April *2007*

North Carolina Medicaid Bulletin

Visit DMA on the Web at: *http://www.ncdhhs.gov/dma*

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

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

Attention: All Providers

Have You Reported Your National Provider Identifier (NPI) to the Division of Medical Assistance (DMA)?

Only 32 percent of providers have reported their National Provider Identifier (NPI) to the Division of Medical Assistance (DMA). You must report an NPI for each of your Medicaid provider numbers to the DMA's Provider Enrollment unit to comply with HIPAA guidelines. (Atypical providers excluded.) At this time, the National Plan and Provider Enumerator are not providing NPI information to health plans.

Instructions and addresses to report the NPI and taxonomy number can be found on the DMA's Web site at http://www.ncdhhs.gov/dma/NPI.htm. Two options are available for submitting this information: the NPI Collection Spreadsheet (EDI) and the NPI Collection form. Instructions for both are posted on the DMA Web site. A copy of the NPI certification (either letter or email) from the National Plan and Provider Enumeration System (NPPES) must be included with each submission to update your DMA provider enrollment file. (If the same NPI represents multiple Medicaid provider numbers, only one NPPES certification is needed.) The NPI reporting process will not be complete without this information. The NPI must be reported and the NPPES certification must be submitted to DMA Provider Enrollment.

NPI Poses No Change in Medicaid Policy or Billing Requirements:
The implementation of NPI requirements does not change Medicaid policy or current billing requirements. Claims processing will not be affected by such NPI changes as taxonomy codes and NPI numbers. Program coverage, reimbursement and Medicaid policy remain the same. Please continue to refer to program enrollment and guidelines to file claims.

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

Attention: All Providers

New NPI Electronic Mailing List

The NPI electronic mailing list is now complete for providers, software vendors, clearinghouses, and other interested parties. The purpose of the mailing list is for N.C. Medicaid to provide immediate updates regarding NPI. To subscribe to the mailing list, please visit http://www.dhhs.state.nc.us/dma/NPI.htm and select NPI Mailing List. N.C. Medicaid encourages everyone to subscribe to the mailing list in order to stay up to date with the latest NPI information

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

NPI – Get it! Share It! Use It! Getting one is free – Not having one can be costly!

Attention: All Providers

Submitting Service Facility Location on Claims

If a service is rendered at a location other than the billing address on the claim, providers need to complete the service facility location. The service facility location indicates the site where the patient was seen. This information is currently required on the 837 professional and institutional transactions when the location of health care service is different than that carried in the 2010AA (Billing Provider) or 2010AB (Pay-to-Provider) loops. On paper claims, this information is reported in block 32 of the CMS-1500 form. The NCECS Web format currently does not have a field to enter this information, but providers can begin submitting it once NCECSWeb tool is updated on May 18, 2007. This information is required on all claims except in situations where services are rendered in the recipient's home. The service facility location will be an important component for claims processing once NPI is implemented; therefore, it is imperative for providers to include this information 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

Taxonomy and NPI Required on Electronic and Paper Claims

Taxonomy codes will be required on claims upon NPI implementation. The taxonomy codes are mandatory on both electronic and paper claims. For electronic claims, follow the rules of the 837 Implementation Guides to populate the taxonomy for billing and attending provider numbers. For paper claims, the taxonomy must be populated for both billing and attending provider numbers. Claims missing taxonomy codes will deny.

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

Basic Medicaid Seminars
(Reprint from March 2007 General Medicaid Bulletin)

Basic Medicaid seminars are being held during the month of April 2007. Seminars are intended to educate providers on the basics of Medicaid billing.

The seminars are scheduled at the locations listed below. Pre-registration is required. Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

Providers may register for the Basic Medicaid seminars by completing and submitting the following registration form online at: http://www.ncdhhs.gov/dma/semreg/seminar_basicmed.aspx.

Sessions will begin at 9 a.m. and end at 12 p.m. Providers are encouraged to arrive by 8:45 to complete registration.

Tuesday, April 17,2007 Holiday Inn 1707 Owen Drive Fayetteville, North Carolina	**Wednesday, April 18, 2007** Jane S. McKimmon Center 1101 Gorman Street Raleigh, North Carolina
Thursday, April 26, 2007 Sheraton Hotel at Four Seasons 3121 High Point Road Greensboro, North Carolina	**Monday, April 30, 2007** Crowne Plaza One Resort Drive Asheville, North Carolina

Basic Medicaid Seminar
April 2007 Seminar Registration Form
(No fee)

Provider Name _____

Medicaid Provider Number_____NPI Number_____

Mailing Address_____

City, Zip Code_____County_____

Contact Person_____ E-mail_____

Telephone Number (____) _____ Fax Number_____

1 or **2** person(s) will attend the seminar at_____ on _____
(Circle one) (Location) (Date)

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

Directions to Basic Medicaid Seminars

Holiday Inn Fayetteville-Bordeaux
Traveling east on I-40**:** Take exit 38- toward Sanford. Turn right onto Martin Luther King Jr / US-421. Continue to follow US-421 S. Turn right onto NC-87 S. Turn right onto Santa Fe Dr. Turn left to take the All American Freeway/ Wilkes Road ramp. All American Freeway becomes Owen Drive.

