March 2009 Medicaid Bulletin

In This Issue . . . Page

Attention: All Providers

EOB Codes for National Provider Identifiers

To prepare for National Provider Identifier (NPI) implementation in May, providers should familiarize themselves with the following EOB codes and their descriptions. **If a Medicaid Provider Number (MPN) is submitted on a claim on or after May 1, 2009, the claim will be denied unless the billing provider is atypical.**

EOB Codes for NPI:

- **EOB 3101** – The taxonomy code for the attending provider is missing.
- **EOB 3102 –** The taxonomy code for the billing provider is missing.
- **EOB 3105** (for pharmacy claims only) – The NPI submitted for the prescribing provider is missing or invalid.
- **EOB 3106** (for pharmacy claims only) – The NPI submitted for the prescribing provider cannot be the same as the pharmacy's NPI.
- **EOB 3107 –** Claim should contain NPI only without Medicaid Provider Number as provider is not atypical. (This EOB will apply to billing, attending, and referring MPNs on claims.)
- **EOB 3208 –** Void or adjustment cannot be processed. Billing NPI does not match NPI on file for original provider.
- **EOB 3209 –** Void or adjustment cannot be processed. Billing NPI does not match NPI filed on original claim.

Modified EOB Codes for NPI:

- **EOB 270** – Billing provider is not the recipient's Carolina ACCESS PCP. Authorization is missing or unresolved. Contact PCP for auth or EDS Provider Services if auth is correct.
- **EOB 3007** (hospice) – Patient facility identification is missing, invalid, or unresolved. Verify patient facility ID and resubmit as a new claim or contact EDS Provider Services if ID is correct.
- **EOB 8326** – Attending provider ID is missing or unresolved. Attending provider is required. Verify attending provider ID and resubmit as a new claim or contact EDS Prov SVC if ID is correct.
- **EOB 2270 –** Service must be referred by Carolina ACCESS PCP, LME, or Medicaid-enrolled psychiatrist. Enter referral number on claim or contact EDS Provider Services if referral number is correct.

The following EOB codes will no longer be effective as of May 1, 2009. They will be replaced with one of the EOB codes above.

- **EOB 3091** – Billing NPI and/or Billing Taxonomy is missing. Attending NPI and/or Attending Taxonomy, when required, is missing.
- **EOB 3092** – Billing NPI and/or Billing Taxonomy is missing.
- **EOB 3093** – Attending NPI and/or Attending Taxonomy is missing.
- **EOB 3094** – Referring NPI is missing.

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: Dental Providers

National Provider Identifier Claim Submission Instructions

All dental (ADA) paper and electronic claims should contain a National Provider Identifier (NPI) in fields 49 (billing) and 54 (attending) for NPI mapping purposes. Please be sure to verify all information submitted on your claims. Beginning May 1, 2009, N.C. Medicaid will no longer accept Medicaid Provider Numbers on claims.

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 Drug Code Information

Please refer to the March 2009 Special Bulletin, *National Drug Code Implementation Phase III* (http://www.ncdhhs.gov/dma/bulletin/), for up-to-date information on National Drug Codes. This Special Bulletin replaces the October 2008 version of the Special Bulletin.

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

Attention: All Providers

Computer Sciences Corporation to Assume N.C. Medicaid Provider Enrollment, Credentialing, and Verification Activities

In late April 2009, Computer Sciences Corporation (CSC) will assume the Medicaid provider enrollment, credentialing, and verification activities currently performed by DMA Provider Services. This operational transition from DMA to CSC is occurring as part of the N.C. Department of Health and Human Services (DHHS) Replacement Medicaid Management Information System (MMIS) contract with CSC.

This operational transition is only for the provider enrollment and maintenance activities currently carried out by DMA. Providers will continue to follow the current practices for inquiries on claims billing, claim status, and claims payment.

Additional information will be published in the April 2009 general Medicaid Bulletin (http://www.ncdhhs.gov/dma/bulletin/) and on the DMA website.

Linda Pruitt
DMA, 919-855-4106

Attention: All Providers

Clinical Coverage Policies

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

- 1A-4, *Cochlear and Auditory Brainstem Implants*
- 1B-1, *Botulinum Toxin Treatment: Type A (Botox); Type B (Myobloc)*
- 1K-2, *Bone Mass Measurement*
- 3D, *Hospice Services*
- 3H-2, *Home Tocolytic Infusion Therapy*
- 5C-1, *Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair*
- 8A, *Enhanced Mental Health and Substance Abuse Services*

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

Local Management Entity Utilization Management Project

Session Law 2008-107, Section 10.15(x), requires the Department of Health and Human Services to return the service authorization, utilization review, and utilization management (UM) functions to the Local Management Entities (LMEs). By July 1, 2009, utilization reviews, UM, and service authorizations for publicly funded mental health, developmental disabilities, and substance abuse services must be performed by LMEs representing in total at least 30% of the state's population.

In response to this mandate, a project team was created with representation from DMA and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH). In November, all LMEs were sent a proposal package, which included instructions for submitting a proposal, the requirements and procedures document, and a response document. A question-and-answer session was held and proposals from interested LMEs were received in December.

An evaluation committee reviewed and scored the proposals received and conducted site visits. We are pleased to announce that four LMEs have been selected: The Durham Center, Eastpointe, Mecklenburg Area MH/DD/SAS Authority, and Western Highlands Network.

Implementation of Medicaid UM at the four selected LMEs is targeted to begin July 1, 2009. Additional information on how this transfer will take place will be forthcoming.

Debbie Pittard, LME UM Project Manager
DMA, 919-855-4220

Attention: All Providers

HCPCS Procedure Code Changes for the Physician's Drug Program

The following HCPCS procedure code changes were made to comply with CMS HCPCS procedure code changes.

End-Dated Codes with No Replacement Codes

Effective with date of service December 31, 2008, the following HCPCS procedure codes were discontinued, with no replacement codes available.

End-Dated HCPCS Codes	Description	Unit
J9182	Etoposide	100 mg
Q4096	Von Willebrand factor complex, human, ristocetin cofactor (not otherwise specified)	Per I.U.

New HCPCS Procedure Codes

The following HCPCS procedure codes were added to the list of covered codes for the Physician's Drug Program effective with date of service January 1, 2009.

