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North Carolina Medicaid Bulletin

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

Attention: All Providers

Radiation Treatment Delivery and Management Codes Billing Guidelines

Use the following guidelines to bill radiation treatment delivery (CPT codes 77401 through 77416), portal verification films (77417), and radiation treatment management (CPT codes 77427 through 77470).

Radiation Treatment Delivery Codes

- Radiation treatment delivery codes are reimbursable as technical component - only procedures and do not carry professional physician components. Bill the codes with modifier TC in block 24D of the CMS-1500 claim form.
- Treatment delivery codes are based on the level of energy delivered and the number of areas treated.
- Codes 77402 through 77416 are limited to three per day. Code 77401 can only be reported once per treatment session regardless of the number of sites treated.
- Enter the actual date of treatment in block 24A of the CMS-1500 claim form. When one level of treatment is rendered on consecutive days, and only one treatment was rendered on each day, a span of dates can be billed on a single detail line. Bill the number of units for each procedure code on separate details when various energy levels are delivered during the course of treatment.
- Enter the total number of treatments delivered in block 24G of the CMS-1500 claim form.
- Submit the claim at the end of the course of treatment.

Treatment Delivery Codes

CPT Code	Description of Radiation Treatment Delivery	Energy Level
77401	One or more separate sites	Superficial and/or ortho voltage
77402	Single treatment area, single port or parallel opposed ports, simple blocks or no blocks	Up to 5 MeV
77403	Single treatment area, single port or parallel opposed ports, simple blocks or no blocks	6 – 10 MeV
77404	Single treatment area, single port or parallel opposed ports, simple blocks or no blocks	11 – 19 MeV
77406	Single treatment area, single port or parallel opposed ports, simple blocks or no blocks	20 MeV or greater
77407	Two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks	Up to 5 MeV
77408	Two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks	6 – 10 MeV
77409	Two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks	11 – 19 MeV
77411	Two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks	20 MeV or greater
77412	Three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, special particle beam (e.g., electron or neutrons)	Up to 5 MeV
77413	Three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, special particle beam (e.g., electron or neutrons)	6 – 10 MeV
77414	Three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, special particle beam (e.g., electron or neutrons)	11 – 19 MeV
77416	Three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, special particle beam (e.g., electron or neutrons)	20 MeV or greater

Portal Verification Film(s) – Code 77417

- This code is a technical component-only procedure and does not carry a professional physician component.
- The review and interpretation is considered part of the physician's weekly treatment management.
- Billing of portal verification film(s) is limited to once per day, regardless of the number of films required.

Radiation Treatment Management Codes

- Radiation treatment management represents the physician's professional services and typically consists of the review of portal films; review of dosimetry, dose delivery, and treatment parameters; review of recipient treatment set up; and the examination of patient for medical evaluation and management (E/M) to assess the recipient's response to treatment. **A separate E/M code must not be reported during the course of treatment.**
- These codes are limited to one per day with a maximum of five in a four-week period. Bill only one code per detail with the applicable date of service.

Radiation Treatment Management Codes

CPT Code	Description	Comments
77427	Radiation treatment management, five treatments	Reported in units of five treatment sessions, regardless of the actual time period in which the services are furnished. Weekly is interpreted as five treatments, not a calendar week. The services need not be furnished on consecutive days. Multiple treatment sessions furnished on the same day may be counted separately, as long as there has been a distinct break in therapy sessions and are usually furnished on different days. Examination for medical evaluation and management is included and a separate E/M code is not reported during treatment. This code is also reported if there are three or four sessions beyond a multiple of five at the end of a course of treatment.
77431	Radiation therapy management with complete course of therapy consisting of one or two sessions only	One or two treatments comprise the full course of therapy. Not to be used to report the last one or two days of a longer treatment course. Only two units allowed in a seven day period.
77432	Stereotactic radiation treatment management of cerebral lesion(s) (complete course of treatment consisting of one session)	Charged only once for each course of treatment of the cerebral lesion. If more than one treatment is delivered, use 77432 on day one, then use 77427 or 77431 per these codes' rules and criteria.
77470	Special treatment procedure (e.g. total body irradiation, hemibody radiation, per oral, endocavitary or intraoperative cone irradiation)	Report only once per course of therapy. This code is used in clinical situations where additional physician effort and work for special radiation procedures are needed.

