter of Attestation as required by Section 6023 of the Deficit Reduction Act (DRA) of 2005. Effective May 1, 2008, outdated enrollment packets will no longer be accepted. Providers who are enrolling or re-enrolling must complete and submit the most recent version (December 2007 and after) of the provider enrollment packets, including the signed Letter of Attestation. Providers will be notified by e-mail, telephone, or written correspondence if a new provider enrollment packet must be submitted.

To ensure that there is no delay in processing an enrollment application, providers should obtain the current version of the provider enrollment packets from DMA's website at http://www.ncdhhs.gov/dma/provenroll.htm.

Provider Services
DMA, 919-855-4050

Attention: All Providers

New Form for Medicaid Provider Refund Requests

The process for submitting refunds to the N.C. Medicaid program has changed. Previously, the process stated that the provider should highlight the appropriate recipient information, claim information, and dollar amount of the refund on a copy of the Remittance Advice and Status Advice (RA) submitted with the refund check.

EDS recognizes that due to increasing number of providers receiving an electronic RA (835) or the potential for an RA to be used by more than one provider, the provider requesting a refund may not have an RA available to submit with a refund request. EDS has therefore developed the Medicaid Provider Refund Request form to replace the previous process for submitting refunds to Medicaid. The form, which can be completed and printed in Microsoft Excel, does not require a copy of the RA, claim forms, or other documentation to be submitted in order for EDS to process the refund.

The Medicaid Provider Refund Request form is available on the DMA website at http://www.ncdhhs.gov/dma/formsprov.html under the heading "Claim and Claim Adjustments." A copy of the form and the instructions for completing the form are included on the following page for reference.

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

MEDICAID PROVIDER REFUND FORM INSTRUCTIONS

1. To ensure that you are using the most current version of the Medicaid Provider Refund Request form, access the form from the Division of Medical Assistance's website at http://www.ncdhhs.gov/dma/formsprov.html each time you use it.
2. If you want to make sure your individual claim refunds total to the amount of your check, enter the expected or actual check amount in cell L12. If you do not want to use that to check your entries, leave L12 blank and enter the calculated amount in that field to balance intended and calculated.
3. To help reduce questions from EDS when the check and form are received, enter the information into the form before printing it.
4. Enter information for each claim by detail line. As entries are made into the form, the total refund amount will be calculated.
5. The sum of the entries must equal the amount of the refund check submitted with this form.
6. Print a copy of the completed Electronic Refund Form and submit to have it approved and paid
7. Send form and refund check to address : EDS – Finance Department
PO Box 300011
Raleigh, NC 27622
8. We strongly recommend that you save copy as a filename you recognize (example "Check123" or "DrKildaire789")

Field	**Description**
ICN (Medicaid Claim ID Number)	Claim ID number assigned by Medicaid (15 digits)
Billing Medicaid Provider Name	Name of Provider who billed the claim
Billing Medicaid Provider Number	Medicaid Provider Number of Provider who billed the claim
Recipient Full Name	Name of Recipient who received service
Recipient MID	Medicaid ID number for Recipient (9 digits, 1 letter)
Date(s) of Service	Dates service was performed
Amount Billed	Detail billed amount
Amount Paid by Medicaid	Detail amount paid by Medicaid
Date Medicaid Paid	Date of payment by Medicaid
Amount of Refund	Amount that should be applied back to detail ****Note: The total of this field column must match the amount of the refund check.**
Reason for Refund	Reason the refund is being applied. Select appropriate drop-down value

If you have any questions regarding this form or the refund process, please call **1-800-688-6696** if you are outside Raleigh; if you are in Raleigh, please call **851-8888.**

Medicaid Provider Refund Request Form

How to submit a refund:

Complete Refund Request Form

*Please itemize dates of service for each recipient.

Submit a Check for Total amount of Refund

Refund Contact Name _____

Refund Contact Number _____

This will always be page 1 - please see additional file worksheets for additional detail lines.
If submitting more than 39 claim lines, please do so on a separate check and use another form.