New HCPCS Codes	Description	Unit
J0641	Levoleucovorin calcium	0.5 mg
J3300	Triamcinolone acetonide, preservative free	1 mg
J7186	Antihemophilic factor VIII/von Willebrand factor complex (human)	Per factor VIII I.U.

End-Dated Codes with Replacement Codes

The following HCPCS procedure codes were end-dated with date of service December 31, 2008, and replaced with new codes effective with date of service January 1, 2009. Claims containing the end-dated codes submitted for dates of service on or after January 1, 2009, will be denied.

End-Dated HCPCS Codes	Description	Unit	New HCPCS Code	Description	New Unit
Q4097	Immune globulin (Privigen) intravenous, non-lyophilized (e.g., liquid)	500 mg	J1459	Immune globulin (Privigen) intravenous, non-lyophilized (e.g., liquid)	500 mg
Q4098	Iron dextran	50 mg	J1750 Reinstated	Iron dextran	50 mg

New Codes for Drugs Previously Billed with the Miscellaneous HCPCS Procedure Codes J3490 and J9999

Effective with date of service January 1, 2009, the N.C. Medicaid Program covers the individual HCPCS procedure codes for the drugs listed in the following table. Claims containing the unlisted drug codes J3490 or J9999 for these drugs submitted for dates of service on or after January 1, 2009, will be denied. An invoice is not required.

End-Dated HCPCS Codes	Description	Unit	New HCPCS Code	Description	New Unit
J3490	Doripenem	500 mg	J1267	Doripenem	10 mg
J3490	Fosaprepitant	115 mg	J1453	Fosaprepitant	1 mg
J3490	Lanreotide	1 mg	J1930	Lanreotide	1 mg
J3490	Levetiracetam	500 mg	J1953	Levetiracetam	10 mg
J3490	Temsirolimus	25 mg	J9330	Temsirolimus	1 mg
J9999	Bendamustine	100 mg	J9033	Bendamustine HCl	1 mg
J9999	Ixabepilone	1 mg	J9207	Ixabepilone	1 mg

Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. Refer to the March 2009 Special Bulletin, *National Drug Code Implementation Phase III*, on DMA's website at http://www.ncdhhs/gov/bulletin/ for instructions.

Refer to the fee schedule for the Physician's Drug Program on DMA's website at http://www.ncdhhs.gov/dma/fee/ for the latest available fees.

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

Attention: All Providers

Reimbursement Rate for Targeted Case Management

DMA is faced with establishing a rate for targeted case management (TCM) that is consistent with the methodology mandated by CMS guidelines and with obtaining CMS approval for a long outstanding State Plan Amendment (SPA).

In order to balance the need for compliance, and to ensure that we have a rate setting methodology that meets CMS guidelines and represents an equitable payment for services, DMA has implemented the following:

- The DMA staff collaborated with a representative group of providers identified to review CMS guidelines, and to review actual cost data, supporting documentation, and justification for a final proposed TCM rate.
- The work group has completed work on development of a new TCM rate for submission to CMS. The work group reviewed accumulated cost and productivity data to develop a methodology in response to CMS's last direction for establishing a TCM rate.
- The rate that was implemented on January 1, 2009, of $18.75 per 15 minute unit of service is the rate submitted to CMS and will remain in effect beyond March 1, 2009.
- Upon receiving CMS approval, DMA will pay claims at the rate approved by CMS.

Rate Setting
DMA, 919-855-4200

Attention: All Providers

Bone Mass Measurement

Effective with date of service February 1, 2009, CPT procedure codes 77078 through 77083, 78350 through 78351, and 76977 were changed as follows:

Table 1: The following codes are no longer reimbursable procedures by N.C Medicaid:

CPT Code	Description
77082	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture assessment
77083	Radiographic absorptiometry (eg, photodensitometry, radiogrammetry), 1 or more sites
78350	Bone density (bone mineral content) study, 1 or more sites; single photon absorptiometry
78351	Bone density (bone mineral content) study, 1 or more sites; dual photon absorptiometry, 1 or more sites

Table 2: The following codes are reimbursable once every two years, except for diagnoses listed in Table 3.

CPT Code	Description
77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)
77079	Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)
77080	Dual energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg hips, pelvis, spine)
77081	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)
76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method

Table 3: CPT procedure codes 77078, 77079, 77080, 77081, and 76977 (described above) are allowed more frequently than every once every two years for one of the following conditions:

Condition	Bill ICD-9-CM Diagnosis Code	Description
Long-term glucocorticoid therapy of 5.0 mg of prednisone or more per day of more than three months' duration	V58.65	Long-term (current) use of steroids
Long-term anticonvulsant therapy of more than three months' duration	V58.69	Long-term (current) use of other medications
Monitoring with uncorrected primary hyperparathyroidism	252.01	Primary hyperparathyroidism

Clinical Coverage Policy 1K-2, *Bone Mass Measurement,* is available on the DMA website at http://www.ncdhhs.gov/dma/mp/.

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

Attention: All Providers

Status Update for the PASARR Segment of the Medicaid Uniform Screening Tool

The Pre-admission Screening and Annual Resident Review (PASARR) segment of the Medicaid Uniform Screening Tool (MUST) has been operational since November 3, 2008. Federal regulation requires PASARR screening for all individuals admitted to a nursing facility before or at the time of admission and annually thereafter for anyone who received a PASARR level II evaluation.

Due to provider concerns about converting to the MUST application, DMA has decided to postpone the full implementation of the MUST tool, which would incorporate additional Medicaid programs such as PDN, PCS, CAP/C, CAP/DA, and CAP/Choice. However, providers may continue to submit PASARR requests through the web-based tool, by fax or via online submission through ProviderLink.

Providers registered in the MUST application who have not logged in or submitted a screening in the last 90 days are encouraged to do so to keep their accounts active. After 90 days of inactivity, North Carolina Identity Management (NCID) will lock the user account. Providers with a user account that is locked will not be able to gain access to the MUST application. NCID will notify providers by e-mail 10 days prior to locking the account. If you have been locked out, please contact NCID at

ITS Customer Service Center
(800) 722-3946
ITS.Incidents@ncmail.net

Training and Support

One-on-one training sessions are available to assist providers with registering in and using the MUST application to submit PASARR screenings. The trainings are conducted remotely via a secured remote access link, which means **participants do not have to travel** to attend the training. The participant is required to have a computer with Internet connectivity. To sign up for a one-on-one training session, please visit the MUST website at http://www.ncmust.com and click on "Sign Up for One on One Training."

