April 2008 Medicaid Bulletin

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

In This Issue ..... *Page#*

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

In This Issue ..... *Page#*

Attention: All Providers

National Provider Identifier Implementation and Ready Letters

Effective May 23, 2008, all claims must contain a National Provider Identifier (NPI). The N.C. Medicaid Program will no longer accept claims submitted without an NPI effective May 23, 2008. Unless the provider is atypical, failure to use the NPI by this date will result in a claim denial.

All claims should contain the following information:

- **National Provider Identifier**
  - ♦ Billing provider
  - ♦ Attending provider, if applicable
  - ♦ Referring provider, if applicable

- **Medicaid Provider Number (optional after May 22, 2008)**
  - ♦ Billing provider
  - ♦ Attending provider, if applicable
  - ♦ Referring provider, if applicable

- **Taxonomy Code**
  For all claims (except pharmacy) that are submitted electronically, a taxonomy code must be included for the billing provider. However, if the procedure or service is billed with an attending provider number, only the taxonomy code for the attending provider is included on the electronic claim submission. For paper claims, a taxonomy code for the both the billing provider and, if applicable, the attending provider must be included on the claim.

Note: Pharmacy providers must submit claims with their NPI number and the prescriber's NPI number or DEA number entered on the claim.

For placement of data on the 837 transaction, consult the X12 Implementation Guide at http://www.wpc-edi.com. The NCECSWeb tool now contains fields to report this information. For CMS-1500, UB-04, and ADA claim forms, consult the June 2007 Special Bulletin, *New Claim Form Instructions*, on the DMA website at http://www.ncdhhs.gov/dma/bulletinspecial.htm.

DMA encourages all providers (except pharmacies) to continue to submit their NPI, Medicaid Provider Number (MPN), and taxonomy. DMA will notify the billing provider by mail (Provider Ready letter) once it is determined that the NPI submitted on the claim is mapping correctly to the MPN submitted by the provider. Refer to future general Medicaid bulletins for additional information on the Provider Ready letters.

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

Notification of National Provider Identifier/Medicaid Provider Number Mismatch

All providers (except pharmacy) are encouraged to submit a National Provider Identifier (NPI), Medicaid Provider Number (MPN), and taxonomy code on all claims. DMA is analyzing claims that contain this information to prepare for NPI implementation. Analysis has found that some providers are submitting claims with a different NPI than what was reported to DMA for their MPN(s). At implementation, claims will process based on the NPI reported for the MPN(s) in the provider database. Therefore, it is imperative that providers use the same NPI on claims.

DMA will send a letter to providers who are submitting claims using an NPI and MPN combination that is different from what was reported to DMA. Each mismatch will be listed in the letter. Please note that only claims submitted with an NPI, MPN, and taxonomy code are eligible for this letter. In addition, providers will receive a letter if they submit a claim with an NPI that has not been reported to DMA.

To troubleshoot, providers can verify that the correct NPI(s) are on file by searching the NPI and Address Database (http://www.ncdhhs.gov/dma/WebNPI/default.htm). Search by NPI and MPN to ensure that each MPN has a corresponding NPI on file. Also, verify with vendors and clearinghouses that the correct NPI is being submitted on claims.

To update or change an NPI on file with DMA, print the correction form from the NPI and Address Database, make the appropriate change, and fax the form to DMA Provider Services. Allow two weeks for updates to be processed. Providers are encouraged to verify all information prior to May 23, 2008.

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

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

Attention: All Providers

Referring Provider Numbers for Carolina ACCESS Referral Authorizations

Upon National Provider Identification (NPI) implementation, the NPI will replace the referring provider number for Carolina ACCESS referral authorizations. Providers are encouraged to submit both the NPI and the Medicaid Provider Number (MPN) on claims today, unless the referring provider is an atypical provider.

To determine whether to obtain the group or individual NPI for the referral, refer to the recipient's Medicaid identification card. If a group name is listed on the card as the Primary Care Provider (PCP), obtain the group NPI. If an individual's name is listed as the PCP, obtain the individual's NPI.

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

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

Attention: Private Duty Nursing Providers

Correction to Recommended Taxonomy Code for National Provider Identifier Mapping

The list of recommended taxonomy codes that are used to map private duty nursing providers' National Provider Identifier numbers to their Medicaid Provider Numbers during the claim adjudication process has been updated. The taxonomy code for private duty nursing providers has been corrected to **25100000X**.

The list of recommended taxonomy codes is available on DMA's website at http://www.dhhs.state.nc.us/dma/NPI/taxonomy_codes.html.

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

Unknown National Provider Identifier Report

Upon implementation of National Provider Identifiers (NPIs), if a claim is submitted with an NPI only and the NPI is not on file in the provider database, the NPI is considered "unknown" and claims will be denied. Because the NPI is not on file, these claims will not appear on the Remittance and Status Report (RA). However, for claims submitted via the 837 transaction or NCECSWeb tool, a new report, the *Unknown NPI Report*, will be generated on the same schedule as the weekly checkwrite cycle and will be sent to the billing provider address submitted on the 837 transaction or NCECSWeb tool. The *Unknown NPI Report* will list all claims submitted with an NPI that is not on file.