Once documents are completed please submit to:

EDS - Finance Department
PO Box 300011
Raleigh, NC 27622

(please use to compare actual and expected)

The refund check amount intended is: $ -

The claims refunded below total to: $ -

Difference (must be zero to be processed): $ -

PROVIDER CHECK NUMBER

PROVIDER CHECK DATE

	ICN (Medicaid Claim ID number)	Billing Provider Name	Billing Provider Number	Recipient Full Name	Recipient MID		Date(s) of Service	Amount Billed	Amount Paid by Medicaid	Date Medicaid Paid	Amount of Refund	Reason for Refund
					nine numerals	one alpha						
1											0	
2											0	
3											0	
4											0	
5											0	
6											0	
										Page Subtotal	$ -	

IF YOU NEED TO CHANGE WHERE YOUR REMITTANCE ADVICE REPORTS ARE SENT, CLICK ON THIS LINK OR PLACE THE FOLLOWING IN YOUR INTERNET BROWSER ADDRESS

version 2/5/2008 http://www.ncdhhs.gov/dma/formsprov.html

Attention: All Providers

Payment Error Rate Measurement in North Carolina

In compliance with the Improper Payments Information Act of 2002, CMS implemented a Payment Error Rate Measurement (PERM) program to measure improper payments in the Medicaid program and the State Children's Health Insurance Program (SCHIP). North Carolina has been selected as one of 17 states required to participate in PERM reviews of claims paid in federal fiscal year 2007 (October 1, 2006 through September 30, 2007).

CMS is using three national contractors to measure improper payments. One of the contractors, Livanta LLC (Livanta), will be communicating directly with providers and requesting medical record documentation associated with the sampled claims (approximately 800 to 1200 claims for North Carolina). Providers are required to furnish the records requested by Livanta within a timeframe indicated by Livanta.

Livanta began requesting medical records for the sampled claims in North Carolina on November 20, 2007. Providers are urged to respond to these requests promptly. Records must be submitted by providers no later than 60 days after issuance of the contractor's letter requesting such records (PERM Final Rule, Federal Register/Vol. 72, No. 169/Friday, August 31, 2007/Rules & Regulations, pg. 50496).

Providers are reminded of the requirement in Section 1902(a)(27) of the Social Security Act and 42 CFR Part 431.107 to retain any records necessary to disclose the extent of services provided to individuals and, upon request, furnish information regarding any payments claimed by the provider for rendering services.

Provider cooperation to furnish requested records is critical in this CMS project. No response to requests and/or insufficient documentation will be considered a payment error. This can result in a payback by the provider and a monetary penalty for the N.C. Medicaid program.

Program Integrity
DMA, 919-647-8000

Attention: All Providers

Legislative Visit Limitation

When first published, the October 2007 general Medicaid Bulletin included an article stating that recipients are allowed 30 visits per year, instead of the existing 24 visits. This article has since been revised. Session Law 2007-323 modified the law concerning Medicaid visit limitations. DMA is in the process of implementing these changes and a detailed bulletin article will be published as we get closer to completion of the project.

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

Attention: All Providers

Program of All-inclusive Care for the Elderly Recipient Eligibility

The Program of All-inclusive Care for the Elderly (PACE) is a managed care program that enables elderly individuals who are certified to need nursing facility care to live as independently as possible. The PACE provider receives monthly Medicare and/or Medicaid capitation payments for each eligible enrollee. The PACE provider assumes full financial risk for participants' care without limits on amount, duration or scope of services. Medicaid will not reimburse non-PACE providers for services provided to PACE participants.

Effective February 1, 2008, to enroll in this program, an individual must be Medicaid-eligible and

- 55 years of age or older;
- meet the State's Medicaid criteria for nursing facility level of care;
- able to live safely in the community at the time of enrollment; and
- reside in the service area of the PACE organization.