The PASARR/Uniform Screening Helpdesk is available Monday through Friday from 8:00 a.m. to 5:00 p.m. by dialing 1-800-688-6696, option 7.

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

Attention: All Providers

Changes to the Electronic Remittance Advice (835 Transaction)

Effective with the July 7, 2009 checkwrite, EDS will include the patient account number in the provider adjustment identifier data element (PLB03-2, PLB05-2, PLB07-2, PLB09-2, PLB11-2, and/or PLB13-2) in the PLB segment when reporting the offsetting entry for refunds processed at the claim level. EDS will also begin to include Institutional Part C claims and no history adjustments on the 835. These will also be reported in the PLB segment. When the patient account is available, it will be reported in the provider adjustment identifier data element. If you use a software vendor, please ensure that these changes are communicated to them. Providers and vendors may contact EDS Electronic Commerce Services at 1-800-688-6696 or 919-851-8888 with any questions.

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

Attention: All Providers

Laboratory Billing Reminder

DMA has received several questions regarding laboratory services. Please refer to the information below when billing for laboratory services.

Collection of Specimens

CPT procedure code 36415 (collection of venous blood by venipuncture) was added as a covered service during the 2005 CPT code update. CPT code 36415 replaced G0001 as of January 1, 2005. Providers must use 36415 when billing this service to N.C. Medicaid.

N.C. Medicaid reimburses for the collection of venous blood by venipuncture specimen only to the provider who extracted the specimen. The provider billing for the specimen collection must send the lab work outside their office to be performed. One collection fee is covered per recipient regardless of the number of specimens drawn.

Hospital Inpatient Services

When the recipient is an inpatient in the hospital, venipuncture and specimen collection are included in the Diagnostic Related Group (DRG) payment and is not reimbursed separately.

Rural Health Clinics/Federally Qualified Health Centers

Rural health clinic/federally qualified health center (RHC/FQHC) providers must bill laboratory services that are performed at the RHC/FQHC using their "C" suffix provider number. Laboratory services not rendered in the RHC/FQHC but sent to a referring laboratory must be billed by the referring laboratory. The laboratory that performs the service must meet CLIA certification requirements and bill for the service rendered.

Nominal reimbursement is available for collecting samples for lab testing in addition to the amount paid under the laboratory fee schedule. Only one collection fee is allowed for each venipuncture for each recipient encounter, regardless of the number of specimens drawn. When a series of specimens is required to complete a single test (e.g., glucose tolerance test), the series is treated as a single encounter. Only the provider who has extracted the specimen from the recipient may bill the collection code. Bill CPT procedure code 36415 on the CMS-1500 claim under the RHC/FQHC's "C" suffix provider number.

Because there is a national cap on payment for laboratory services, the maximum allowable rate for laboratory services is established through the laboratory fee schedule. No additional reimbursement for laboratory services is provided through cost adjustments at the end of the year.

Date of Service

The date of service is the date the specimen was collected, not the date the test was run. For specimens collected over a period that spans two calendar days, the date of service is the date the collection ended.

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

Attention: All Providers

Medicaid Credit Balance Reporting

All providers participating in the Medicaid Program are required to submit to the 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 and recover "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 required documentation 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 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/provider/forms.htm.

Debbie Odette
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

Change in Deadline Date for Resubmission of Denied Claims for Annual Exam Visits for Family Planning Waiver Recipients

As previously published in the December 2008 general Medicaid Bulletin, changes have been made in the claims processing system to allow a provider to bill for an annual physical exam for a Family Planning Waiver (MAFD benefit category) recipient, even if the recipient had another annual physical exam within the previous 365-day period. Claims with dates of service from October 1, 2005, to October 15, 2008, that were denied because the MAFD recipient received an annual physical exam under another Medicaid coverage category within the previous 365 days can be resubmitted as a new claim (not as an adjustment). **The timeframe to resubmit claims has changed from what was previously published to March 1, 2009, through May 31, 2009**.

Once a claim is resubmitted, a new Internal Control Number (ICN) will be assigned to the claim. Only claims resubmitted and assigned an ICN between March 1 and May 31 will pass through the time limit override and continue processing. Providers who plan to re-submit a paper claim should allow additional time to ensure that the claim will be received during the March 1 through May 31 timeframe and assigned an ICN date within that date range.

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

Attention: Outpatient Behavioral Health Service Providers

Payment of Psychiatric Reduction on Professional Crossover Claims

Effective with date of processing March 1, 2009, the Medicare psychiatric reduction amount is allowed to be billed to Medicaid for claims submitted for dates of service on or after April 1, 2008. For the original announcement of this policy change, refer to the October 2008 general Medicaid Bulletin article titled *Medicaid Reimbursement for the Psychiatric Reduction* on DMA's website at http://www.ncdhhs.gov/dma/bulletin/1008bulletin.htm#psych. The Medicare psychiatric reduction cannot be billed to Medicaid for dates of service prior to April 1, 2008.

If providers have claims that have already processed and paid for dates of service on or after April 1, 2008, and would like to include the Medicare psychiatric reduction amount, those claims may be submitted as electronic replacement claims. Ensure that the Medicare psychiatric reduction amount has been entered on the replacement claim transaction. For NCECSWeb Tool electronic replacement claim guidelines, refer to the June 2007 general Medicaid Bulletin article titled *Electronic Adjustments (Replacement Claims)* on DMA's website at http://www.ncdhhs.gov/dma/bulletin/0607bulletin.htm#ele.

If the electronic replacement claim option is not available, providers may submit manual adjustments. The Medicaid Claim Adjustment Request form can be found on DMA's website at http://www.ncdhhs.gov/dma/provider/forms.htm.

Payment of psychiatric reduction on crossover claims is a percentage based on the billing provider type and specialty.