The first page of the report will contain instructions to advise the provider how to proceed. If the NPI listed in the report is an incorrect NPI, resubmit the claims with the correct NPI. If the NPI submitted on the claims is correct, the NPI has not been reported. Visit the NPI and Address Database on the DMA website (http://www.ncdhhs.gov/dma/WebNPI/default.htm) to report the NPI. If the NPI is correct and the NPI has already been reported to Medicaid, contact EDS Provider Services at 1-800-688-6696.

The report will include the following information: the recipient's Medicaid identification (MID) number, the recipient's name, date of service, the patient account number or medical record number (if entered), the total billed amount of each claim submitted, the internal claim number (ICN), and the unknown NPI as submitted on the claim. The status of claims listed in the *Unknown NPI Report* will not be available through the Automated Voice Response (AVRS) system. Once the NPI has been reported, providers will need to resubmit all claims listed on the *Unknown NPI Report*. Do not report the NPI and resubmit claims on the same day.

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: Institutional Claim (UB-04) Billers

Medicare Health Maintenance Organization

The N.C. Medicaid Program is in the process of making system changes that will allow UB-04 claims for Medicare Health Maintenance Organization (Part C) services to be billed with the National Provider Identifier (NPI) only. However, until the change is implemented, beginning May 23, 2008, all UB-04 claims for Part C services must be submitted with both the Medicaid Provider Number (MPN) and the NPI.

Please submit the following information for the billing provider.

- NPI entered in form locator 56
- MPN entered in form locator 57
- Taxonomy entered in form locator 81 with qualifier B3

Providers must continue to follow the instructions outlined in the October 2006 general Medicaid Bulletin article titled *Medicare Health Maintenance Organization* [for UB-92 Billers]. The October 2006 general Medicaid Bulletin is available on DMA's website at http://www.ncdhhs.gov/dma/bulletin.htm.

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

Clinical Coverage Policies

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

1L-2, Moderate (Conscious) Sedation
5A, Durable Medical Equipment

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

Community Care of North Carolina/Carolina ACCESS Referral Policy

All providers serving as primary care providers (PCP) in the Community Care of North Carolina/Carolina ACCESS (CCNC/CA) health care plan sign an *Agreement for Participation as a Primary Care Provider in North Carolina's Patient Access and Coordinated Care Program*. Sections IV-4.8 and IV-4.10 address the PCP's obligations to provide or arrange patient care within the standards of appointment availability based on CCNC/CA policy. These standards are

- Emergency care—immediately upon presentation or notification
- Urgent care—within 24 hours of presentation or notification
- Routine sick care—within 3 days of presentation or notification
- Routine well care—within 90 days of presentation or notification (15 days if recipient is pregnant)

PCPs agree to provide care for their CCNC/CA enrolled patients or arrange for another provider to see these patients. Arranging care means referring the recipient to another provider or authorizing payment for another provider to see the PCP's patients. If a recipient has failed to establish a medical record with the PCP or if the PCP fails to notify the local department of social services of recipients who are erroneously linked to his/her practice, the PCP is still responsible for managing the recipient's care.

The name and phone numbers of the PCP are printed on the Medicaid identification (MID) card. **It is important that providers LOOK AT THE CURRENT MID CARD before rendering treatment to ensure the correct PCP is contacted.** Information about the PCP can also be obtained by calling the Automated Voice Response (AVR) system at 1-800-723-4337.

If a CCNC/CA enrollee seeks care from a provider who is not his/her PCP, it is the responsibility of that provider to contact the PCP identified on the recipient's MID card and request authorization to treat the patient. It is in the purview of the PCP to deny authorization and to schedule the patient for evaluation or treatment according to the standards of appointment availability listed above or authorize the provider to treat the patient. The PCP must make this decision based on medical necessity.

Managed Care
DMA, 919-647-8170

Attention: All Providers

NDC Codes for Outpatient Institutional Claims

The Deficit Reduction Act of 2005 (DRA) includes provisions regarding state collection and submission of data for the purpose of collecting Medicaid drug rebates from manufacturers for all professional and institutional claim forms.

The N.C. Medicaid Program, in compliance with this law, requires that professional claims and institutional (at this time dialysis providers only) claims include both the 11-digit National Drug Code (NDC) and the NDC units in addition to the HCPCS code and units.

The N.C. Medicaid Program is in the process of changing the MMIS+ system to accept HCPCS codes with NDC codes and NDC units on all outpatient institutional claims for pharmacy-related Revenue Codes. Providers affected by this change **must** implement a process to record and maintain the NDC(s) of the drug(s) administered to the recipient as well as the quantity of the drug(s) given. An 11-digit NDC must be billed with the individual HCPCS code that corresponds to the appropriate Revenue Code.

Please review future general Medicaid bulletin articles for more information.

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

Attention: Dental Providers and Health Department Dental Centers

Billing Taxonomy Not Required in Field 35 of the 2006 Dental ADA Claim Form

DMA has instructed EDS to remove the requirement of the billing taxonomy in field 35 on the 2006 Dental ADA claim form. Since the 837 guidelines require only a single taxonomy per claim for electronic billing, DMA will no longer require the billing taxonomy in field 35 on the paper claim. Providers will be required to submit the taxonomy for the attending provider only (dentist rendering the service) in field 56A on the 2006 Dental ADA claim form.