Traveling West on I-40: Take exit 328A for I-95 S. Merge onto I-95 BR S / US-301 S via EXIT 56. Travel approximately 8.6 miles. Turn right onto Owen Drive.

Jane S. McKimmon Center – Raleigh
Traveling East on I-40: Take exit 295 and turn left onto Gorman Street. Travel approximately 2.5 miles. The McKimmon Center is located on the right corner of Gorman Street and Western Boulevard.

Traveling West on I-40: Take exit 295 and turn right into Gorman Street. Travel approximately 2.5 miles. The McKimmon Center is located on the right on the corner of Gorman Street and Western Boulevard.

Sheraton Hotel – Greensboro
Traveling East on I-40: Take exit 217 for High Point Road. Travel .2 mile and cross over High Point Road. The Sheraton will be on your left.

Traveling West on I-40: Take exit 217 for Koury Boulevard. The Sheraton will be on your left.

Crowne Plaza – Asheville
Traveling West on I-40: Take Exit 53 to I-240 West. Pass downtown Asheville. As you cross the French Broad River Bridge, stay in the right lane and take Exit 3B - Westgate and Resort Drive (former Holiday Inn Drive). Pass the Westgate Shopping Center on your right. After passing Mr. Transmission, you will see our entrance sign. Turn right onto Resort Drive and proceed to the main entrance.

Traveling East on I-40: Take Exit 46 (left exit) for I-240 East. Continue on I-240 and stay the left lane. Take Exit 3A. Circle around right and exit onto Patton Avenue. Turn right at the second light into Regent Business Park (between Denny's and Pizza Hut). Turn right; the entrance is on the left around a curve approximately 1000 yards. Follow Resort Drive to the main entrance of the resort on the left.

Attention: All Providers

Clinical Coverage Policies

The following new or amended clinical coverage policies are now available on the Division of Medical Assistance's Web site at http://www.ncdhhs.gov/dma/mp/mpindex.htm:

1E-1, Hysterectomy Procedures
1E-2, Therapeutic and Non-therapeutic Abortions
1E-4, Fetal Surveillance
1G-1, Burn Treatment
1G-2, Bioengineered Skin
3D, Hospice Services
3H-1, Home Infusion Therapy
5A, Durable Medical Equipment
5B, Orthotics and Prosthetics
7, Hearing Aid Services
8A, Enhanced Mental Health and Substance Abuse Services
10C, Local Education Agencies (LEAs)

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

Delay in Implementation of the New CMS-1500 Form

Centers for Medicare and Medicaid Services (CMS) has extended the acceptance period of the CMS 1500 (1290). Electronic Data Systems (EDS) will also extend the April 1st deadline for implementing the revised CMS -1500 to June 1, 2007. Until June 1, 2007 either the CMS 1500 (0805) or the CMS 1500 (12/90) will be accepted.

Source: CMS Web site

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

Attention: All Providers

Epogen HCPCS Procedure Code Changes for Dialysis Facilities and Physician's Drug Program

Effective with date of service January 1, 2007, CMS issued HCPCS procedure code Q4081 (*injection, epoetin alfa, 100 units; for ESRD on dialysis).* This code has been placed in the claims payment system with a payment effective date of April 1, 2007.

Refer to the following information for billing guidelines, paying particular attention to the difference between the units of the J0886 code and the Q4081 code.

Dialysis Facility Providers (837I or UB-92 Claim Form)
Dialysis facilities submitting Epogen claims for dates of service April 1, 2007, or after must bill with code Q4081. Code Q4081 represents 100 units of Epogen. Code Q4081 will not be reimbursed prior to April 1, 2007. Providers should continue to bill with Epogen code J0886 (1,000 units) through March 31, 2007 dates of service. Beginning with April 1, 2007 dates of service, providers will no longer be reimbursed for J0886.

Providers submitting claims for code Q4081 with dates of service prior to April 1, 2007 will receive detail denials for this service. Providers must submit claims with code Q4081 for dates of service prior to April 1, 2007 as adjustments. Please contact EDS Provider Services if you have questions regarding submission of adjustment requests.

Effective with date of service April 1, 2007, the maximum reimbursement rate for HCPCS procedure code Q4081 (100 units = 1 Medicaid unit) is $0.96 per Medicaid unit.