Provider Type	Percent Payment on Psychiatric Reduction
Psychiatrist Licensed Psychologist Multi-Specialty Physician Group	95%
Certified Nurse Practitioner Mental Health Nurse Practitioner	80.75%
Local Management Entities Licensed Clinical Social Worker (LCSW) Licensed Professional Counselor (LPC) Licensed Marriage and Family Therapist (LMFT) Certified Clinical Nurse Specialist (CCNS) Licensed Psychological Associate (LPA) Certified Clinical Supervisor (CCS) Certified Clinical Addictions Specialist (CCAS) Independent Mental Health Practitioner Group	56.67%

For any provider type not listed above, 0% will be paid by Medicaid against the Medicare psychiatric reduction amount. Claims for dually eligible recipients that do not automatically cross over can be filed on a paper CMS-1500 claim form or as an 837 professional transaction. The CMS-1500 paper claim form must be submitted with the Medicare voucher attached. For further 837 professional transaction guidelines, refer to the *X12 Implementation Guide* (http://www.wpc-edi.com/).

The NCECSWeb Tool was modified to include a new field to enter the Medicare psychiatric reduction amount.

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

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) for CAP/DA lead agencies.

The first quarterly training session this year will be held on March 24, 2009, 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 new users in their counties who should attend this session. We recommend that all attendees read and become familiar with the AQUIP User Manual prior to the training session. The manual is available on the AQUIP website (https://www2.mrnc.org/aquip) under "Downloads." Current users who would like to attend the session may do so if space is available. However, the information to be presented is intended for new users.

The seminar is scheduled to begin at 9:00 a.m. and end at 3:00 p.m. The session will provide information on Resource Utilization Group (RUG) scores and will focus on 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, Diagnosis and Treatment (EPSDT) for Medicaid-eligible recipients under the age of 21.

Pre-registration is required. New AQUIP users should contact their CAP/DA lead agency to verify if their name is on the required attendance list. Online registration for the seminar will be available beginning March 2, 2009, and can be accessed by going to https://www2.mrnc.org/aquip and clicking on "Training Sessions." Attendees will receive a computer-generated confirmation number, which they 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.

Driving Directions

Hilton Charlotte at University Place

Take Exit 45A on I-85 (Exit 131 from I-40) onto W. T. Harris Boulevard East. Travel approximately 0.5 mile. The high-rise hotel is located in the University Place complex and is visible from Harris Boulevard. Turn left onto J.M. Keynes Drive, which goes directly into the hotel's parking lot.

CCME, 1-800-682-2650

Attention: Ambulatory Surgical Centers

Ambulatory Surgical Centers Revised Payment System

CMS revised the ambulatory surgical center (ASC) payment system effective January 1, 2008. The final CMS rule established the list of ASC-covered surgical procedures, identified covered ancillary services, and set forth the amount and factors used to determine the payment rates under the revised payment system. The codes listed in the ASC payment methodology changed from pricing based on individual groups to fee schedule pricing.

Effective March 1, 2009, DMA will provide coverage by N.C. Medicaid under the revised payment system retroactive to date of service January 1, 2008. The new pricing methodology will allow ASCs to bill using the Medicaid-covered surgical CPT codes included in the 2008 ASC list as published in the August 2, 2007, Federal Register, Addendum AA – Illustrative ASC Covered Surgical Procedures for CY 2008 and surgical procedure codes added for 2009.

System changes have been made in order for claims to process using the new fee schedule. Claims for dates of service on or after January 1, 2008, that processed after January 1, 2008, will be automatically reprocessed through system adjustments. Providers have the option to resubmit claims that have already processed and paid for dates of service on or after January 1, 2008. Claims may be submitted as an electronic replacement claim.

For NCECSWeb Tool electronic replacement claim guidelines, refer to the June 2007 general Medicaid Bulletin article titled *Electronic Adjustments (Replacement Claims)* on DMA's website at http://www.ncdhhs.gov/dma/bulletin/0607bulletin.htm#ele. If the electronic replacement claim option is not available, providers may submit manual adjustments. The Medicaid Claim Adjustment Request form can be found on DMA's website at http://www.ncdhhs.gov/dma/provider/forms.htm.

Refer to the DMA fee schedule at http://www.ncdhhs.gov/dma/fee/ for a list of the Medicaid-covered codes. DMA is in the process of reviewing the codes included in the CMS list of codes in the BB Addendum – Illustrative ASC Covered Ancillary Services Integral to Covered Surgical Procedures for CY 2008. Providers will be informed of coverage decisions in a future Medicaid bulletin.

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

Attention: Nurse Practitioners and Physicians

Plerixafor 1.2 ml Single-use Vials for Injection (Mozobil, HCPCS Procedure Code J3490) – Billing Guidelines

Effective with date of service December 1, 2008, the N.C. Medicaid Program covers plerixafor injectable (Mozobil) for use in the Physician's Drug Program when billed with HCPCS procedure code J3490 (unclassified drug). Mozobil is available as 1.2 ml single-use vials with a concentration of 20 mg/ml.

Mozobil, in combination with granulocyte-colony stimulating factor (G-CSF), is indicated to mobilize hematopoietic stem cells to the peripheral blood for collection and subsequent autologous transplantation in patients with non-Hodgkin's lymphoma and multiple myeloma. Mozobil may cause fetal harm when administered to a pregnant woman. Thus, women of childbearing age should be advised to avoid becoming pregnant while receiving treatment with Mozobil and breast-feeding is not recommended due to the potential for serious adverse reactions in the nursing infant.

Mozobil is administered as a subcutaneous injection approximately 11 hours prior to initiation of apheresis and after the patient has received G-CSF once daily for four days. The recommended dose for Mozobil is 0.24 mg/kg of actual body weight daily for up to four consecutive days.

For Medicaid Billing

- Providers should bill Mozobil with HCPCS procedure code J3490 (unclassified drug).
- One Medicaid unit of coverage is 1 mg. The maximum reimbursement rate is $244.14 per 1 mg.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. Refer to the March 2009 Special Bulletin, *National Drug Code Implementation Phase III,* on DMA's website at http://www.ncdhhs.gov/dma/bulletin/ for instructions.
- Providers must indicate the number of units used in block 24G on the CMS-1500 claim form.
- Providers must bill their usual and customary charges.

The fee schedule for the Physician's Drug Program is available on DMA's website at http://www.ncdhhs.gov/dma/fee/.