For complete coverage criteria and additional billing guidelines, please refer to Clinical Coverage Policy 4A, *Dental Services,* or 4B, *Orthodontic Services,* on the DMA website at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

Dental Program
DMA, 919-855-4280

Attention: All Providers

Payment Error Rate Measurement in North Carolina

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

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

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

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

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

Program Integrity
DMA, 919-647-8000

Attention: Durable Medical Equipment Providers

Change in Requests for Prior Approval for Pediatric Mobility Devices

Effective with date of request April 1, 2008, Children's Special Health Services will no longer review requests on behalf of DMA for prior approval for pediatric mobility devices. On that date, EDS will begin the review for prior approval of these devices. Please see Clinical Coverage Policy 5A, *Durable Medical Equipment*, located on DMA's website at http://www.ncdhhs.gov/dma/mp/mpindex.htm and refer to **Attachment B, How a Recipient Obtains Durable Medical Equipment and Supplies** for detailed instructions regarding submission of prior approval requests.

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

Attention: All Providers

Correction to March 2008 Article Titled Update: PedvaxHIB Recall – Reimbursement for PedvaxHIB and ActHIB Allowed for UCVDP/VFC Program Eligibles

The following article is being republished to correct an error in the CPT procedure codes that were listed for PedvaxHIB and ActHIB. The correct code for PedvaxHIB is 90647; the correct code for ActHIB is 90648.

Effective with date of service December 13, 2007, and until further notice, N.C. Medicaid will reimburse for purchased PedvaxHIB (CPT procedure code 90647) or ActHIB (CPT procedure code 90648), when administered to recipients through 18 years of age because of a recent vaccine recall and a resulting shortage.

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

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

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

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

Medicaid continues to reimburse for the Hib vaccine for those recipients over 18 years of age, who are at high risk for invasive Hib disease, in accordance with the existing recommendations of the Advisory Committee on Immunization Practices. Other billing requirements regarding vaccines also remain in effect.

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

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

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

Attention: All Providers

N.C. Medicaid's Uniform Screening Program Regional Training Sessions

Regional training sessions for the new Uniform Screening Program (USP) and the N.C. Medicaid Uniform Screening Tool (MUST) application are scheduled for May 26, 2008 through July 11, 2008. These training sessions are designed to educate providers on changes to workflow procedures and processes due to the implementation of this new web-based tool.

Any entity providing direct services in, or providing referrals for, the eight programs listed below or using the forms listed below should attend a regional training session.

Effective September 12, 2008, the N.C. Medicaid Program will no longer accept the forms listed below; the MUST will replace them. Any forms received will be mailed back to the provider.

- FL2
- FL2e
- Pre-admission Screening and Annual Resident Review (PASARR) Level 1 screen
- Telephone prior approval for nursing facility level of care
- Community Alternatives Program for Children (CAP/C) Referral Form
- Nursing Facility Tracking Form
- Ventilator Addendum Form

The MUST will also be used to screen applicants and to document their medical, functional, and behavioral health status. Initially, the MUST will be used **prior** to entry into the following eight long-term care programs:

- Nursing facilities
- Adult care homes (basic personal care services, enhanced personal care services, and special care/Alzheimer's units)
- Personal Care Services (PCS)
- PCS–Plus
- Community Alternatives Program for Disabled Adults (CAP/DA)
- Community Alternatives Program–Choice (CAP/Choice Independence Plus Waiver)
- Community Alternatives Program for Children (CAP/C)
- Private duty nursing (PDN)

All MUST screeners, as well as any user of the USP (administrators, trackers, etc.), are considered qualified after completing the MUST regional training and passing the MUST online exam. Ongoing authorization will be monitored through several of DMA's quality assurance initiatives. Only qualified screeners may submit screenings through the MUST.

For more information on the MUST application, please refer to the March 2008 general Medicaid Bulletin at http://www.ncdhhs.gov/dma/bulletin.htm.

Preregistration for **each** attendee is required and may be accomplished by completing and submitting the registration form on page 17 or by using the online registration form at http://www.ncdhhs.gov/dma/prov.htm or http://www.ncmust.com. A confirmation notice will be e-mailed to each registered participant. The deadline for registration is the date of each training session. If you are unable to attend your scheduled class, please notify EDS of the cancellation in order to allow the vacant space to be filled.

The training sessions begin at 8:30 a.m. and end at 4:30 p.m. Providers should arrive at least 30 minutes early to complete the registration process. Lunch will not be served; however, there will be a lunch break. Because meeting room temperatures vary, dressing in layers is strongly advised.

Training materials are available at http://www.ncmust.com. **Please print the MUST User Documentation Manual and bring it with you to the training.** Although an online tutorial will also be available, attendance at a regional training session is strongly recommended.

Note: Training sessions are subject to change. If a training session is postponed and you are registered for that session, you will be notified by e-mail.