  Note: Currently, PACE is available only in New Hanover and Brunswick counties through the Elderhaus, Inc. PACE organization. Additional PACE sites are being developed in Fayetteville and Burlington.

Services provided directly by the PACE provider include, but are not limited to

- interdisciplinary team case management
- adult day health program
- skilled nursing care
- primary care physician services
- specialized therapies
- personal care services
- nutrition counseling
- meals
- transportation
- prescriptions

EDS, 1-800-668-6696 or 919-851-8888

Attention: All Providers

Registration for Basic Medicaid Seminars

Basic Medicaid seminars will be held in April 2008. Registration information, a list of dates, and site locations for the seminars are listed below.

Seminars will begin at 9:00 a.m. and will end at 12:00 p.m. 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.**

Due to limited seating, registration is limited to two staff members per office. Preregistration is required. Unregistered providers are welcome to attend if space is available. Providers may register for the seminars by completing and submitting the registration form online at http://www.ncdhhs.gov/dma/prov.htm, under "Seminar Information." Providers may also complete the Seminar Registration Form on the following page and fax it to the number listed on the form. Please indicate on the registration form the session you plan to attend.

The *Basic Medicaid Billing Guide* will be used as the primary training document for the seminar. Please review and print the **April 2008** version and bring it to the seminar. The April 2008 *Basic Medicaid Billing Guide* will be available the first week of March 2008 on DMA's website at http://www.ncdhhs.gov/dma/medbillcaguide.htm.

Morganton **April 8, 2008** Western Piedmont Community College Moore Hall Building 1001 Burkemont Ave. Morganton, NC 28655 828-438-6000	**Winston-Salem** **April 9, 2008** Holiday Inn Select 5790 University Parkway Winston-Salem, NC 27105 336-767-9595
Wilmington **April 15, 2008** Coastline Convention Center 501 Nutt St. Wilmington, NC 28403 910-763-2800	**Raleigh** **April 17, 2008** The Royal Banquet Center 3801 Hillsborough St. Suite. 109 Raleigh, NC 27607 919-621-0540

Directions to the Basic Medicaid Seminars:

Western Piedmont Community College – Morganton, NC

Traveling West on I-40

From Hickory, take Exit #103 and turn right onto Burkemont Avenue. Travel one block. Western Piedmont Community College is on the right, one block from I-40.

Traveling East on I-40

From Asheville, take Exit #103 and turn left onto Burkemont Avenue. Cross the bridge over I-40. Western Piedmont Community College is on the right, one block from I-40.

Traveling on NC 18 from Lenoir

Turn left onto South Sterling Street. Turn right at Burger King onto W. Fleming Drive. At the N.C. School for the Deaf, turn left onto Burkemont Avenue. Western Piedmont Community College is on the left at the second traffic light.

Traveling on NC 64 from Rutherfordton
Driving into Morganton, cross over I-40. Western Piedmont Community College is on the right, one block beyond I-40.

Holiday Inn Select – Winston-Salem, NC
Traveling East or West on I-40
Take I-40 to the NC 52 North exit. Travel eight miles to exit 115B (University Pkwy South). The Holiday Inn Select is located on the right.

Traveling North on NC 52
Take NC 52 South to University Parkway, exit 115. Keep right at the fork to go on University Parkway.

Traveling South on NC 52
Take NC 52 North to University Parkway South, exit 115B. The Holiday Inn Select is located on the right.

Coastline Convention Center – Wilmington, NC
Traveling East on I-40
Take I-40 East towards Wilmington. As you approach Wilmington, turn right onto MLK Parkway/NC 74 West/Downtown. Continue on this route towards downtown Wilmington. The road becomes Third Street. Follow Third Street for five blocks until you reach Red Cross Street. Turn right onto Red Cross Street and continue for two blocks. Turn right onto Nutt Street. The entrance to the Coastline Convention Center is the second drive way on the left.