Medicaid will not reimburse for office visits, burn treatment, care of infected skin, follow-up exams or infusion therapy for 30 days after the last date of service for radiation treatment management codes. Medicaid policy is based on the *Correct Coding Initiative (CCI) Manual, Version 11.0.* According to CCI, the codes listed below are considered to be included within the weekly management and should not be billed separately.

CPT Codes Included in the Weekly Management Codes

11920	11921	16000	16010	16015	16020	16025	16030	36425	51701	51702	51703
90804	90805	90806	90807	90808	90809	90816	90817	90818	90819	90821	90822
90847	96150	96151	96152	96153	96154	97802	97803	97804	99183	99185	99211
99212	99213	99214	99215	99238	99281	99282	99283	99284	99285	99354	99355
99356	99357	99360									

Additionally, code 61795 is included with 77432 in the weekly management and should not be billed separately from 77432.

Example of Billing on the CMS-1500 Form

24. A						**B**	**D**		**E**	**F**	**G**	
Dates of Service						**Place of Service**	**Procedures, services, or supplies**		**Diagnosis Code**	**Charges**	**Days or Units**	
From			**To**									
mm	**dd**	**yy**	**mm**	**dd**	**yy**							
06	08	05	06	08	05	21	77404	TC		50	00	1
06	09	05	06	10	05	21	77403	TC		100	00	2
06	11	05	06	11	05	21	77404	TC		50	00	1
06	12	05	06	12	05	21	77406	TC		50	00	1
06	12	05	06	12	05	21	77427			200	00	1
06	15	05	06	15	05	21	77408	TC		100	00	2

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

Attention: CAP/DA, CAP/C, CAP/AIDS, and CAP/Choice Case Managers

Coding Change

Effective with date of service April 1, 2005 HCPCS code S8409, Disposable Liner/Shield for Incontinence, will no longer be valid for billing this service. The code will be replaced by T4535, Disposable Liner/Shield/Pad for Incontinence.

Continue use of code S8409 through March 31, 2005 dates of service.

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

Attention: All Providers

Sincalide (Kinevac) Coverage

Effective with date of service December 31, 2004, CPT code 78990, provision of diagnostic radiopharmaceutical(s), was discontinued by the American Medical Association (AMA). Effective January 1, 2005, providers billing Sincalide (Kinevac) must bill using HCPCS code A4641, supply of radiopharmaceutical diagnostic imaging agent, not otherwise classified.

Billing Guidelines:

- Bill on the CMS-1500 claim form, with an invoice attached.
- The invoice must include the recipient's name and Medicaid identification number, the name of the agent, the dose administered, and the cost per dose.
- Providers must bill **A4641** (Sincalide / Kinevac)

AND

- **78223** (Hepatobiliary ductal system imaging, including gallbladder, with or without pharmacologic intervention, with or without quantitative measurement of gallbladder function)

AND/EITHER

- **A9510** (Hepatolite / Disofenin)

OR

- **A9513** (Choletec / Mebrofenin)

If **A9510** or **A9513** and **78223** are not billed with **A4641** on the same claim with the same date of service by the same provider, the claim will deny.

Claims submitted without an invoice will deny. Reimbursement is based on the actual invoice price of the agent only (less the shipping and handling).

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

Attention: All Providers

Medicaid Provider Survey

Provider Input Requested!

The Office of Medicaid Management Information System Services (OMMISS) has prepared a survey to identify opportunities to better serve providers who participate in Medicaid and other DHHS reimbursement programs that will be replaced by the new *NCLeads* system in 2006.