MAY	
Raleigh **May 27, 2008** Jane S. McKimmon Center 1101 Gorman St. Raleigh, NC 27606 919-515-2277	**Charlotte** **May 28, 2008** Queens University of Charlotte 1900 Selwyn Ave. Charlotte, NC 28274 704-337-2560
JUNE	
Asheville **June 3, 2008** Crowne Plaza Hotel 1 Holiday Inn Drive Asheville, NC 28806 828-254-3211	**Hickory** **June 4, 2008** Park Inn Gateway Conference Center 909 US Highway 70SE Hickory, NC 28602 828-328-5101
Charlotte **June 10, 2008** Queens University of Charlotte 1900 Selwyn Ave. Charlotte, NC 28274 704-337-2560	**Winston-Salem** **June 11, 2008** Holiday Inn Select 5790 University Pkwy Winston-Salem, NC 27105 336-767-9595
Williamston **June 17, 2008** Martin Community College 1161 Kehukee Park Rd. Williamston, NC 27892 252-792-1521	**Greenville** **June 18, 2008** Hilton Greenville 207 SW Greenville Blvd. Greenville, NC 27834 252-355-5099
Raleigh **June 19, 2008** Jane S. McKimmon Center 1101 Gorman St. Raleigh, NC 27606 919-515-2277	**New Bern** **June 25, 2008** New Bern Riverfront Convention Center 203 South Front St. New Bern, NC 28560 252-637-1551
Wilmington **June 26, 2008** Coastline Convention Center 503 Nutt St. Wilmington, NC 28401 910-763-2800	

JULY	
Nags Head **July 2, 2008** Comfort Inn South 8031 Old Oregon Inlet Rd. Nags Head, NC 27959 252-441-6315	**Greensboro** **July 9, 2008** Holiday Inn Greensboro Airport Burnt Poplar Rd. Greensboro, NC 27409 336-668-0421
Salisbury **July 10, 2008** Holiday Inn Salisbury 530 Jake Alexander Blvd. Salisbury, NC 28146 704-637-3100	

Directions to the MUST Training Sessions:

ASHEVILLE
Holiday Inn Crowne Plaza and Resort
Traveling West on I-40
Take I-40 West to exit 53B. Merge onto I-240 towards downtown Asheville. As you cross the French Broad River Bridge, merge into the far right-hand lane for exit 3B (Westgate and Resort Drive). Merge into the right lane as you pass the Westgate Shopping Center. The entrance to the hotel is on the right immediately as you round the curve in the road.

Traveling East on I-40
Take I-40 East. Follow the signs for I-240 East towards downtown Asheville. The exit is on the left. Merge into the left land and take exit 3A, which merges onto Patton Avenue. At the 2nd traffic light, turn right onto Regent Park Boulevard (between Denny's and Pizza Hut). The road will bear to the right. The entrance to the hotel is on the left just before the entrance to the Sam's Club parking lot. Follow the road past eh gold course to the main entrance of the hotel.

CHARLOTTE
Queens University of Charlotte
Traveling North from South Carolina
Take I-85 North. Exit onto I-77 North. Take Exit 6A (Woodlawn Road/Queens University of Charlotte). Cross South Boulevard and Park Road. Turn left onto Selwyn Avenue. Travel on Selwyn Avenue for approximately one mile. The campus is located on the left after the intersection of Wellesley Avenue with Selwyn Avenue.

Traveling South from Greensboro
Take I-85 South. Exit onto I-77 South. Take Exit 6A (Woodlawn Road/Queens University of Charlotte. Cross South Boulevard and Park Road. Turn left onto Selwyn Avenue. Travel on Selwyn Avenue for approximately one mile. The campus is located on the left after the intersection of Wellesley Avenue with Selwyn Avenue.

Traveling North or South on I-77
Take Exit 6A (Woodlawn Road/Queens University of Charlotte). Cross South Boulevard and Park Road. Turn left onto Selwyn Avenue. Travel on Selwyn Avenue for approximately one mile. The campus is located on the left after the intersection of Wellesley Avenue with Selwyn Avenue.

Traveling West from Monroe
Take US 74 West. Turn left onto Sharon Amity. Turn right on Providence. Turn left onto Queens Road. After the first stoplight, Queens Road becomes Selwyn Avenue. The campus is located on the right after the stoplight.

GREENSBORO
Holiday Inn Greensboro Airport
Traveling West on I-40
Take I-40 West towards Greensboro. Take exit 211 (Gallimore Dairy Road). Turn right at the end of the exit ramp. At the first stoplight, turn left onto Burnt Poplar Rd. The Holiday Inn is located on the right.

Traveling North on I-85
Take I-85 North towards Greensboro. Merge onto I-40 East. Take exit 211 (Gallimore Dairy Road). Turn right at the end of the exit ramp. At the first stoplight, turn left onto Burnt Poplar Rd. The Holiday Inn is located on the right.

GREENVILLE
Hilton Greenville
Take US 64 East to US 264 East to Greenville. Turn right at the 2nd traffic light as you come into the city onto Allen Road/US Alternate 264. Travel approximately two miles. Allen Road becomes Greenville Boulevard/Alternate 264. Follow Greenville Boulevard for 2½ miles. The Hilton Greenville is located on the right.

HICKORY
Park Inn Gateway Conference Center
Take I-40 to exit 123. Follow the signs to Highway 321 North. Take the first exit (Hickory exit) and follow the ramp to the traffic light. Turn right at the light onto US 70. The Gateway Conference Center is located on the right.

NAGS HEAD
Comfort Inn South
Traveling East on US 64
Take US 64 East to Manteo. In Manteo, cross the bridge to Beach Road. The hotel is located on the left approximately 1/5 mile from the bridge.

Traveling South on I-95
Take exit 291B to NC 168/NC 158. Follow NC 158 into Nags Head. Turn left at milepost 16.5 onto Beach Road. The hotel is located on the left approximately 1/3 mile from the turn.