Traveling South on US 17
As you approach Wilmington, US 17 becomes Market Street. Continue on Market Street until you see the sign for MLK Parkway/NC 74 West/Downtown. Take NC 74 West (MLK Parkway) towards downtown Wilmington (approximately four miles). Turn right onto Red Cross Street and continue for two blocks. Turn right onto Nutt Street. The entrance to the Coastline Convention Center is the second driveway on the left.

Traveling North on US 17 or NC 74/76
After crossing the Cape Fear Memorial Bridge into Wilmington, turn left at the first stoplight onto Third Street. Turn left onto Red Cross Street. At the bottom of the hill (approximately three blocks), turn right onto Nutt Street. The entrance to the Coastline Convention Center is the second driveway on the left.

The Royal Banquet Center – Raleigh, NC
Traveling West on I-40
Take I-40 West towards Raleigh. Take the Wade Avenue exit. Merge onto I-440 S/US 1 South toward I-40 East/Hillsborough Street/Sanford. Take Exit 3 for NC 54/Hillsborough Street. Turn left onto Hillsborough Street/NC 54. Turn right at the 3rd traffic light at Meredith College and Playmakers (the turn is located in front of Quizno's and Ben & Jerry's). Go to the end of the parking lot and turn left to park BEHIND the building or in the covered parking area.

Traveling East on I-40

Take I-40 East into Raleigh. Take Exit 293 for I-440/US 1/US 64/Raleigh/Wake Forest. The exit will split into two lanes. Stay in the right-hand lane to merge onto I-440/Inner Beltline/Raleigh. Take Exit 3 for NC 54/Hillsborough Street. Turn left at the bottom of the exit ramp. Turn right at the 3rd traffic light at Meredith College and Playmakers (the turn is located in front of Quizno's and Ben & Jerry's). Go to the end of the parking lot and turn left to park BEHIND the building or in the covered parking area.

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

Basic Medicaid Workshops
April 2008 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

Tax Identification Information

The N.C. Medicaid program must have the correct tax information on file for all providers. This ensures that 1099 MISC forms are issued correctly each year and that correct tax information is provided to the IRS. Incorrect information on file with Medicaid can result in the IRS's withholding 28% of a provider's Medicaid payments. The individual responsible for maintenance of tax information must receive the information contained in this article.

How to Verify Tax Information

The last page of the Medicaid Remittance and Status Report (RA) indicates the tax name and number on file with Medicaid for the provider number listed. Review the Medicaid RA throughout the year to ensure that the correct tax information is on file for each provider number. If you do not have access to a Medicaid RA, call EDS Provider Services at 919-851-8888 or 1-800-688-6696 to verify the tax information on file for each provider.

How to Correct Tax Information

All providers are required to complete a W-9 form for each provider for whom incorrect information is on file. Please go to the following website to obtain a copy of a W-9 form http://www.irs.gov/pub/irs-pdf/fw9.pdf. Correct information must be received by **November 1, 2008**.

All providers who identify incorrect tax information must submit a completed and signed W-9 form along with a completed and signed Medicaid Provider Change form (http://www.ncdhhs.gov/dma/formsprov.html) to the address listed below:

Division of Medical Assistance - Provider Services
2501 Mail Service Center
Raleigh NC 27699-2501

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

Attention: All Providers

Update: PedvaxHIB Recall – Reimbursement for PedvaxHIB and ActHIB Allowed for UCVDP/VFC Program Eligibles

Effective with date of service December 13, 2007, and until further notice, N.C. Medicaid will reimburse for purchased PedvaxHIB (CPT procedure code 90467) or ActHIB (CPT procedure code 90468), when administered to recipients through 18 years of age because of a recent vaccine recall and a resulting shortage.