This survey is intended to identify the provider community's current access to systems and the Internet, along with technical support availability. It is also important for us to understand and track your claims submittal process and satisfaction levels with the current MMIS+.

You are encouraged to complete the survey located at http://ncleads.dhhs.state.nc.us/survey to ensure the new *NCLeads* system will address your access requirements and system education preferences. Survey participants can be assured that their responses will be considered for *NCLeads* improvement opportunities as well as to tailor provider education and communication about the *NCLeads* solution.

If you have any questions about the survey, please e-mail NCMMIS.Provider@ncmail.net. Thank you for your participation in this effort!

Tom Liverman, OMMISS Provider Relations
919-647-8315
NCMMIS.Provider@ncmail.net

Attention: All Providers

NCLeads Update

Information related to the implementation of the new Medicaid Management Information System, *NCLeads*, scheduled for implementation in mid-2006 can be found online at http://ncleads.dhhs.state.nc.us. Please refer to this website for information, updates, and contact information related to the *NCLeads* system.

Thomas Liverman, Provider Relations
Office of MMIS Services
919-647-8315

Attention: Durable Medical Equipment Providers

Correction Fluid and Correction Tape on Certificate of Medical Necessity and Prior Approval Forms

The use of correction fluid and/or correction tape is not allowed on medical documents. EDS will continue to deny any requests submitted with either of those products applied to the Certificate of Medical Necessity and Prior Approval forms.

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

Attention: Durable Medical Equipment Providers

Enteral Nutrition HCPCS Codes Rate Change

Effective with date of service February 1, 2005, the Medicaid maximum reimbursement rate for the following DME enteral medical supplies has been increased.

HCPCS Code	Description	Reimbursement Rate
B4034	Enteral feeding supply kit; syringe, per day	$5.78
B4035	Enteral feeding supply kit; pump fed, per day	11.02
B4036	Enteral feeding supply kit; gravity fed, per day	7.55
B4081	Nasogastric tubing with stylet	20.42
B4082	Nasogastric tubing without stylet	15.20
B4083	Stomach tube – Levin type	2.32

Providers must bill their usual and customary charges. Fee schedules are available on DMA's website at http://www.dhhs.state.nc.us/dma/fee/fee.htm.

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

Attention: Health Check Providers

Health Check Seminars

Health Check seminars for all providers except health departments are scheduled for May 2005. Attendance at these seminars is very important. The seminars will focus on Health Check billing requirements, as well as vision and hearing assessments and developmental screenings.

A separate teleconference for local health departments sponsored by the Division of Public Health is scheduled for Monday, May 23, 2005. Health departments should refer to the next page for information on registering for the teleconference. Both the seminars and the teleconference will use the April 2005 Special Bulletin III, *Health Check Billing Guide 2005*, as the primary handout for the session. Providers must access and print the PDF version of the special bulletin from DMA's website at http://www.dhhs.state.nc.us/dma/bulletin.htm and bring it to the session.

Pre-registration is required. Providers not registered are welcome to attend the seminars if space is available. Providers may register by completing the form on the next page or by registering online at http://www.dhhs.state.nc.us/dma/provsem.htm. Please indicate on the registration form the session you plan to attend. Seminars are scheduled to begin at 10:00 a.m. and end at 1:00 p.m. or earlier. Lunch will not be served. Providers are encouraged to arrive by 9:45 a.m. to complete registration.

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

Schedule for the Health Check Seminars:

Wednesday, May 11, 2005 Jane S. McKimmon Center 1101 Gorman Street Raleigh, NC	**Thursday, May 12, 2005** Greenville Hilton 207 Greenville Blvd. SW Greenville, NC
Wednesday, May 18, 2005 Blue Ridge Community College Bo Thomas Auditorium College Drive Flat Rock, NC	**Thursday, May 19, 2005** Hilton University Place 8629 J.M. Keynes Drive Charlotte, NC 28262

Directions to the Health Check Seminars

Jane S. McKimmon Center – Raleigh, North Carolina

Traveling East on I-40

Take exit 295 and turn left onto Gorman Street. Travel approximately one mile. The McKimmon Center is located on the right at the corner of Gorman Street and Western Boulevard.