NEW BERN
New Bern Riverfront Convention Center
Take US 64 East to US 264 East to Greenville. Exit onto US 264 E towards NC 97 for Wilson/Greenville (Stantonsburg Road). Turn right onto W. Arlington Boulevard. Turn left onto US 264 Alternate. Turn right onto S. Charles Boulevard/NC 43. Follow NC 43 towards New Bern. Merge onto US 17 South. Exit onto US 70 Business towards New Bern. Turn right onto NC 55/US 17/US 70 Business. Turn left onto S. Front Street.

RALEIGH
Jane S. McKimmon Center
Traveling East on I-40
Take I-40 to exit 295. Turn left at the bottom of the exit ramp onto Gorman Street. Travel approximately 2½ miles. The McKimmon Center is located on the right at the corner of Gorman Street and Western Boulevard.

Traveling West on I-40
Take I-40 to exit 295. Turn right at the bottom of the exit ramp onto Gorman Street. Travel approximately 2½ miles. The McKimmon Center is located on the right at the corner of Gorman Street and Western Boulevard.

SALISBURY
Holiday Inn Salisbury
Traveling South on I-85
Take I-85 to exit 75. At the end of the exit ramp, turn right onto Jake Alexander Boulevard. Travel approximately ½ mile. The Holiday Inn is located on the right.

Traveling North on I-85
Take I-85 to exit 75. At the end of the exit ramp, turn left onto Jake Alexander Boulevard. Travel approximately ½ mile. The Holiday Inn is located on the right.

WILLIAMSTON
Martin Community College
Building 2 Auditorium
Traveling East on US 64
Take US 64 West to the intersection at McDonald's in Williamston. Turn left on the Highway 13/17 Bypass. The name will change to Old Highway 64 Bypass. Continue approximately 2.3 miles and turn left on Kehukee Park Road. The college is located on the right approximately ½ mile from the intersection.

Traveling West on US 64
Take US 64 East to exit 512 (Prison Camp Road). Turn right on Prison Camp Road. Drive for approximately ½ mile and turn left on Kehukee Park Road. The college is located on the right approximately ½ mile from the intersection.

Traveling North on US 13/US 17
Take US 13/US 17 South to Williamston. Continue to follow US 13/US 17 until it becomes Old Highway 64 Bypass. Continue driving for approximately 2½ miles. Turn left on Kehukee Park Road. The college is located on the right approximately ½ mile from the intersection.

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

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

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

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

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

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

North Carolina Medicaid Uniform Screening Program Training Session
Registration Form (No Fees)
(Please print clearly)

Provider Name_____

Address_____

City, Zip Code_____County_____

Name of Training Session Attendee_____

Attendee's E-mail Address_____

Telephone Number ( )_____

Fax Number ( )_____

I will attend the training session on_____(date) at_____(location)

Please fax completed form to:
Uniform Screening Program
EDS Provider Services
P.O. Box 300015
Raleigh, NC 27622
Fax: 919-816-3145

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

Attention: All Providers

Registration for Health Check/EPSDT Seminars

Health Check/EPSDT seminars are scheduled for May 2008. Registration information, a list of dates, and site locations for the seminars are listed below.

Seminars will begin at 9:00 a.m. and will end at 12:00 noon. Providers are encouraged to arrive by 8:45 a.m. to complete registration. Lunch will not be provided at the seminars. **Because meeting room temperatures vary, dressing in layers is strongly advised.**

Due to limited seating, registration is limited to two staff members per office. Preregistration is required. Unregistered providers are welcome to attend if space is available. Providers may register for the seminars by completing and submitting the registration form online at http://www.ncdhhs.gov/dma/prov.htm, under "Seminar Information." Providers may also complete the Seminar Registration Form on page 20 and fax it to the number listed on the form. Please indicate on the registration form the session you plan to attend.

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

Hickory **May 13, 2008** Park Inn Gateway Conference Center 909 Hwy 70 SW Hickory, NC 28602 828-328-5101	**Wilmington** **May 15, 2008** Coastline Convention Center 501 Nutt St. Wilmington, NC 28401 910-763-2800
Greenville **May 21, 2008** Hilton Greenville 207 SW Greenville Blvd. Greenville, NC 27834 252- 355-5000	**Raleigh** **May 22, 2008** The Royal Banquet Center 3801 Hillsborough St. Ste. 109 Raleigh, NC 27607 919-621-0540

Directions to the Health Check/EPSDT Seminars:

GREENVILLE
Hilton Greenville
Take US 64 East to US 264 East to Greenville. Turn right at the 2nd traffic light as you come into the city onto Allen Road/US Alternate 264. Travel approximately 2 miles. Allen Road becomes Greenville Boulevard/Alternate 264. Follow Greenville Boulevard for 2½ miles. The Hilton Greenville is located on the right.

HICKORY
Park Inn Gateway Conference Center
Take I-40 to exit 123. Follow the signs to Highway 321 North. Take the first exit (Hickory exit) and follow the ramp to the traffic light. Turn right at the light onto US 70. The Gateway Conference Center is located on the right.

RALEIGH

The Royal Banquet Center

Traveling East on I-40

Take I-40 East towards Raleigh. Take Exit 289 for Wade Avenue. Pass the exits for Edwards Mill Road and Blue Ridge Road, then merge right onto I-440 S/US 1 South toward I-40 East/Hillsborough Street/Sanford (the Outer Beltline). Take Exit 3 for NC 54/Hillsborough Street. Turn left at the bottom of the exit ramp onto Hillsborough Street. Turn right at the 3rd stoplight at Meredith College and Playmakers (the turn is located in front of Quizno's and Ben & Jerry's). Go to the end of the parking lot and turn left to park BEHIND the building or in the covered parking area.