On December 13, 2007, Merck and Company announced a voluntary recall of certain lots of PedvaxHIB vaccine due to manufacturing issues. Subsequently, the Universal Childhood Vaccine Distribution Program/Vaccines for Children Program notified participants that there is currently a shortage of *Haemophilus influenzae* Type b (Hib) products. Additionally, the requirement to administer a booster dose of Hib vaccine on or after the age of 12 months has been temporarily suspended. As the recommendations state, the suspension affects the **routine** booster. Children who are in specified high-risk groups should receive the booster dose. The recommendations for the Hib vaccines from the Centers for Disease Control and Prevention can be found at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5650a4.htm (*MMWR Weekly*, Dec. 21, 2007/56(50);1318-1320).

The decision about whether the child should receive a two- or three-dose series depends on the vaccine product used. Please refer to the following table for guidelines.

Population	Administration Guidelines
Children receiving PedvaxHIB at 2 months and 4 months of age	Primary series complete; no booster during the suspension **unless high-risk**
Children receiving PedvaxHIB at 2 months of age and ActHIB at 4 months of age	One more dose of ActHIB at 6 months to complete primary series; no booster during the suspension **unless high risk**
Children receiving all doses ActHIB	2, 4, and 6 months to complete the primary series; no booster during the suspension **unless high risk**

The SC modifier must be appended to the procedure code to indicate that purchased vaccine was administered.

Medicaid continues to reimburse for the Hib vaccine for high-risk recipients according to the existing recommendations of the Advisory Committee on Immunization Practices. Other billing requirements regarding vaccines also remain in effect.

EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions indicated above and without meeting the specific criteria in this section when such services are medically necessary health care services to correct or ameliorate a defect, physical or mental illness, or a condition (health problem); that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. Additional information on EPSDT guidelines may be accessed at http://www.ncdhhs.gov/dma/EPSDTprovider.htm.

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

Attention: All Providers

Update to the Implementation of the Web-based Medicaid Uniform Screening Tool

The web-based Medicaid Uniform Screening Tool (MUST) will soon replace the FL2, the FL2e, the Pre-Admission Screening and Annual Resident Review Level I screen, telephone prior approvals for nursing facility level of care, the Community Alternatives Program for Children (CAP/C) Referral form, the Nursing Facility Tracking form, and the Ventilator Addendum form used to screen applicants and to document their medical, functional, and behavioral health status. Initially, the MUST will be used prior to entry into the following Medicaid covered services/facilities:

- nursing facilities
- adult care homes (basic, enhanced personal care services, and special care/Alzheimer's units)
- personal care services (PCS)
- PCS–Plus
- Community Alternatives Program for Disabled Adults (CAP/DA)
- Community Alternatives Program-Choice (CAP/Choice Independence Plus Waiver)
- Community Alternatives Program for Medically Fragile Children (CAP/C)
- private duty nursing (PDN)

Authorized and trained screeners (local professionals) will enter the medical, functional and behavioral health information into the automated web-based tool. The data will be processed through a rules engine that contains the clinical coverage criteria as documented in the Medicaid program's clinical coverage policies.

A "best fit" service will be presented to the screener, along with other service options for which the recipient may apply. The screener and the applicant will jointly determine which service option to select and the screener can then make a referral to the service provider.

Eligible screeners include

1. Clinical professionals utilizing MUST to make a referral to Medicaid for long-term-care services and supports (covered under the Uniform Screening Program and expanding over time), including
    a. physicians
    b. physician assistants, family nurse practitioners, and other mid-level practitioners
    c. registered nurses and licensed practical nurses
    d. medical/clinical social workers, qualified professionals, and psychologists
2. Hospital discharge planners and case managers who make referrals to long-term-care services and supports
3. Case managers from regional, local, and community organizations who make referrals to long-term-care services and supports.
4. Staff of Aging Disability Resource Centers; local departments of social services; and other providers, agencies, and networks whose entity administrator determines the potential screener has the experience and informal training with which to complete the screenings.

All MUST screeners will be qualified to be screeners by participating in MUST training and by demonstrating competency in the use of the tool as evidenced by passing the MUST test. Ongoing authorization will be monitored through several DMA quality assurance initiatives. DMA reserves the right to revoke the screener's access to the web-based MUST.