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

Attention: Nurse Practitioners and Physicians

Rasburicase, 0.5 mg (Elitek, HCPCS Procedure Code J2783)

Effective with date of service January 1, 2008, rasburicase (Elitek) was added to the Physician's Drug Program. Elitek is indicated for the management of plasma uric acid levels in **pediatric patients** with leukemia, lymphoma, and solid tumor malignancies who are receiving anti-cancer therapy expected to result in tumor lysis and subsequent elevation of plasma uric acid levels. Rasburicase is usually administered as an IV infusion daily for five days.

For Medicaid Billing

- Providers should bill Elitek with HCPCS procedure code J2783.
- Providers must indicate the number of HCPCS units used in block 24G on the CMS-1500 claim form.
- Providers must bill 11-digit National Drug Codes (NDCs). The NDC units must also be indicated on the claim. When calculating the NDC units, the drug in its original state must be considered, NOT the reconstituted amount.
- Providers must bill their usual and customary charges. Entire single-dose vials may be billed, but the actual dose administered should be billed when multi-dose vials are used.
- One Medicaid unit of coverage is 0.5 mg. The maximum reimbursement amount for each Medicaid unit is $149.54.
- Refer to the March 2009 Special Bulletin, *National Drug Code Implementation Phase III*, on DMA's website at http://www.ncdhhs.gov/dma/bulletin/ for instructions.

The Physician's Drug Program fee schedule may be found on DMA's website at http://www.ncdhhs.gov/dma/fee/.

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

Attention: Dialysis Providers, Hospitals, and Physicians

Pre-Dialysis ESRD Focused Care Study

Beginning in March 2009, DMA will be conducting a Pre-Dialysis ESRD Focused Care Study. The objective of this study is to obtain baseline data to assess the quality of end-stage renal disease (ESRD) care prior to initiation of hemodialysis.

DMA has contracted with The Carolinas Center for Medical Excellence (CCME) to perform chart reviews in N.C. Medicaid provider offices. Practices randomly chosen for this study will be contacted starting in February. Chart reviews and chart requests will take place at inpatient hospitals as well as at sites of outpatient medical care, including physician offices.

Medical record abstraction should be completed by May, and results of the study will subsequently be posted on the DMA website at http://www.ncdhhs.gov/dma/quality/. Please note that results from all practices will be presented in aggregate and will not identify individual provider data.

For additional information or questions regarding this study, please contact Nubya Shabazz at Nubya.Shabazz@ncmail.net or call 919-855-4173.

Quality, Evaluation, and Health Outcomes Unit
DMA, 919-855-4100

Attention: Physicians

Medical Risk Management Project

In December 2008, DMA launched a new behavioral health initiative called Medical Risk Management (MRM). The initiative interfaces with the Behavior Pharmacy Management (BPM) project that DMA rolled out in late 2005. Both MRM and BPM are products of Comprehensive NeuroScience, Inc. (CNS), a clinical research company that focuses on improving care and reducing cost through integrated care management solutions. Funding for the project is provided by Eli Lilly and Company.

The MRM product will begin as a pilot project in Stanly, Cabarrus, and Rowan counties in the Piedmont Behavioral Health Care catchment area and in the Southern Piedmont Community Care Plan of the Community Care of North Carolina (CCNC) network. Approximately 800 ongoing patients are targeted for the intervention. The targeted patients are those at high risk for adverse health outcomes because of serious mental illness and complex comorbidities.

The primary purposes of MRM are to assist with care coordination, to identify arising care issues, and to help ensure optimum care for patients. Every other month, integrated behavioral and medical health information is provided to the patients' key health providers. This information is provided in a report called an integrated health profile (IHP). The report becomes a useful tool to access comprehensive health information about the patient. Information about diagnoses, emergency room and office visits, and medication adherence is included in the report.

Providers who receive an IHP and have questions about it or the information it contains should contact Kathy Sayers (telephone 919-674-0266; e-mail mksayers@cnsmail.com), the MRM Healthcare Liaison for North Carolina. A provider feedback form is enclosed with the IHP. Providers are encouraged to make voluntary comments and return the form according to the instructions.

Pharmacy and Ancillary Services
DMA, 919-855-4300

Attention: Behavioral Health Providers, Board-eligible Professional Counselors, Local Management Entities, Marriage and Family Therapists in the Associate Licensure Status, Physicians, Provisionally Licensed Psychologists, Provisionally Licensed Social Workers, and Provisionally Licensed Clinical Addiction Specialists

Behavioral Health Services Provided by Provisionally Licensed Professionals in Physician Offices

Working with the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, DMA has developed a proposal to allow for reimbursement for the services of provisionally licensed providers who work under the supervision of a physician. DMA will expand the "incident to" policy in order to allow physicians to bill for the services of provisionally licensed professionals. These provisionally licensed professionals are receiving clinical supervision approved by their respective licensing boards and are able to provide clinical services under supervision. They have completed their education and training and have passed or are preparing to take their respective licensing examinations. Physicians may employ or have a contractual agreement with these provisionally licensed providers and bill for their services utilizing the physician's Medicaid provider number.

Previously, providers were notified by North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services Implementation Updates # 43 and # 44 that effective July 1, 2008, physicians could bill for services of the provisionally licensed professionals listed below "incident to" the physician. The Implementation Updates also included billing guidelines to be used when billing for these services.

This bulletin article supersedes any previously published information pertaining to billing for provisionally licensed professionals "incident to" physicians including that which was published in Implementation Updates #43 and #44.

Effective July 1, 2008, the following professionals registered with their individual boards as provisionally licensed professionals can provide reimbursable services that can be billed "incident to" the services of a physician when the service is provided pursuant to the policy outlined in this bulletin article:

- provisionally licensed psychologists
- provisionally licensed social workers
- board-eligible professional counselors
- marriage and family therapists in the associate-licensure status
- provisionally licensed clinical addiction specialists

See the **Procedure Codes** section below for a list of services that the provisionally licensed professionals may provide and the CPT codes that may be used to bill for these services.

Rules and Requirements for Provisionally Licensed Professionals

1. In order for the provisionally licensed professionals listed above to provide services "incident to" a physician, all of the following must be true of the **provisionally licensed professional.**
   a. Must be employed by or have a contractual relationship with
      (1) a physician (individual or group); or
      (2) a behavioral health provider organization that employs a physician; or
      (3) a behavioral health provider organization that contracts with a physician.