Traveling West on I-40

Take exit 295 and turn right onto Gorman Street. Travel approximately one mile. The McKimmon Center is located on the right before you reach Western Boulevard.

Greenville Hilton – Greenville, North Carolina

Take Highway 64 East to Highway 264 East. Follow 264 East to Greenville. Once you enter Greenville, turn right on Allen Road. After approximately 2 miles, Allen Road becomes Greenville Boulevard/Alternate 264. Follow Greenville Boulevard for 2 ½ miles. The Greenville Hilton is located on the right.

Blue Ridge Community College, Bo Thomas Auditorium – Flat Rock, North Carolina

Take I-40 to Asheville. Travel east on I-26 to exit 22. Turn right and then take the next right. Follow the signs to Blue Ridge Community College. Turn left at the large Blue Ridge Community College sign. The college is located on the right. Take the first right-hand turn into the parking lot for the Bo Thomas Auditorium.

Hilton University Place – Charlotte, North Carolina

Exit from I-85 exit 45A, Harris Boulevard Eastbound, from either North or South on 85. Hilton Charlotte University Place is on the left in the University Place complex. The hotel is the high rise building in the complex, totally visible from Harris Boulevard. The left turn at J M Keynes Drive goes right into the hotel parking lot.

Registration Form for the Health Check Seminars

(cut and return registration form only)

Health Check Seminar Registration Form

(No Fee)

Provider Name _____ Provider Number _____

Address _____ Contact Person _____

City, Zip Code _____ County _____

Telephone Number (___) _____ Fax Number (___) _____ E-mail Address _____

1 or **2** (circle one) person(s) will attend the seminar at _____ on _____
(location) (date)

Return to: Provider Services
EDS
P.O. Box 300009
Raleigh, NC 27622

Attention: Health Departments

Training for Local Health Departments on Health Check Requirements and Billing

A training session is scheduled for local health department staff from 1:00 p.m. through 4:00 p.m. on May 23, 2005 via the Public Health Training and Information Network (PHTIN). This session, entitled *Health Check - 2005 Update*, will cover vision and hearing assessments and the developmental screening requirements for the Health Check Program.

Registration information has been sent to local health departments. If you do not receive this registration information by April 15, 2005, please contact the Public Health Nursing & Professional Development Unit in the Division of Public Health at 919-733-6850. The target audience for this session is both clinical staff who perform the Health Check screenings and billing staff.

The April 2005 Special Bulletin III, *Health Check Billing Guide 2005*, is the primary handout for this session. Attendees must access and print the PDF version of this special bulletin from the Division of Medical Assistance's website at http://www.dhhs.state.nc.us/dma/bulletin.htm. Copies of this handout will not be provided onsite.

Joy Reed, Local Technical Assistance and Training
Division of Public Health
919-715-4385

Attention: Hospice Providers

Pharmacy Charges for Hospice Recipients

Effective with date of service February 25, 2005, transactions submitted through the pharmacy point of sale (POS) system for a recipient who has elected the hospice benefit will be denied because medications related to the recipient's terminal illness are covered through the hospice program. Reimbursement arrangements must be made between the hospice agency and the pharmacy regarding the dispensing of medications related to the treatment of the recipient's terminal illness. Medicaid continues to cover medications for hospice recipients when the medication is not related to the recipient's terminal illness. To override the POS system when billing for a medication unrelated to the recipient's terminal illness, the pharmacist must enter the appropriate ICD-9-CM diagnosis code. The pharmacy must contact the recipient's hospice provider to obtain the diagnosis code.

Overrides are not allowed for the following drug classes: narcotic analgesics, hematinics, antiemetics, and most chemotherapeutics.