Providers Who Bill on the 837P or CMS 1500 Claim Form
Providers who bill on the 837P or CMS 1500 claim form may continue to bill Epogen code J0886 (1,000 units). On or after April 1, 2007, providers may also bill HCPCS procedure code Q4081 (100 units), for dates of service April 1, 2007, and after.

Effective with date of service April 1, 2007, the maximum reimbursement rate for J0886 (1,000 =1 Medicaid unit) is $9.57 per Medicaid unit.

Effective with date of service April 1, 2007, the maximum reimbursement rate for Q4081 (100 units= 1 Medicaid unit) is $0.96 per Medicaid unit.

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

Attention: All Providers

Human Papilloma Virus Vaccine/Gardasil (CPT Procedure Code 90649) - Reimbursement Billing Guidelines

Effective with date of service February 1, 2007, a human papilloma virus (HPV) vaccine, Gardasil, was added to the list of vaccines covered through the Universal Childhood Vaccine Distribution Program (UCVDP)/Vaccines for Children (VFC) Program. These programs provide all vaccines required by the Advisory Committee of Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC). UCVDP/VFC HPV vaccine is available to VFC-eligible children through 18 years of age.

The North Carolina Immunization Branch distributes childhood vaccines to local health departments, hospitals and private providers under guidelines of the North Carolina UCVDP/VFC programs. Only VFC-eligible females through age 18 may receive state-supplied HPV vaccine.

According to ACIP, the final recommendation for routine administration of HPV vaccine is for adolescent females 11-12 years of age, although the vaccination series can be started in girls as young as 9 years of age. Catch-up vaccination is recommended for young women 13-26 years of age who have not been previously vaccinated, or who have not completed the full vaccine series. The vaccine should be administered as a three-dose series, with the second dose administered two months after the first, and the last dose given four months later (0, 2 months, 6 months). For maximum benefit, the vaccine should be administered before the onset of sexual activity; however females who are already sexually active can also benefit from being vaccinated. The complete ACIP final recommendations for HPV vaccine are online at http://www.cdc.gov/mmwr/pdf/rr/rr5602.pdf.

Billing Reminders:

1. Medicaid does not reimburse for HPV vaccine that is supplied through UCVDP/VFC for recipients 9 through 18 years of age. Medicaid will reimburse for the administration of the HPV vaccine for those VFC recipients by either CPT code 90471 or 90472, with the EP modifier appended.
2. Medicaid will reimburse for the HPV vaccine for females aged 19 through 20 years in accordance with the ACIP recommendations when it is billed with CPT procedure code 90649. Medicaid will also reimburse for the administration of the vaccine for this population when it is billed with CPT procedure code 90471 or 90472, as appropriate.
3. Refer to "Corrected Coverage of Immunization Administration Codes for Oral/Intranasal Vaccines" (pp. 12–20 in the March 2007 general Medicaid bulletin) for how to bill using immunization administration codes.
4. Providers should bill with ICD-9-CM diagnosis code V04.89, as appropriate.
5. For Medicaid billing, one Medicaid unit of the HPV vaccine is 0.5 ml. The maximum reimbursement rate of one unit is $129.60.
6. The Medicaid system will be ready for processing claims for Gardasil and the administration of Gardasil the week of April 16, 2007. Therefore, providers must NOT report or bill claims for Gardasil or the administration of Gardasil prior to April 15, 2007, or their claims will deny.

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

Attention: All Providers

North Carolina Medicaid Aid Program Classes for All North Carolina Medicaid Aid Programs Added to the AVRS and EDI Vendor Responses

Beginning April 1, 2007 both Automated Voice Response System (AVRS) and Electronic Data Interchange (EDI) (vendor responses 270/271 electronic transmittals) will be updated to review the first four characters of a recipient's eligibility. This change will ensure providers have access to all recipient coverage including Medicaid restrictive coverage. The AVRS and EDI enable providers to access information regarding recipient eligibility.

Providers that access eligibility through the AVRS system will continue to get eligibility as they did in the past. However, this update will advise providers if a recipient has restricted coverage. For example if a recipient is only eligible for pregnancy related services, the voice response will now indicate, "This is a restrictive coverage category. Recipient is eligible for pregnancy related services only on date of service."