      The behavioral health provider organization must demonstrate that it has been endorsed by the Local Management Entity (LME) to provide enhanced services. Additionally, the organization must have achieved national accreditation with at least one of the designated accrediting agencies within the organization's accreditation guidelines. The organization must be established as a legally constituted entity capable of meeting all of the above. For additional information on enhanced services, service definitions, and exclusions, see Clinical Coverage Policy 8A, *Enhanced Mental Health and Substance Abuse Services,* on DMA's website at http://www.ncdhhs.gov/dma/mp/.

b. Must practice at the same site where the physician practices.
   (1) Services provided by the provisionally licensed professional are intended to be primarily office-based.
   (2) If clinically indicated, the provisionally licensed professional may deliver the service in locations such as a recipient's home, school or office as long as the physician and the person providing clinical supervision both agree that the provisionally licensed professional has the skills to provide these services in locations outside the office and that the service location is clinically appropriate for the recipient.
   (3) If the service location is outside the office, the physician must document approval in the recipient's record, and the clinical supervisor must document approval in the supervision record.

c. May provide only those services that have been determined to be medically necessary by the physician who is billing for the service and meets the requirements in #1a, above.

d. Must adhere to all the rules of their respective boards relating to provisional licensure.

e. Must provide only those services that are within the scope of practice for the applicable provisional licensure.

2. **The physician billing "incident to"**

a. Must have a face-to-face visit with the recipient, on or before the first visit for which the provisionally licensed professional provides services, to determine or confirm medical necessity, if the physician does not already have an established relationship with the recipient. Documentation must be maintained by the physician to support medical necessity and the need for referral for outpatient therapy.

b. Must be readily available to the provisionally licensed professional at all times. (This means readily available by phone and able to return to the office if the patient's condition requires it. The physician does not have to be on the same premises; however, the premises must be the location where the physician practices, except as noted in #1b, above.)

c. Must assume responsibility for the individual's work.

d. May, at his or her discretion, add additional requirements for the provisionally licensed professional above and beyond those specified by the individual licensing boards.

3. **The physician, physician group or behavioral health organization billing "incident to" the physician must do the following:**

a. Verify licensure status and the length of time the provisionally licensed professional may have a provisional license upon hiring, and at least annually thereafter, to verify that the provisionally licensed professional remains provisionally licensed and in good standing with the respective board;

b. Maintain documentation to support the verification process of all such licenses; and

c. Verify and document who is providing the clinical supervision to the provisionally licensed professional and ensure that the provisionally licensed professional is receiving clinical supervision.

Supervision

The physician is primarily responsible for the services delivered by any individual and billed "incident to" the physician's services. Clinical supervision must be provided according to the requirements of the respective licensing board of each provisionally licensed professional. The provisionally licensed professional will need to arrange for a qualified clinical supervisor as determined by the respective board. The board-approved clinical supervisor assumes professional responsibility for the services provided by the provisionally licensed professional and spends as much time as necessary directly supervising services to ensure that recipients are receiving services in a safe and efficient manner in accordance with accepted standards of practice. The supervisor does not have to be on site unless a qualified on-site supervisor is a board requirement. However, the supervisor must be available by telephone while services are being provided. Documentation as required by the licensing board must be kept to support the clinical supervision provided in the delivery of medically necessary services.

Billing Guidelines

Reimbursement requires compliance with all Medicaid guidelines. For billing instructions refer to

- Clinical Coverage Policy 8C, *Outpatient Behavioral Health Services Provided by Direct Enrolled Providers*, at http://www.ncdhhs.gov/dma/mp/
- May 2005 Special Bulletin IV, *Expansion of Provider Types for Outpatient Behavioral Health Services Phase II*, at http://www.ncdhhs.gov/dma/bulletin/

When a provisionally licensed professional is employed by or has a contractual relationship with a physician (individual or group), the services are "incident to" the physician and should be billed under the physician provider number. No supervisory fee can be billed by the physician.

Services rendered by a provisionally licensed professional cannot be billed for a patient receiving services provided by the ACT Team.

Procedure Codes

Earlier publications listed the following codes – H0001, H0004, H0005, H0031 – for use by physicians billing for provisionally licensed professionals. Effective with dates of service May 1, 2009, use the designated CPT codes listed below rather than the H codes. The SC modifier must be appended to all CPT codes used to bill for the services of a provisionally licensed professional.

The table below lists the CPT codes that should be used (with modifier SC) instead of H0001, H0004, H0005, and H0031.

CPT Code	Description
90801	Psychiatric diagnostic interview examination
90802	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication
90804	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient
90806	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient
90846	Family psychotherapy (without patient present)
90847	Family psychotherapy (conjoint psychotherapy) (with patient present)
90853	Group psychotherapy (other than a multiple-family group)
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (eg. AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (eg. AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes

HCPCS Codes	CPT Replacement Codes
H0001	Bill using CPT codes 99408 or 99409 with the SC modifier
H0004	Bill using CPT codes 90804 or 90806 with the SC modifier
H0004HS	Bill using CPT code 90846 with the SC modifier
H0004HR	Bill using CPT code 90847 with the SC modifier
H0004HQ	Bill using CPT code 90853 with the SC modifier
H0005	Bill using CPT code 90853 with the SC modifier
H0031	Bill using CPT codes 90801 or 90802 with the SC modifier

- Providers who have billed "incident to" the physician using H0001, H0004, H0005, and H0031 and have had their claims denied should resubmit their claims by May 1, 2009. Providers who have not submitted claims must also submit their claims by May 1, 2009.
- Effective May 1, 2009, all providers must bill for services provided by provisionally licensed professionals "incident to" the physician using the CPT codes with the SC modifier.
- Providers must always bill their usual and customary charges.

Prior Approval

Agencies that have contacted ValueOptions since July 1, 2008, for prior approval for the H0001, H0004, H0005, and H0031 will not be required to receive a new prior approval for CPT codes for dates of service provided prior to May 1, 2009. Prior approval is required using CPT codes with the SC modifier for dates of service effective May 1, 2009. While DMA understands that getting new prior approval for services already authorized may cause some additional hardship, this is the best alternative available to allow DMA to move forward with this implementation.