MUST is currently being field tested by a cross section of all provider groups mentioned above. This process consists of two testing periods: February 11 through March 14 for round No. 1 and March 31 through April 25 for round No. 2. Following each testing period, the current Uniform Screening Program contractor, EDS, will refine the tool. Regional training classes will be held across the state once field testing is completed.

MUST **regional** training is scheduled to begin May 26, 2008. Training dates and site locations, along with registration information, will be published in the April general Medicaid Bulletin and on April 1, 2008, on the MUST website (http://www.ncmust.com).

Once a screener attends the training and passes the test, he/she may begin using the MUST to replace the FL2 in the work flow. No FL2 or FL2e will be accepted after September 12, 2008.

Julie Budzinski, Facility and Community Care
DMA, 919-855-4360

Attention: Children's Developmental Service Agencies, Health Departments, Home Health Agencies, Independent Practitioners, Local Management Entities, Outpatient Hospital Clinics, and Physicians

Web-based Survey for Outpatient Specialized Therapies Prior Authorization Website

The Carolinas Center for Medical Excellence (CCME) website for Prior Authorization (PA) of Outpatient Specialized Therapies marked its first anniversary on February 5, 2008. We would like to take this opportunity to solicit your feedback regarding the current PA process including the new fax forms and the option for electronic submission for PA as well as the overall convenience of the website.

The survey will be available March 1 through 16, 2008, via a link on our home page: https://www2.mrnc.org/priorauth/. Please share your opinions with CCME by completing this brief survey. Your feedback and comments are greatly appreciated.

CCME, 1-800-228-3365

Attention: CAP/DA Lead Agencies

Automated Quality and Utilization Improvement Program Quarterly Training Seminar

The Carolinas Center for Medical Excellence (CCME) (http://www.thecarolinascenter.org) announces continued quarterly training for new users of the Automated Quality and Utilization Improvement Program (AQUIP) in CAP/DA lead agencies.

The first quarterly training session this year will be held on March 18, 2008, at the Hilton Charlotte University Place in Charlotte. Attendance at this meeting is of the utmost importance for new AQUIP users. CAP/DA lead agency contacts have been informed via e-mail of any identified new users in their counties who should attend this session. We recommend that all attendees read and become familiar with the AQUIP User Manual, which can be accessed by going to the AQUIP website (https://www2.mrnc.org/aquip) and clicking on Downloads, prior to the training session. Current users who would like to attend the session may do so if space permits. However, the information presented will be designed for new users.

The seminar is scheduled to begin at 9:00 a.m. and end at 3:00 p.m. The session will focus on Resource Utilization Group (RUG) scores, accurately completing the three parts of the AQUIP tool (client information sheet, data set assessment, and plan of care), and resolving common data entry errors. The session will end with an overview of Health Check/Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for Medicaid-eligible recipients under the age of 21.

Preregistration is required. Contact your CAP/DA lead agency to verify if your name is on the required attendance list. You may register for the seminar online, beginning March 3, 2008, by going to https://www2.mrnc.org/aquip and clicking on Training Sessions. You will receive a computer-generated confirmation number, which you should bring to the seminar. Check-in will be from 8:30 a.m. until 9:00 a.m. on the day of the seminar; lunch will be on your own.

CCME, 1-800-682-2650

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

Use of the Miscellaneous Medical Supply Code T1999

The use of miscellaneous code T1999 is permitted only in instances where a medical supply item is needed and is medically necessary for the recipient's treatment or illness, but no code describing the item is listed on the Home Health Fee schedule. The need for this code will continue with the ongoing updates and advances in medical treatment and the continual development of new and more effectual products. The use of this code is a provision made to allow billing and reimbursement for these supplies on a temporary basis.