Providers that access eligibility through EDI (vendor responses 270/271 electronic transmittals) will now receive four characters, instead of three. The characters include the aid program category and class. In addition, to the four characters providers will continue to get a "yes" or "no" that indicates a recipient's eligibility. Providers are responsible to determine if the recipient has full Medicaid coverage or restricted coverage using the eligibility and class categories listed below:

Eligibility and Class Categories

N.C. Medicaid recipients receive benefits in the following assistance categories:

Medicaid Program Name	Abbreviation	Fourth Character Class Identifier	Medicaid Eligibility
Work First Family Assistance	AAF	C	Recipient is eligible for Medicaid
Aid to the Aged	MAA	C, G, or N	Recipient is eligible for Medicaid
		B or Q	Recipient is eligible for Medicaid and payment of Medicare Part B premiums
		M or P	After meeting a deductible recipient is eligible for Medicaid (for EDI users a yes will indicate eligible and a no will indicate not eligible)
		F, H, O, or R	This is a restrictive coverage category. **Recipient is eligible for emergency services only.**
Aid to the Blind	MAB	C, G, or N	Recipient is eligible for Medicaid
		B or Q	Recipient is eligible for Medicaid and payment of Medicare Part B premium
		M or P	After meeting a deductible recipient is eligible for Medicaid (for EDI users a yes will indicate eligible and a no will indicate not eligible)
		F, H, O, or R	This is a restrictive coverage category. **Recipient is eligible for emergency services only.**

Medicaid Program Name	Abbreviation	Fourth Character Class Identifier	Medicaid Eligibility
Aid to the Disabled	MAD	C, G, or N	Recipient is eligible for Medicaid
		B or Q	Recipient is eligible for Medicaid and payment of Medicare Part B premium
		M or P	After meeting a deductible recipient is eligible for Medicaid (for EDI users a yes will indicate eligible and a no will indicate not eligible)
		F, H, O, or R	This is a restrictive coverage category. **Recipient is eligible for emergency services only.**
Families and Children	MAF	C, G, N, T, or W	Recipient is eligible for Medicaid
		M or P	After meeting a deductible recipient is eligible for Medicaid (for EDI users a yes will indicate eligible and a no will indicate not eligible)
		F, H, O, R, U, or V	This is a restrictive coverage category. **Recipient is eligible for emergency services only.**
Families and Children, Family Planning Waiver	MAF-D	D	This is a restrictive coverage category. Recipient is limited to **Family Planning Services only**, under the Family Planning Waiver.
Infants and Children	MIC	1, G, or N	Recipient is eligible for Medicaid
		F or H	This is a restrictive coverage category. **Recipient is eligible for emergency services only.**
North Carolina Health Choice	MIC	A, J, K, L, or S	Recipient is covered by North Carolina Health Choice (NCHC). Request NCHC ID card or contact Blue Cross Blue Shield for verification.
Pregnant Women	MPW	I or N	This is a restrictive coverage category. Recipient is **eligible for pregnancy-related services only.**
		F or H	This is a restrictive coverage category. Recipient is **eligible for emergency services only, including labor and delivery.**
Special Assistance to the Blind	MSB	C	Recipient is eligible for Medicaid
		B or Q	Recipient is eligible for Medicaid and payment of Medicare Part B premium
Foster Care; Adoption Subsidy	HSF; IAS	C, G, or N	Recipient is eligible for Medicaid
		M or P	After meeting a deductible recipient is eligible for Medicaid (for EDI users a yes will indicate eligible and a no will indicate not eligible)
		F, H, O, or R	This is a restrictive coverage category. **Recipient is eligible for emergency services only.**

Medicaid Program Name	Abbreviation	Fourth Character Class Identifier	Medicaid Eligibility
Special Assistance – Aid to the Aged	SAA	C	Recipient is eligible for Medicaid
		Q or B	Recipient is eligible for Medicaid and payment of Medicare Part B premium
Special Assistance – Aid to the Disabled	SAD	C	Recipient is eligible for Medicaid
		Q or B	Recipient is eligible for Medicaid and payment of Medicare Part B premium
Medicare-Qualified Beneficiaries	MQB	Q	This is a restrictive coverage category. **Medicaid pays the Medicare premium and cost sharing charges only.**
		B or E	**No Medicaid coverage**. Recipient is eligible for payment of the Part B premium only.
Refugees	MRF	N	Recipient is eligible for Medicaid
		M	After meeting a deductible recipient is eligible for Medicaid (for EDI users a yes will indicate eligible and a no will indicate not eligible)
Refugee Assistance	RRF	C	Recipient is eligible for Medicaid

Providers who have general eligibility questions should contact their local Department of Social Services office. A list of all the local offices is available online at http://www.ncdhhs.gov/dss/local/.

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

Attention: All Providers

New Medicaid ID Numbers Will Be Assigned Due to Identity Theft Mandates

The N.C. Identity Theft Protection Act mandates that Social Security Numbers (SSNs) cannot be embedded in any kind of number issued for recipients to receive benefits. The Eligibility Information System has over 500,000 SSN-based IDs that must be reassigned by July 1, 2007, to be in compliance with this mandate. Beginning in March 2007, the affected ID numbers will be changed and cross-referenced with new assigned numbers. As a result, it is possible that the ID number on a Medicaid card presented to you may not be the same ID number you have in your records. You do not need to do anything except be aware of this change. This will not affect claims processing. Providers that bill under an old ID number will still receive payment, as the new ID number will cross reference with the old ID number.