Prior approval is required for services that exceed the limit of 8 visits each calendar year (for recipients 21 years of age and over)or 26 visits per calendar year (for recipients under 21). The ValueOptions Prior Approval Request Form must be completed by the provisionally licensed professional and signed by the physician billing "incident to." For more information on prior approval refer to

- Clinical Coverage Policy 8C, *Outpatient Behavioral Health Services Provided by Direct Enrolled Providers*, at http://www.ncdhhs.gov/dma/mp/
- May 2005 Special Bulletin IV, *Expansion of Provider Types for Outpatient Behavioral Health Services Phase II*, at http://www.ncdhhs.gov/dma/bulletin/
- ValueOptions, http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm

Physicians who employ a provisionally licensed professional must read the ValueOptions information to ensure correct completion of the Outpatient Review Form (ORF2) for prior approval.

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

Attention: Hospice Providers

Hospice Rate Review

On October 10, 2008, DMA issued a memorandum regarding deferment of rate increases. Providers affected by this memorandum included hospice providers. Upon further review of federal regulation, hospice providers are potentially not subject to this deferment. DMA is reviewing all available regulatory requirements and will notify the hospice associations and providers should there be any forthcoming changes.

Rate Setting
DMA, 919-855-4207

Attention: Enhanced Mental Health and Substance Abuse Service Providers

Professional Treatment Services in Facility Based Crisis Programs

Information published in Implementation Update #48 (http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/) stated that Facility Based Crisis Programs could not be billed and reimbursed for adults under the age of 21 years old. Through further advocacy with CMS, their decision was reversed, allowing Medicaid reimbursement for these services. The implementation of this service expansion will occur as follows:

For Medicaid recipients age 18 through 20 years old, a new procedure code/modifier combination was implemented effective with date of service **March 1, 2009.**

- Providers who are direct-enrolled can be reimbursed for services rendered by billing S9484 with modifier HA.
- The rate of reimbursement for S9484 with modifier HA is $17.99 per unit (1 unit = 1 hour).
- No more than 16 units can be billed and reimbursed per date of service.
- No more than 480 units (30 days) can be billed and reimbursed within a calendar year.
- All current policy applicable to S9484 with no modifier will apply to S9484 with modifier HA.

For Medicaid recipients age 21 years old and older, S9484 with no modifier should continue to be billed for reimbursement.

- The rate of reimbursement for S9484 with no modifier will continue to be $17.99 per unit (1 unit = 1 hour).
- No more than 16 units can be billed and reimbursed per date of service.
- No more than 480 units (30 days) can be billed and reimbursed within a calendar year.
- All current policy applicable to S9484 with no modifier remains in place.

The application of these separate procedure code/modifier combinations will allow DMA to assess the impact of the policy change. The Service Definition Review Work Group convened by DMA and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services will be asked to develop the endorsement and service definition criteria for Facility Based Crisis Program services specific to Medicaid recipients under age 18. Further information will be communicated as this process unfolds.

For any questions concerning this change in billing procedures, please contact EDS Provider Services at 1-800-688-6696 or 919-851-8888.

Behavioral Health Services
DMA, 919-855-4290

Attention: All Providers

Registration for Basic Medicaid Seminars

Basic Medicaid seminars are scheduled for April 2009. Registration information, a list of dates, and site locations for the seminars are listed below.

Each Basic Medicaid seminar series will begin with a general session followed by break-out sessions specific to each claim form type. An NCECSWeb Tool overview is one of the break-out options. Please refer to the descriptions below to determine which session(s) you would like to attend. (Please note that the claim form break-out sessions are not program-specific.)

Pre-registration is required and you must register separately for each individual session. Due to limited seating, registration is limited to two staff members per office. A confirmation letter will be sent to you in response to your registration request. Please print and bring the confirmation letter with you to the Basic Medicaid seminars. 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/provider/seminars.htm. Providers may also complete the Seminar Registration Form at the end of this article and fax it to the number listed on the form.

The April 2009 Basic Medicaid seminar series schedule is as follows:

General Session, 9:00 a.m. to 11:00 a.m.

Information presented at the general session is a general review of N.C. Medicaid and is applicable to all provider types. The *Basic Medicaid Billing Guide* on DMA's website will be used as the primary training document for the seminar. Please review and print the April 2009 version and bring it to the seminar. The April 2009 *Basic Medicaid Billing Guide* is available on DMA's website at http://www.ncdhhs.gov/dma/basicmed/. To register, go to http://www.ncdhhs.gov/dma/provider/seminars.htm.

ADA Dental Claim/Dental NCECSWeb, 11:30 a.m. to 12:30 p.m.

Information presented at the ADA Dental Claim/Dental NCECSWeb Tool session is a general review of information on paper claim forms and NCECSWeb Tool ADA claim submission guidelines. Providers interested in attending this session are advised to print Section 5 of the April 2009 *Basic Medicaid Billing Guide* and the July 2007 Special Bulletin, *NCECSWeb Instruction Guide* and bring them to the seminar. The Special Bulletin is available on DMA's website at http://www.ncdhhs.gov/dma/bulletin/. To register, go to http://www.ncdhhs.gov/dma/provider/seminars.htm.

Institutional Claim (837I/UB-04)

First session: 1:00 p.m. to 2:00 p.m.
Second session: 2:30 p.m. to 3:30 p.m.

Information presented at the Institutional Claim (837I/UB-04) session is a general review of information on Institutional paper claim forms and submission guidelines. Providers interested in attending this session are advised to print Section 5 of the April 2009 *Basic Medicaid Billing Guide* and bring it to the seminar. Please select from one of the two available sessions to attend. The sessions are identical. To register, go to http://www.ncdhhs.gov/dma/provider/seminars.htm.

Professional Claim (837P/CMS-1500)

First session: 1:00 p.m. to 2:00 p.m.
Second session: 2:30 p.m. to 3:30 p.m.

Information presented at the Professional Claim (837P/CMS-1500) session is a general review of information on Professional paper claim forms and submission guidelines. Providers interested in attending this session are advised to print Section 5 of the April 2009 *Basic Medicaid Billing Guide*, and bring it to the seminar. Please select from one of the two available sessions to attend. The sessions are identical. To register, go to http://www.ncdhhs.gov/dma/provider/seminars.htm.