Traveling West on I-40

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

WILMINGTON

Coastline Convention Center

Traveling East on I-40

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

Traveling South on US 17

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

Traveling North on US 17 or NC 74/76

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

Health Check/EPSDT
May 2008 Seminar Registration Form
(No Fee)

Provider Name_____

Medicaid Provider Number_____ NPI Number_____

Mailing Address_____

City, Zip Code_____County_____

Contact Person_____E-mail_____

Telephone Number(____)_____Fax Number_____

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

Please fax completed form to: 919-851-4014

Please mail completed form to:
EDS Provider Services
P.O. Box 300009
Raleigh, NC 27622

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

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

Changes in Drug Rebate Manufacturers

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

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

Code	Manufacturer	Date
29336	Graceway Pharmaceuticals, LLC	January 1, 2008
54458	International Labs, Inc	March 5, 2008

Voluntarily Terminated Labelers
The following labelers have requested voluntary termination effective on the dates indicated below:

Code	Manufacturer	Date
50907	FEI Products, LLC	January 1, 2008
55370	Stada Pharmaceuticals, Inc	January 1, 2008
58291	Snuva Incorporated	January 1, 2008
64860	Stada Pharmaceuticals, Inc	January 1, 2008

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

Attention: Pharmacists

Focused Risk Management Program Quarterly Letter Update

Beginning in May 2008, the Focused Risk Management Program (FORM) quarterly letters that pharmacists receive indicating their patients that participate in the FORM program will include the following new features:

- The quarterly letter will include a list of recipients deleted from the program since the previous quarter's letter.
- If the quarterly letter is longer than one page, it will be mailed all in one envelope instead of separately for the same provider.

These changes are in addition to the new feature added to the February 2008 FORM letters, which included the addition of the dates FORM recipients are entered into the FORM program. FORM letters will be mailed out at the end of February, May, August, and November each year.

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

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

UB-04 Changes to Be Implemented April 25, 2008

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

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

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

Bill Type Changes

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

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

Revenue Code Changes

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

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

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

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

Attention: Pharmacists and Prescribers

New Pharmacy Prior Authorization Program for Second Generation Antihistamines

On April 4, 2008, the N.C. Medicaid Outpatient Pharmacy Program will implement a new prior authorization (PA) program for second generation antihistamines. Medications that will require PA include Clarinex, Allegra, fexofenadine, Xyzal, and Zyrtec (prescription versions only). All over-the-counter (OTC) versions of loratadine, Claritin, cetirizine, and Zyrtec will not require PA. On this date, pharmacists will begin receiving a point-of-sale message that PA is required for these medications. An additional message will indicate that override at point-of-sale is allowed for these medications. If the prescriber has indicated, by writing one of the following phrases on the face of the prescription in his or her own handwriting, that the PA criteria have been met, the pharmacist will be able to override the PA edit:

- **For generic fexofenadine**
  1. "Failed loratadine and failed cetirizine for 30 days"
  2. "Allergy to loratadine and cetirizine"
- **For liquid formulations other than loratadine syrup and cetirizine syrup**
  1. "Failed loratadine and failed cetirizine syrup for 30 days"
  2. "Allergy to loratadine and cetirizine syrup"
- **For all other second generation antihistamines**
  1. "Failed loratadine for 30 days, failed cetirizine for 30 days and failed fexofenadine for 30 days"
  2. "Allergy to fexofenadine, loratadine, and cetirizine"

If the second generation antihistamine has a generic version available, "medically necessary" must also be written on the face of the prescription in the prescriber's own handwriting in order to dispense the brand name drug. A "1" in the PA field (461-EU) or a "2" in the submission clarification field (420-DK) will override the PA edit. These overrides will be monitored by DMA's Program Integrity Section.

Providers may also contact ACS at 866-246-8505 (telephone) or 866-246-8507 (fax) to request PA for these medications. The PA criteria and request form for the second generation antihistamines will be available on the N.C. Medicaid Enhanced Pharmacy Program website at http://www.ncmedicaidpbm.com. If the PA is approved by ACS, the point-of-sale override codes will not be needed.

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

Attention: Pharmacists and Prescribers

New SmartPA Pharmacy Prior Authorization Program

In April 2008, the N.C. Medicaid Program will implement SmartPA to conduct point-of-sale (POS) clinical editing and pharmacy prior authorizations. SmartPA is a clinical editing and pharmacy prior authorization program that delivers pharmaceutical cost containment, efficient pharmacy benefit administration, and continued access to quality medications. Unlike other prior authorization programs, this program uses a clinical rules system, in conjunction with drug and medical claims data, to help providers determine the appropriateness of dispensing certain medications to Medicaid patients.

SmartPA streamlines the prior authorization process for all stakeholders—physicians, pharmacists, recipients, and payers. The SmartPA tool adjudicates prior authorization requests online in real time. Prescriptions that meet a predefined set of criteria are approved in seconds. A provider whose prescription is rejected by SmartPA wil be instructed to contact a call center representative for prior authorization reconsideration.

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

Attention: Nurse Practitioners and Physicians

Bevacizumab (Avastin, HCPCS Procedure Code J9035) – Update to Billing Guidelines

Effective with date of service February 23, 2008, the N.C. Medicaid program added the FDA-approved diagnosis of breast cancer to the required list of diagnoses for bevacizumab (Avastin) when billed through the Physician's Drug Program. This diagnosis was approved under the FDA's accelerated approval program.