Attention: All Providers

Payment Error Rate Measurement in North Carolina
(Reprint from February 2007 General Medicaid Bulletin)

In compliance with the Improper Payments Information Act of 2002, the Centers for Medicare and Medicaid Services (CMS) implemented a national Payment Error Rate Measurement (PERM) program to measure improper payments in the Medicaid program and the State Children's Health Insurance Program (SCHIP). This is to inform you that North Carolina has been selected as one of 17 states required to participate in PERM reviews for Federal fiscal year 2007 (October 1, 2006 – September 30, 2007).

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

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

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

Program Integrity
DMA, 919-647-8000

Attention: All Providers

Providers Filing Paper Adjustments

Paper adjustment processing procedures require that providers attach a copy of all paper Medicaid Remittance Advice (RA) page(s) related to the referenced claim, a copy of the corrected claim, and any other documentation, such as medical records, necessary to process the adjustment.

Since the implementation of electronic HIPAA transactions, EDS has been receiving paper adjustment requests with RA pages generated from the provider's Electronic Medicaid Media Remittance. This provider-generated RA is not an acceptable substitute for the paper copy mailed to providers by EDS. These generated RAs have varied formats and do not include all information necessary for manual adjustment processing.

Paper adjustments that do not include the required RA will continue to be denied with EOB 812, "Adjustment denied. Please refile with all related RA's, including original processing." Providers receiving this denial should resubmit a copy of their adjustment with the requested RA.

Providers who do not have a copy of the paper RA may contact EDS Provider Services to request a replacement. There is a $0.35 per page charge for RA requests that are older than 10 checkwrites before the date requested. RA reprints for the last 10 checkwrites are provided at no charge.

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

Attention: All Providers

Rho(D) Immune Globulins (HCPCS Procedure Codes J2788, J2790 and J2792) Billing Guidelines

Effective with date of service March 31, 2007, the N.C. Medicaid Physician's Drug Program end-dated CPT procedure codes 90384, 90385 and 90386. Effective with date of service April 1, 2007, providers must bill HCPCS procedure codes J2788, J2790, or J2792 for Rho(D) immune globulins. Claims billed with the end-dated codes for dates of service April 1, 2007, and after will be denied. Refer to the following table for billing guidelines for the new codes.

End-dated CPT Code	Description	Unit	New HCPCS Code	Description	Unit	Maximum Reimbursement Rate
90384	Rho(D) immune globulin (RHIG)	300 mcg	J2790	Rho D immune globulin, human, full dose	300 mcg	$26.17
90385	Rho(D) immune globulin (RHIG)	50 mcg	J2788	Rho D immune globulin, human, minidose	50 mcg	$81.59
90386	Rho(D) immune globulin (RHIGIV)	100 IUs	J2792	Rho D immune globulin, IV human, solvent detergent	100 IUs	$16.52

Note: Providers are reminded to bill their usual and customary charge.

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

Attention: Adult Care Home Providers

UPDATE: Prior Approval Process for Medicaid Payment for Recipients Residing in an Adult Care Home (ACH) Special Care Unit for Persons with Alzheimer's and Related Disorders (SCU-A)

Please Note: Instructions here replace any previous instructions.

Effective with the date of service October 1, 2006, the N.C. Medicaid Program implemented a special care rate for ACH providers operating Special Care Units for Persons with Alzheimer's and Related Disorders.

The SCU-A Rate is $46.79 per day for those qualifying homes of 30 beds or less and $51.25 per day for those qualifying homes of 31 or more beds.

Medicaid reimburses providers according to the following procedure:

1. ACH providers who admit Medicaid recipients who receive State and County Special Assistance and have an Ambulation Code of "C" on their eligibility file are eligible to request prior approval to receive a special Medicaid enhanced service rate through the Division of Medical Assistance when that recipient is admitted to a SCU-A.
2. Providers must obtain prior approval from DMA *before* admitting a new resident to a SCU-A. No retroactive prior approval will be approved.
3. Providers must obtain prior approval from DMA within 7 days of admitting a Resident who currently resides in another unit of the ACH into the home's SCU-A. in order to receive the SCU-A rate from the date of admission to that unit. Otherwise, *if approved*, prior approval will be effective the date the request was received by DMA.
4. If information is not complete, a request for additional information will be made by DMA and the approval date *may* be delayed.
5. Providers must send the following information to obtain this prior approval and avoid delays. All information *shall* be clear and legible:
    a. Completed DMA SCU-A Prior Approval Request Form[1].
    b. Current FL-2, signed by a physician, with a primary diagnosis of Alzheimer's and Related Disorders[2]
    c. Copy of the completed Pre-Admission Screening that the home uses to evaluate the appropriateness of an individual's placement in the SCU-A as required by current rule.[3]
    d. Copy of current 3050R and/or Service Plan for the resident that indicates:

[1] Current valid Medicaid Identification number and ACH provider number is required.
[2] ICD-9-CM Acceptance Indicator – A list of diagnosis codes relating to Alzheimer's and Related Disorders--- Alzheimer's Disease 331, Multi-Infarct Dementia 290.4, Parkinson's disease 332, Huntington's disease 333.4, Creutzfeldt - Jakob disease 294.10, Pick's Disease 331.11, Lewy Body Dementia 331.82. One of these diagnosis codes must be listed as the primary diagnosis on the claim for payment of SCU-A codes.
[3] 10A NCAC 13F.1301

individualized care plans that stress the maintenance of resident's abilities and promote the highest possible level of physical and mental functioning, methods of behavior management which preserve dignity and specify programming that involves environmental, social, and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities.[4]

e. Copy of the Provider's current ACH License with SCU-A designation[5].
f. Copy of Provider's current ACH SCU-A Disclosure statement.

6. Upon approval of the resident specific information DMA will communicate to the fiscal agent the specific SCU-A effective date and end date. The end date is one year from the date of the care plan that is submitted with the recipient's information.

7. DMA will send an approval notification to the home indicating that the resident was approved, the effective date and the end date of the approval.

8. In the event that the resident is discharged due to death, level of care change or any other discharge from the home then the home must notify DMA by phone to be followed by the faxing of the information within two business days. The information to be faxed is the recipient's name, MID #, Discharge date and discharge destination. DMA will then notify the fiscal agent as appropriate.

9. Providers send the requested information via US Mail to:

Division of Medical Assistance
Facility and Community Care Section
ACH Unit
1985 Umstead Drive
2501 Mail Service Center
Raleigh, NC 27699-2501

Only requested follow-up and or discharge information may be faxed to DMA Attention: SCU-A Approval @ 919-715-2372.

10. The DMA SCU-A form may be located on the DMA Web site at: http://ncdhhs.gov/dma/forms.html#prov .

11. THIS IS A HIPAA REQUIREMENT: The completed form and information must be sent in a sealed envelope with "confidential" written in red and then placed in another envelope and addressed as in #6 below. The actual original recipient prior approval request information cannot be faxed.

12. DMA CLINICAL POLICY AND PROGRAMS
Charles Jackson @ 919-855-4346 or Charles.Jackson@ncmail.net or
Julie Budzinski @ 919-855-4368 or Julie.Budzinski@ncmail.net

[4] 10A NCAC 13F.1307
[5] Complete facility information is only due once per year –as per schedule or upon facility status change or as needed. Current year active license is required.

Attention: CAP-MR/DD Targeted Case Managers and CAP-MR/DD Service Providers

Medicaid Provider Numbers Required on CTCM Forms

CAP/Targeted Case Management (CTCM) Request for Authorization forms submitted to ValueOptions to request discrete services for individuals receiving services under North Carolina's 1915 (c) waiver for Individuals with Mental Retardation/Developmental Disabilities (CAP-MR/DD) **must** clearly identify the provider's **correct** provider number. Failure to provide the correct provider number for the provider listed for each service requested may cause delayed or incorrect authorization.

In the future, CTCM forms that request authorization for CAP-MR/DD discrete services but do not identify the providing agency by Medicaid provider number will be returned to the TCM agency as incomplete.

NOTE: Each provider agency must be identified by complete name of agency and provider number to ensure accurate prior approval of services.

Behavioral Health
DMA, 919-855-4290

Attention: Dental Providers and Health Department Dental Clinics

Upcoming June Seminars

Seminars on Dental Medicaid billing guidelines are scheduled for June 2007. Registration information, a list of dates, and site locations for the seminars will be published in the May 2007 General Medicaid bulletin.

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

Attention: Durable Medical Equipment Providers

Coverage Policy for Farrell Valve Enteral Gastric Pressure Relief System

Clinical policy for the Farrell valve enteral gastric pressure relief system went into effect April 1, 2007. Please refer to Clinical Coverage Policy #5A, Durable Medical Equipment (http://www.dhhs.state.nc.us/dma/dme/dmepdf.pdf), for coverage details. Section 9.0 of that policy lists the changes that were made by effective date.

Clinical Policy and Programs
DMA, 919-855-4310

Attention: Durable Medical Equipment Providers

New Coverage Policy for Cough-Stimulating Device, Alternating Positive and Negative Airway Pressure (E0482)

Clinical policy for the cough-stimulating device (Cough Assist) went into effect March 1, 2007. Please refer to Clinical Coverage Policy #5A, Durable Medical Equipment (http://www.dhhs.state.nc.us/dma/dme/dmepdf.pdf), for coverage details. Section 9.0 of that policy lists the changes that were made by effective date.