A recent review of home health supply billing revealed that some providers are not adhering to coding guidelines regarding the use of the miscellaneous medical supply code T1999. Providers should refer to Section 3.6 of Clinical Coverage Policy #3A, *Home Health Services*, for complete instructions on billing supplies and the use of the miscellaneous medical supply code. The policy can be found on the DMA website at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

The Home Health Fee Schedule lists the Medicaid-covered home health medical supplies that can be reimbursed when billed by home health agencies, Community Alternatives Program (CAP) case managers, and private duty nursing providers. The fee schedule includes the applicable national HCPCS code for each covered supply code as mandated under HIPAA and is posted on the DMA website at http://www.ncdhhs.gov/dma/fee/fee.htm.

Periodic updates are made to the fee schedule to accommodate coding changes made by CMS and as needed to include the items that are medically necessary and reasonable to treat the illnesses, diseases, or injuries common to the Medicaid home care population. The codes generically describe the supply item and list the unit quantity measurement. Providers must use the national HCPCS code that fits the item description and bill the units accordingly. Misuse of code T1999 may result in the recoupment of any payment made for the medical supply item billed.

Clinical Policy and Programs
DMA, 919-855-4380

Attention: Independent Laboratories and Physicians

Clinical Laboratory Improvement Amendments Certification-related Claim Denials

It has come to DMA's attention that some providers continue to receive claim denials when billing certain laboratory procedure codes with modifier QW. In order to ensure that claims are coded appropriately when submitted, providers should refer to the CMS website at http://www.cms.hhs.gov/CLIA/10_Categorization_of_Tests.asp for the current lists as follows:

- waived tests
- tests categorized as provider-performed microscopy procedures (PPMP)
- tests (CPT-4 codes) subject to CLIA edits, including non-waived and non-PPMP tests
- tests (CPT-4 codes) excluded from CLIA edits

The lists may be printed and retained for future reference; however, this information is periodically updated and new tests are added as they are approved.

Billing Reminders

If a CPT code is listed with the QW modifier on the list of waived tests, the modifier must be appended to the CPT code for reimbursement. Failure to append the QW modifier will result in claims being denied for EOB 0936, "Certification not valid for DOS/Level." Claims submitted with the QW modifier appended to a CPT code that is not indicated on the list of waived tests will also deny for EOB 0936.

If a test is not included on the QW list, providers should contact CLIA at the Licensure and Certification Section of the N.C. Division of Health Service Regulation at 919-855-4620 to discuss their certificate type and the tests that can be performed based on the certificate type.

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

Attention: Institutional (UB-92/UB-04) Claim Billers

UB-04 Changes to Be Implemented April 25, 2008

This article, originally published in the February 2008 general Medicaid Bulletin, includes information on additional bill type changes.

The National Uniform Billing Committee (NUBC) previously released the UB-04 paper claim and manual for billing. DMA will implement claim processing modifications on April 25, 2008 based on the UB-04 manual. These changes apply to the UB-04 paper claim form, 837 Institutional transactions, and UB claims submitted through the NCECSWeb claim submission tool. Providers will receive a claim denial if they bill using any UB code that has been labeled by the NUBC in the UB-04 manual as "Reserved for assignment by the NUBC." The impacted form locators and data elements are:

Form Locator	Description
FL 4	Type of Bill (including the Type of Bill Frequency codes)
FL 14	Priority (Type) of Visit
FL 15	Source of Referral for Admission or Visit
FL 17	Patient Discharge Status
FL 18 through 28	Condition Codes
FL 31 through 34	Occurrence Codes and Dates
FL 35 through 36	Occurrence Span Codes and Dates
FL 39 through 41	Value Codes and Amounts
FL 42	Revenue Code

Bill Type Changes

Due to a definition change in the UB-04 Manual, the following Bill Types are required for claims received on or after April 25, 2008. Claims received on or after that date without the required Bill Types will be denied.