Pharmacies may contact the Division of Medical Assistance (919-855-4300) for assistance with determining if a medication is related to the recipient's terminal illness.

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

Attention: All Mental Health and Substance Abuse Providers

New Contract for Utilization Review

ValueOptions, Inc. (VO) has been awarded the North Carolina Medicaid contract for Utilization Review for Mental Health and Substance Abuse Services for Medicaid recipients across the state. This new contract period begins July 1, 2005. VO will continue to perform utilization review for the following services: acute inpatient/substance abuse hospital care for Medicaid recipients through age 64; Psychiatric Residential Treatment Facilities (PRTF); Levels II through IV Residential Treatment Facilities; outpatient psychiatric services; elective and emergency admission reviews; concurrent continued stay reviews; post payment reviews and post discharge reviews; out-of-state services for Residential Level IV and PRTF; and Criterion 5 services for recipients under 17 years of age. VO will broaden the scope of utilization review to incorporate the following services: Assertive Community Treatment Team (ACTT), Case Management; Day Treatment; Partial Hospitalization; Community Based Services; Psychosocial Rehabilitation; Professional Treatment Services in Facility Based Crisis Program; Outpatient Treatment; and Levels II-IV Residential Treatment Services beginning with the initial authorization and authorizing continued stay.

Note: When the Local Management Entity/ (LME) are deemed ready by the Department of Health and Human Resources (DHHS), these listed Community Based Services may be authorized by the LME for their catchment area. Information about provider training and seminar sites will be published in the general Medicaid bulletin in May along with a Special Medicaid Bulletin for use as a training manual.

Behavioral Health Services
919-855-4291

Attention: Physicians

Pegaptanib, 0.3 mg (Macugen, J3490) – Billing Guidelines

Effective with date of service April 1, 2005, the N.C. Medicaid program covers pegaptanib (Macugen) for use in the Physician's Drug Program. Macugen is a vascular endothelia growth factor (VEGF) inhibitor. The FDA states that it is indicated for the treatment of neovascular (wet) age-related macular degeneration (AMD). The FDA indicates that the usual adult dose is 0.3 mg intravitreous injection into affected eye every six weeks.

The ICD-9-CM diagnosis code required when billing for Macugen is 362.52 (Exudative senile macular degeneration of retina).

Providers must bill J3490, the unclassified drug code, with an invoice attached to the CMS-1500 claim form. **An invoice must be submitted with each claim.** The paper invoice must indicate the recipient's name and Medicaid identification number, the name of the medication, the dosage given, the National Drug Code (NDC) number from the vial(s) used, the number of vials used, and the cost per dose. Providers must indicate the number of units given in block 24G on the CMS-1500 claim form. For Medicaid billing, one unit of coverage is 0.3mg/0.9mL. The maximum reimbursement rate per unit is $1,119.37. Providers must bill their usual and customary charge. Add this drug to the list of injectable drugs published in the November 2004 general Medicaid bulletin.

Physicians' Billing Requirements

- Use the CMS-1500 claim form.
- Enter ICD-9-CM diagnosis code 362.52 in block 21.
- Enter the date of service in block 24A.
- Enter the place of service in block 24B.
- Enter HCPCS code J3490 in block 24D.
- Enter the usual and customary charge in block 24F.
- Enter the units given in block 24G (0.3 mg = 1 unit).