NCECSWeb Tool

First session: 1:00 p.m. to 2:00 p.m.
Second session: 2:30 p.m. to 3:30 p.m.

Information presented at the NCECSWeb Tool session is a general review of the N.C. Medicaid Web-based Electronic Claims Submission (NCECSWeb) Tool. The tool is an online application for submitting Institutional, Professional, and Dental HIPAA-compliant claims to N.C. Medicaid. Providers interested in attending this session are advised to print the July 2007 Special Bulletin, *NCECSWeb Instruction Guide*, and bring it to the seminar. Please select from one of the two available sessions to attend. The sessions are identical. To register, go to http://www.ncdhhs.gov/dma/provider/seminars.htm.

Providers are encouraged to arrive at least 15 minutes before each individual session to complete registration. Lunch will not be provided at the seminars. **Because meeting room temperatures vary, dressing in layers is strongly advised.**

Lenoir **Tuesday, April 21, 2009**	**New Bern** **Thursday, April 23, 2009**	**Raleigh** **Wednesday, April 29, 2009**
J.E. Broyhill Civic Center 1914 Hickory Boulevard Lenoir NC 28645	New Bern Convention Center 203 South Front Street New Bern NC 28563	Wake Tech Community College Student Services Building 9101 Fayetteville Road Raleigh NC 27603

Directions to the Basic Medicaid Seminars

LENOIR
J.E. Broyhill Civic Center
Traveling East on I-40: Take exit 123 North (US-321N/US-70/State Hwy 127N) and drive 15.3 miles. The J.E. Broyhill Civic Center is ahead on the right.

From Morganton: Take Hwy. 18 into Lenoir. Turn right onto Southwest Boulevard and go 5.5 miles to the end of the highway. Take the northbound exit to Lenoir. The J.E. Broyhill Civic Center is ahead on the right.

From Boone: Take Hwy. 321 South into Lenoir. From the US 321/US 64-NC 18 intersection, the J.E. Broyhill Civic Center is 2 miles ahead on the left.

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

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

RALEIGH
Wake Technical Community College
Student Services Building
Take I-440 to US 401 South/S. Saunders Street (Exit 298). Stay to the right to continue on US 401 South/Fayetteville Road. Continue to travel on US 401 South/Fayetteville Street through Fuquay-Varina. The college is located on the left approximately 1 mile from the intersection with NC 1010. Turn left onto Chandler Ridge Circle. Visitor parking is on the left.

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

Basic Medicaid Workshops
April 2009 Seminar Registration Form
(No Fee)

Provider Name _____

Medicaid Provider Number _____ NPI Number _____

Mailing Address _____

City, Zip Code _____ County _____

Contact Person _____ E-mail _____

Telephone Number (____) _____ Fax Number _____

1 or **2** person (s) will attend the following sessions (check all that apply):
(circle one)

- ☐ General Session, 9:00 a.m. to 11:00 a.m.
- ☐ ADA Dental Claim/ Dental NCECSWeb Tool, 11:30 a.m. to 12:30 p.m.
- ☐ Institutional Claim, 1:00 p.m. to 2:00 p.m.
- ☐ Institutional Claim, 2:30 p.m. to 3:30 p.m.
- ☐ Professional Claim, 1:00 p.m. to 2:00 p.m.
- ☐ Professional Claim, 2:30 p.m. to 3:30 p.m.
- ☐ NCECSWeb Tool, 1:00 p.m. to 2:00 p.m.
- ☐ NCECSWeb Tool, 2:30 p.m. to 3:30 p.m.

Please specify seminar location and date:

- ☐ Lenoir
- ☐ New Bern
- ☐ Raleigh

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

Early and Periodic Screening, Diagnosis and Treatment and Applicability to Medicaid Services and Providers

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria stated in this publication **may be exceeded or may not apply to recipients under 21 years of age** if the provider's documentation shows that

- the requested service is medically necessary to correct or ameliorate a defect, physical or mental illness, or health problem; and
- all other Early and Periodic Screening, Diagnostic and Treatment (EPSDT) criteria are met.

This applies to both proposed and current limitations. Providers should review any information in this publication that contains limitations in the context of EPSDT and apply that information to their service requests for recipients under 21 years of age. A brief summary of EPSDT follows.

EPSDT is a federal Medicaid requirement (42 U.S.C. § 1396d(r) of the Social Security Act) that requires the coverage of services, products, or procedures for Medicaid recipients under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (including any evaluation by a physician or other licensed clinician).

This means that EPSDT covers most of the medical or remedial care a child needs to

- improve or maintain his or her health in the best condition possible OR
- compensate for a health problem OR
- prevent it from worsening OR
- prevent the development of additional health problems

Medically necessary services will be provided in the most economic mode possible, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure that is unsafe, ineffective, experimental, or investigational; that is not medical in nature; or that is not generally recognized as an accepted method of medical practice or treatment.

If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **not** eliminate the requirement for prior approval.

For important additional information about EPSDT, please visit the following websites:

- *Basic Medicaid Billing Guide* (especially sections 2 and 6): http://www.ncdhhs.gov/dma/basicmed/
- *Health Check Billing Guide:* http://www.ncdhhs.gov/dma/healthcheck/
- EPSDT provider information: http://www.ncdhhs.gov/dma/epsdt/.

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/mpproposed/. To submit a comment related to a policy, refer to the instructions on the website. Providers without Internet access can submit written comments to the address listed below.

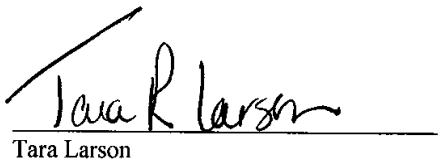
Loretta Bohn
Division of Medical Assistance
Clinical Policy Section
2501 Mail Service Center
Raleigh NC 27699-2501

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

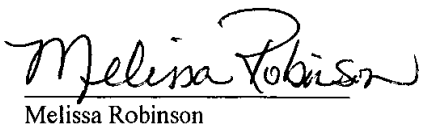
2009 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
February	02/26/09	03/03/09
March	3/5/09	3/10/09
	3/12/09	3/17/09
	3/19/09	3/26/09

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



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



Melissa Robinson
Executive Director
EDS, an HP Company