Clinical Policy and Programs
DMA, 919 855-4310

Attention: Local Management Entities, CAP-MR/DD Case Managers, and CAP-MR/DD Service Providers

Rate Change for Day Supports

Medicaid providers enrolled to offer the waiver service of **Day Supports Individual** (T2021) and **Day Supports Group** (T2021HQ), please note the following rate changes, which reflect the increased cost of transportation:

Service Code	Old Rate	New Rate
T2021 Individual	$5.94/unit	$6.47/unit
T2021HQ Group	$3.31/unit	$3.84/unit

Providers of the waiver service day supports are required to transport the recipient to and from his place of residence to the licensed facility and from the licensed facility to activities that originate from the facility.

This rate is effective as of January 1, 2007. Providers are not required to resubmit their claims. An automatic recoupment and repayment will be done by EDS.

Rate Setting
DMA, 919-855-4200

Attention: Mental Health Service Providers, Psychiatric Hospitals, Psychiatric Residential Treatment Facilities, Local Management Entities and Area Mental Health Centers

Certificate of Need: Procedural Change for Inpatient Psychiatric and Psychiatric Residential Treatment Services to Recipients under Age 21

As described in the July 2006 Medicaid Special Bulletin, *Authorization and Utilization Review for Behavioral Health Services,* Federal regulations require a Certificate of Need form (CON) and prior approval for an inpatient admission to a psychiatric hospital or a psychiatric residential treatment facility for Medicaid recipients under the age of 21. These detailed regulations can be found at 42CFR441.152, 441.153, and 441.156.

To expedite prior approval, the CON is often faxed to ValueOptions (919-461-0599). This is still acceptable, and ValueOptions will no longer withhold prior approval pending receipt of the original. The original must remain in the patient's medical record. All other regulations remain in effect.

Behavioral Health
DMA, 919-855-4290

Attention: Orthotic and Prosthetic Providers

Coverage Policy for Cranial Orthosis for Plagiocephaly

Coverage policy for cranial orthosis for plagiocephaly went into effect April 1, 2007. Please refer to Clinical Coverage Policy #5B, Orthotics and Prosthetics (http://www.ncdhhs.gov/dma/dme/5B.pdf), for coverage details. Section 9.0 of that policy has the changes that were made by effective date.

Clinical Policy and Programs
DMA, 919-855-4310

Attention: Orthotic and Prosthetic Providers

Revised Cast Boot, Post-Operative Sandal or Shoe, Healing Shoe Clinical Coverage Policy

Revised clinical coverage policy for cast boots, post-operative sandals or shoes, and healing shoes went into effect April 1, 2007. There are several significant changes from the previous policy. Please refer to Clinical Coverage Policy #5B, Orthotics and Prosthetics (http://www.ncdhhs.gov/dma/dme/5B.pdf), for coverage details. Section 9.0 of that policy lists the changes that were made by effective date.

Clinical Policy and Programs
DMA, 919-855-4310

Attention: Pharmacists and Prescribers

Botox Online Billing Restriction Removed

Effective immediately, the billing restriction has been removed for Botox in the pharmacy point-of-sale system. All claims for Botox can now process online up to the billed amount of $9,999.99.

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

Attention: Pharmacists and Prescribers

Prior Authorization Criteria Revised for Celebrex, Procrit/Epogen, and Aranesp

The prior authorization criteria have been revised for the following medications in the Medicaid outpatient pharmacy prior authorization program:

- Celebrex
- Procrit/Epogen
- Aranesp

The revised criteria are available on the N.C. Medicaid Enhanced Pharmacy Program Web site (http://www.ncmedicaidpbm.com; click on PA List & Criteria, then on individual drugs).

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

Attention: Pharmacists and Prescribers

Removal of Neupogen from the Prior Authorization Drug List

Effective with date of service February 14, 2007, Neupogen no longer requires prior authorization from the Medicaid outpatient pharmacy program.

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

Attention: Physicians and Nurse Practitioners

17 Alpha Hydroxyprogesterone Caproate (17P), Injection From Bulk Powder - Billing Guidelines

Effective with date of service April 1, 2007, the N.C. Medicaid Physician's Drug Program covers weekly 17 alpha hydroxyprogesterone caproate (17P) intramuscular injections for use in pregnant women with a history of a preterm delivery before 37 weeks gestation but no preterm labor in the current pregnancy. 17P for intramuscular injection is not commercially available, but can be compounded by a pharmacy provider, and must be billed with HCPCS procedure code J3490 *(unclassified drugs)* and a copy of the invoice.

Progesterone therapy as a technique to prevent preterm labor is considered investigational/not medically necessary for pregnant women who do **not** meet the above criteria, or for those with other risk factors for preterm delivery, including but not limited to multiple gestations, short cervical length, or positive tests for cervicovaginal fetal fibronectin.