Current patient literature indicates that Avastin, in combination with paclitaxel, is indicated for the treatment of patients who have not received chemotherapy for metastatic HER2-negative breast cancer. The effectiveness of Avastin in metastatic breast cancer is based on an improvement in progression-free survival. Avastin is not indicated for patients with breast cancer that has progressed following anthracycline and taxane chemotherapy administered for metastatic disease.

Certain ICD-9-CM diagnosis codes are required when billing for Avastin.

1. The following diagnosis codes must be billed with V58.11 (encounter for chemotherapy):
   - **153.0** through **154.8** (malignant neoplasm of the colon, rectum, recto-sigmoid junction, and anus); or
   - **162.2** through **162.9** (unresectable, locally advanced, recurrent or metastatic non-squamous, non-small-cell lung carcinoma); or
   - **174.0** through **175.9; 198.2; 198.81;** or **238.3** (breast cancer).
2. Diagnosis code **362.52** (wet-age macular degeneration) may be billed for Avastin, but does **not** require V58.11.

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

Attention: Nurse Practitioners and Physicians

Dexrazoxane (Totect, HCPCS Procedure Code J3490) – Billing Guidelines

Effective with date of service December 1, 2007, the N.C. Medicaid Program covers dexrazoxane 500 mg single-use vials (Totect) for use in the Physician's Drug Program when billed with HCPCS procedure code J3490 (unclassified drug). Totect is indicated for the treatment of extravasation resulting from intravenous anthracycline chemotherapy.

Totect is sold as a 3-day kit that includes ten 500-mg vials of drug and 10 vials of diluent. Totect is administered as an intravenous infusion of 1000 mg/m^2 on days 1 and 2 (maximum dose: 2000 mg) over a 1- to 2-hour period, followed by 500 mg/m^2 on day 3 (maximum dose 1000 mg). Treatment on days 2 and 3 should start at approximately the same hour as the treatment on day 1 (+/- 3 hours), and treatment should begin as soon as possible, within 6 hours of extravasation.

For Medicaid Billing:

- The ICD-9-CM diagnosis codes required for billing Totect are **any cancer diagnosis**
  AND
  V58.11 (Admission or encounter for chemotherapy)
- Providers must bill Totect with HCPCS procedure code J3490 (unclassified drug).
- One Medicaid unit of coverage is 250 mg.
- For dates of service prior to December 28, 2007, the original invoice or a copy of the original invoice must be 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 11-digit National Drug Code (NDC) number from the vial(s) used, the number of vial(s) used, and the cost per dose. Totect is supplied in single-use vials; therefore, providers may bill for a whole vial, including wastage.
- For dates of service on and after December 28, 2007, providers must bill with the 11-digit NDC codes; a paper invoice is not required. Refer to the revised version (3/03/08) of the October 2007 Special Bulletin, *National Drug Code Implementation* (http://www.ncdhhs.gov/dma/bulletinspecial.htm) for instructions.
- Regardless of the date of service, providers must indicate the number of units given 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/fee.htm.

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

Attention: Nurse Practitioners and Physicians

Doripenem (Doribax, HCPCS Procedure Code J3490) – Billing Guidelines

Effective with date of service October 1, 2007, the N.C. Medicaid program covers injectable doripenem (Doribax) for use in the Physician's Drug Program when billed with HCPCS procedure code J3490 (unclassified drug). Doribax is indicated for the treatment of complicated intra-abdominal infections and complicated urinary tract infections (including pyelonephritis) due to susceptible gram-positive, gram-negative (including *Pseudomonas aeruginosa*), and anaerobic bacteria.

Doribax is administered as an intravenous infusion of 500 mg over 1 hour every 8 hours in patients **18 years of age and older** for up to 14 days. Duration of therapy is 5 to 14 days in length, depending on indication, bacteria involved, and clinical improvement.

For Medicaid Billing:

- Providers must bill Doribax with HCPCS procedure code J3490 (unclassified drug).
- One Medicaid unit of coverage is 500 mg.
- For dates of service before December 28, 2007, the original invoice or a copy of the original invoice must be 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 11-digit National Drug Code (NDC) number from the vial(s) used, the number of vial(s) used, and the cost per dose. Doribax is supplied as a single-use vial; therefore, billing of a whole vial, including wastage, is permitted.
- For dates of service on and after December 28, 2007, providers must bill with the 11-digit NDC codes; a paper invoice is not required. Refer to the revised version (3/03/08) of the October 2007 Special Bulletin, *National Drug Code Implementation* (http://www.ncdhhs.gov/dma/bulletinspecial.htm) for instructions.
- Regardless of the date of service, providers must indicate the number of units given 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/fee.htm.

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

Attention: Nurse Practitioners and Physicians

Fosaprepitant Dimeglumine (Emend, HCPCS Procedure Code J3490) – Billing Guidelines

Effective with date of service January 1, 2008, the N.C. Medicaid program covers fosaprepitant dimeglumine 115-mg/10-ml single-dose vials (Emend) for use in the Physician's Drug Program when billed with HCPCS procedure code J3490 (unclassified drug). Emend is indicated (in combination with other antiemetics) for the prevention of acute and delayed nausea and vomiting associated with moderately and highly emetogenic chemotherapy.