Example

21 Diagnosis	**24A Date(s) of Service**	**24B Place of Service**	**24D Procedures, Services or Supplies**	**24F Charges**	**24G Days or Units**
362.52	04152005	11	J3490	$	1

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

Attention: Physicians and Nurse Practitioners

Alemtuzumab, 10 mg (Campath, J9010) – Billing Guidelines

Effective with date of service April 1, 2005, the N.C. Medicaid program covers alemtuzumab (Campath) for use in the Physician's Drug Program. Campath is indicated for the treatment of B-cell chronic lymphocytic leukemia (B-CLL) in patients who have been treated with alkylating agents and who have failed fludarabine therapy. The FDA's recommended administration of Campath is initiation at a dose of 3 mg administered as a 2 hour IV infusion daily. When the Campath 3 mg daily dose is tolerated (e.g., infusion-related toxicities are Grade 2), the daily dose should be escalated to 10 mg and continued until tolerated. When the 10 mg dose is tolerated, the maintenance dose of Campath 30 mg may be initiated. The maintenance dose of Campath is 30 mg/day administered three times per week on alternate days (i.e., Monday, Wednesday, and Friday) for up to 12 weeks.

The ICD-9-CM diagnosis codes required when billing for Campath are:

- **V58.1** – admission or encounter for chemotherapy
  AND EITHER
- **204.10** (lymphoid leukemia without mention of remission)
  OR
- **204.11** (lymphoid leukemia with remission)

Providers must use HCPCS code J9010 to bill for Campath. For Medicaid billing, 1 unit of coverage is 10mg. The maximum reimbursement rate per unit is $553.77. Providers must bill their usual and customary charge. This drug should be added to the list of injectable drugs published in the November 2004 general Medicaid bulletin.

Physicians' Billing Requirements:

- Use the CMS-1500 claim form.
- Enter ICD-9-CM diagnosis code **V58.1, and either 204.10 or 204.11** in block 21.
- Enter the date of service in block 24A.
- Enter the place of service in block 24B.
- Enter HCPCS code J9010 in block 24D.
- Enter the total charges in block 24F.
- Enter the units given in block 24G (10 mg = 1 unit).

Example:

21 Diagnosis	**24A Date(s) of Service**	**24B Place of Service**	**24D Procedures, Services or Supplies**	**24F Charges***	**24G Days or Units**
204.10	02152005	11	J9010	$	3

Note: The asterisk (*) indicates the provider must bill their usual and customary charge.

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

Attention: Physicians and Podiatrists

Dermagraft Coverage (J7342)

Effective with date of service January 1, 2003, the N.C. Medicaid program covers the wound dressing Dermagraft when supplied by a physician. Dermagraft is a cryopreserved human fibroblast-derived dermal substitute.

Dermagraft Coverage Criteria

Dermagraft is covered for the treatment of full-thickness diabetic foot ulcers when all of the following conditions are met:

- The ulcer has persisted for six weeks or greater duration.
- The ulcer extends through the dermis, but without tendon, muscle, joint capsule or bone exposure.
- The patient has adequate arterial blood supply to the foot.
- The patient has a primary diagnosis of ICD-9 CM diagnosis codes 707.14 or 707.15 and a secondary diagnosis of diabetes in the range of ICD-9 CM diagnosis codes 250.80 through 250.83.
- Dermagraft is used in conjunction with standard wound care regimens.

Non- covered Conditions

Dermagraft is contraindicated and, therefore, not covered for the following conditions:

- Ulcers with signs of clinical infection.
- Ulcers with sinus tracts.
- Patients with known hypersensitivity to bovine products.

Billing Instructions

- Bill on the CMS 1500 form using HCPCS code J7342.
- One unit equals 1 sq. cm.
- A single application of Dermagraft totals 37.5 square centimeters (sq. cm.).
- No more than eight applications of Dermagraft may be applied in a 12 week period.
- The maximum reimbursement rate is $14.58 per sq. cm.
- CPT codes 15000 and 15001 may be used to bill for the site preparation.
- CPT codes 15342 and 15343 may be used to bill for the application of Dermagraft.

24. A						B	C	D		F	G
DATES(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES Explain Unusual Circumstances CPT/HCPCS	MODIFIER	CHARGES	DAY OR UNITS
01	01	05	01	01	05	11		J7342		Usual and customary	37.5

Claims Filing Instructions
New claims submitted for dates of service January 1, 2003 through May 31, 2004 require a time limit override. These claims must be submitted on paper with a Medicaid Resolution Inquiry form attached to the claim and must be received for processing by July 31, 2005. Providers must identify these claims by clearly writing **DERMAGRAFT** in large block letters on **both** the mailing envelope and the Medicaid Resolution Inquiry form. Previously submitted claims that were denied that have not exceeded the time limit may be resubmitted.