The recommended dose of 17P is a 250-mg weekly intramuscular injection administered from gestational weeks 16 through 36.

For Medicaid Billing:

- The ICD-9-CM diagnosis code required for billing 17P is V23.41 *(supervision of pregnancy with history of pre-term labor)*. Providers must verify that the recipient's history includes a preterm delivery that occurred before 37 weeks gestation.
- Providers must bill 17P with HCPCS procedure code J3490 *(unclassified drugs)*, with the original invoice or copy of the original 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 bulk powder used, the amount of bulk powder 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 250 mg. The maximum reimbursement rate for one unit is $20.00.
- Providers must bill their usual and customary charges.

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

Attention: Physicians and Nurse Practitioners

Bevacizumab (Avastin, J9035) – Update to Billing Guidelines

In addition to previously published covered diagnoses, the N.C. Medicaid program covers bevacizumab (Avastin) for use in the Physician's Drug Program for wet age-related macular degeneration for patients who have not responded to therapy with ocular photodynamic therapy with verteporfin or to therapy with intravitreal pegaptanib. Coverage should be limited to patients who are deemed by their treating physician to have failed FDA-approved therapies, or who, in the judgment of their treating physician, based on his/her experience, are likely to have greater benefit from the use of intravitreal bevacizumab. Medical record documentation should validate the use of bevacizumab for the appropriate diagnosis.

Diagnoses previously covered for Avastin include malignant neoplasm of the colon, rectum, recto-sigmoid junction, and anus when used in combination with intravenous 5-fluorouracil based chemotherapy; and unresectable, locally advanced, recurrent or metastatic non-squamous, non-small cell lung carcinoma.

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

- **V58.1 -** admission or encounter for chemotherapy **must be billed**

  And

- An **ICD-9-CM** diagnosis code in one of the following groups:
  1. **153.0 through 154.8**
  2. **162.2 through 162.9**
  3. **362.52**

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

Attention: Rural Health Centers

Change to Medicaid Cost Report Submissions

Previously, freestanding rural health clinics submitted their Medicaid cost reports to Riverbend Government Benefits Administrator. However, effective immediately, **all** rural health clinics are to submit their Medicaid cost reports directly to the Division of Medical Assistance.

The following information **must** be submitted **along with the original Medicaid FQHC/RHC cost report:**

- A copy of the facility's Medicare cost report
- A copy of the facility's "crosswalk" working trial balance to support Medicare report
- Supporting documentation and working papers including, but not limited to, calculation of costs for the Medicare report
- Supporting documentation and working papers including, but not limited to, calculation of costs for the Medicaid report
- Defined chart of accounts
- Log of bad debts, if applicable
- Financial statements, audited or unaudited, at time of submission

Please submit the cost report and information by one of the following means:

US Mail	**Express Mail/Shipping**
Division of Medical Assistance	Division of Medical Assistance
Audit Section	Audit Section
Attn: Jason Hockaday	Attn: Jason Hockaday
2501 Mail Service Center	421 Fayetteville St.
Raleigh NC 27699-2501	Raleigh NC 27601

Audit
DMA, 919-647-8060

Proposed Clinical Coverage Policies

In accordance with Session Law 2005-276, proposed new or amended Medicaid clinical coverage policies are available for review and comment on DMA's Web site at http://www.ncdhhs.gov/dma/prov.htm. To submit a comment related to a policy, refer to the instructions on the Web site. 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

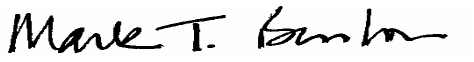
The initial comment period for each proposed policy is 45 days. An additional 15-day comment period will follow if a proposed policy is revised as a result of the initial comment period.

2007 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
April	04/05/07	04/10/07
	04/12/07	04/17/07
	04/19/07	04/26/07
May	05/03/07	05/08/07
	05/10/07	05/15/07
	05/17/07	05/22/07
	05/24/07	05/31/07
	05/31/07	06/05/07
June	06/07/07	06/12/07
	06/14/07	06/21/07
	06/28/07	07/03/07
July	07/05/07	07/10/07
	07/12/07	07/17/07
	07/19/07	07/26/07
August	08/02/07	08/07/07
	08/09/07	08/14/07
	08/16/07	08/23/07
	08/30/07	09/05/07
September	09/06/07	09/11/07
	09/13/07	09/18/07
	09/20/07	09/27/07
October	10/04/07	10/09/07
	10/11/07	10/16/07
	10/18/07	10/23/07
	10/25/07	10/31/07
November	11/01/07	11/06/07
	11/08/07	11/14/07
	11/15/07	11/21/07
	11/29/07	12/04/07
December	12/06/07	12/11/07
	12/13/07	12/20/07

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.

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



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

Cheryll Collier
Executive Director
EDS