- All hospitals should use Bill Type 11X for admissions and discharges.
- **Psychiatric hospital lower level of care beds should use Bill Type 66X for services previously billed under bill type 17X.**
- **Head level of care nursing home bed services should use Bill Type 65X for services previously billed under bill type 28X.**
- Criterion #5 should use Bill Type 65X with Revenue Code 902. Previously, Criterion #5 used Bill Type 14X.
- Residential levels of care I through IV should use Bill Type 86X. Previously, residential levels of care I through IV used Bill Type 84X.
- **Skilled nursing facility and intermediate care facility nursing home beds should use Bill Type 21X or 22X for services previously billed under Bill Type 28X and 67X.**
- Skilled nursing facility swing beds and intermediate care facility swing beds should use Bill Type 18X. Previously SNF/ICF swing beds used Bill Types 15X, 16X, 18X and 88X.
- Ventilator nursing facility bed services will continue to use Bill Type 28X.

Revenue Code Changes
Due to a definition change in the UB-04 Manual claims received on or after April 25, 2008 for Adult Care Home services must use Revenue Code 679 in place of 599. Revenue Code 599 has been discontinued. Claims submitted with Revenue Code 599 will be denied.

Priority (Type) of Visit Changes
DMA will allow code 5 defined as Trauma in FL 14 for claims received on or after April 25, 2008.

Patient Discharge Status Changes
DMA will allow code 70 defined as Discharged/Transferred to another Type of Health Care Institution not Defined Elsewhere in this code list in FL 17 for claims received on or after April 25, 2008.

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

Attention: Institutional (UB-92/UB-04) Claim Billers

Updated Effective Date for Revised UB Claim Form

The National Uniform Billing Committee (NUBC) has issued the revised institutional paper claim format.

All institutional paper claims received on or after April 25, 2008 must be filed on the UB-04 claim form regardless of the date of service.

Providers who submit the UB-92 claim form for processing on or after April 25, 2008 will receive denial EOB 9960, "Resubmit on the new UB04 Claim Form" on their remittance advice.

Refer to the June 2007 Special Bulletin, *New Claim Form Instructions*, (http://www.ncdhhs.gov/dma/bulletin.htm) and the NUBC website at www.nubc.org for specific billing guidelines.

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

Attention: Pharmacists

Days Supply for Prescriptions with "Use as Directed" Instructions

Submitting an accurate days supply is important. Daily supply should be determined from the directions for use and the quantity written on a prescription. For a prescription with instructions "use as directed," the pharmacist should estimate the days supply based on professional judgment and/or contact with the prescriber. The maximum days supply for drugs is 34 days unless the drug meets the criteria to obtain a 90 days supply.

Please refer to the Clinical Coverage Policy #9, *Outpatient Pharmacy Program*, for additional information on days supply. The policy guidelines are available on the DMA website at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

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

Attention: Dialysis Providers, Federally Qualified Health Centers, Health Departments, Nurse Midwives, Nurse Practitioners, Pharmacists, Physicians, and Rural Health Clinics

Changes in Drug Rebate Manufacturers

The following changes are being made for manufacturers with drug rebate agreements. The changes are listed by manufacturer code, which are the first five digits of the National Drug Code.

Additions

The following labelers have entered into drug rebate agreements and have joined the rebate program effective on the dates indicated below:

Code	Manufacturer	Date
67877	Ascend Laboratories LLC	December 28, 2007
00086	Elan Pharmaceuticals, Inc.	January 1, 2008

Voluntarily Terminated Labeler

The following labeler has requested voluntary termination effective on the date below:

Code	Manufacturer	Date
51284	Zila Pharmaceuticals, Inc.	April 1, 2008

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

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.

2008 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
March 2008	02/28/08	03/04/08
	03/06/08	03/11/08
	03/13/08	03/18/08
	03/20/08	03/27/08
April	04/03/08	04/08/08
	04/10/08	04/15/08
	04/17/08	04/24/08

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.

William W. Lawrence, Jr., M.D.
Acting Director
Division of Medical Assistance
Department of Health and Human Services

Cheryll Collier
Executive Director
EDS