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

Attention: Physicians

Ziconotide Intrathecal, 25mcg (Prialt, J3490) - Billing Guidelines

Effective with date of service April 1, 2005, N.C. Medicaid covers ziconotide intrathecal (Prialt®) for use in the Physician's Drug Program. The manufacturer states that Prialt® is indicated for the management of severe chronic pain in patients for whom intrathecal therapy is warranted and who are intolerant of or refractory to other treatment. The maximum recommended daily dose at the beginning of treatment start at a maximum of 2.4 mcg/day. While monitoring for adverse effects titration of the dose takes several weeks until pain relief is adequate. The maximum recommended daily dose is 19.2mcg/day.

Providers must bill J3490, with an invoice attached to the CMS-1500 claim form. **An invoice must be submitted with each claim**. The paper invoice must include the recipient's name and Medicaid identification number, the name of the medication, the dosage given, the National Drug Code (NDC) number from the vial(s) used, the number of vials used, and the cost per dose. Providers must indicate the number of units given in block 24G on the CMS-1500 claim form. For Medicaid billing, **one unit of coverage is 25 mcg.** The maximum reimbursement rate per unit is $171.09. Providers must bill their usual and customary charge. This drug should be added to the list of injectable drugs published in the November 2004 general Medicaid bulletin.

Physicians' Billing Requirements:
- Use the CMS-1500 claim form.
- Enter the ICD-9-CM diagnosis code in block 21.
- Enter the date of service in block 24A.
- Enter the place of service in block 24B.
- Enter HCPCS code J3490 in block 24D.
- Enter the total charges in block 24F.
- Enter the units given in block 24G (1 ml = 1 unit).

Example:

21 Diagnosis	**24A Date(s) of Service**	**24B Place of Service**	**24D Procedures, Services or Supplies**	**24F Charges**	**24G Days or Units**
	05152005	11	J3490	$	3

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

Attention: Hospitals and Nursing Facilities

Reimbursement Rate for Swing Beds and Lower Levels of Care Services

Effective with date of service March 1, 2005, the maximum allowable rate for the following swing beds and lower levels of care services were modified. The new rates are $123.00.

Note: At this time, swing beds and lower levels of care (INC, SNC, H-INC, and H-SNC) are reimbursed at the same rate.

Providers must bill their usual and customary charges. Adjustments will not be accepted for rate changes.

Fee schedules are available on DMA's website at http://www.dhhs.state.nc.us/dma/fee.htm.

Rate Setting, DMA
919-855-4200

Attention: Hospitals and Nursing Facilities

Reimbursement Rate for Vent Beds

Effective with date of service March 1, 2005, the maximum allowable rates for the Vent beds were modified.

Rate Setting, DMA
919-855-4200

Proposed Clinical Coverage Policies

In accordance with Session Law 2003-284, proposed new or amended Medicaid clinical coverage policies are available for review and comment on DMA's website at http://www.dhhs.state.nc.us/dma/prov.htm. To submit a comment related to a policy, refer to the instructions on the website. Providers without Internet access can submit written comments to the address listed below.

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

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

Electronic Cut-Off Schedule

April 8, 2005	May 6, 2005
April 15, 2005	May 13, 2005
April 22, 2005	May 20, 2005
April 29, 2005	

Checkwrite Schedule

April 12, 2005	May 10, 2005
April 19, 2005	May 17, 2005
April 28, 2005	May 26, 2005
May 3, 2005	

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

Mark T. Benton, Interim Director
Division of Medical Assistance
Department of Health and Human Services

Cheryll Collier
Executive Director
EDS