For adults, Emend should be administered as a 115-mg infusion over 15 minutes, 30 minutes prior to chemotherapy on day 1 (followed by aprepitant 80 mg orally on days 2 and 3) in combination with other antiemetics.

For Medicaid Billing:

- Emend is not restricted based on an ICD-9-CM diagnosis code.
- One Medicaid unit of coverage is one single-dose vial, 115 mg.
- Providers should bill Emend with HCPCS code J3490 (unclassified drug). An invoice is not required, as the claim can be submitted electronically; however, the 11-digit National Drug Code (NDC) and the NDC units (quantity) must be indicated on the claim.
  Note: When documenting NDC units, consider the original state of the pharmacy product, not the reconstituted amount. For example, if the product comes in powder form (unit) and the powder must be reconstituted into milliliters, the NDC units would be reported in units, not milliliters.
- When billing for single-dose vials, providers may bill the amount wasted from the vial in addition to the amount actually administered to the recipient. When billing for multi-dose vials, bill only the amount actually administered to the recipient.
- When billing on paper, providers must indicate the number of units given in block 24G on the CMS-1500 claim form.
- For dates of service on and after December 28, 2007, providers must bill with the 11-digit NDC codes. Refer to the revised version (3/3/08) of the October 2007 Special Bulletin, *National Drug Code Implementation* (http://www.ncdhhs.gov/dma/bulletinspecial.htm) for instructions.
- 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/fee.htm.

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

Attention: Nurse Practitioners and Physicians

Human Thrombin Topical Protein (Evithrom, HCPCS Procedure Code J3590) – Billing Guidelines

Effective with date of service December 1, 2007, the N.C. Medicaid program covers human thrombin topical protein (Evithrom) for use in the Physician's Drug Program when billed with HCPCS code J3590 (unclassified biologic). Evithrom is indicated for use as an aid to hemostasis whenever oozing blood and minor bleeding from capillaries and small venules is accessible, and when control of bleeding by standard surgical techniques is ineffective or impractical. Evithrom is the first human thrombin approved since 1954 and is intended to provide an alternative to bovine-derived products that carry a risk for immunogenetic response and associated complications such as severe bleeding, thrombosis and anaphylactic shock.

Evithrom is distributed in 2-, 5-, and 20-ml vials as well as 2- and 5-ml kits, which include Surgiflo.

Evithrom may be used by directly flooding the surface of bleeding tissue or may be applied with pressure using a saturated absorbable gelatin sponge. The amount used depends on the area to be treated; in clinical studies, volumes of up to 10 ml were used in conjunction with a gelatin sponge.

Because of the risk for thrombosis, human thrombin should not be injected directly into the circulatory system.

For Medicaid Billing:

- The ICD-9-CM diagnosis code required for billing Evithrom is **286.9** (Other and unspecified coagulation defects [hemostasis]).
- Providers must bill Evithrom with HCPCS procedure code J3590 (unclassified biologic).
- One Medicaid unit of coverage is 1 IU.
- For dates of service prior to December 28, 2007, the original invoice or a copy of the original invoice must be 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 used, the 11-digit National Drug Code (NDC) number from the vial(s) used, the number of vials used, and the cost per dose.
- For dates of service on and after December 28, 2007, providers must bill with the 11-digit NDC codes; a paper invoice is not required. Refer to the revised version (3/03/08) of the October 2007 Special Bulletin, *National Drug Code Implementation* (http://www.ncdhhs.gov/dma/bulletinspecial.htm) for instructions.
- Regardless of the date of service, 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/fee.htm.

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

Attention: Nurse Practitioners and Physicians

Human Thrombin Topical Protein, Preservative-Free (Recothrom, HCPCS Procedure Code J3590) – Billing Guidelines

Effective with date of service January 1, 2008, the N.C. Medicaid program covers the **preservative-free** human thrombin topical protein Recothrom for use in the Physician's Drug Program when billed with HCPCS code J3590 (unclassified biologic). Recothrom is indicated for use as an aid to hemostasis whenever oozing blood and minor bleeding from capillaries and small venules is accessible, and control of bleeding by standard surgical techniques is ineffective or impractical. Recothrom is distributed as a powder for reconstitution in 5000-IU/5-ml vials.

Recothrom may be used by directly flooding the surface of bleeding tissue or may be applied with pressure using a saturated absorbable gelatin sponge. The amount used depends on the area to be treated.

For Medicaid Billing:

- The ICD-9-CM diagnosis code required for billing Recothrom is **286.9** (Other and unspecified coagulation defects).
- Providers should bill Recothrom with HCPCS code J3590 (unclassified biologic). An invoice is not required, as the claim can be submitted electronically; however, the 11-digit National Drug Code (NDC) and the NDC units (quantity) must be included.
  Note: When documenting NDC units, the original state of the pharmacy product must be considered, not the reconstituted amount. For example, if the product comes in powder form (unit) and the powder must be reconstituted into milliliters, the NDC units would be reported in units, not millileters.
- One unit of coverage is 1 IU.
- When billing for single-dose vials, providers may bill for the amount wasted from the vial in addition to the amount actually administered to the recipient. When billing for multi-dose vials, bill only the amount actually administered to the recipient.
- When billing on paper, providers must indicate the number of units given in block 24G on the CMS-1500 claim form.
- For dates of service on and after December 28, 2007, providers must bill with the 11-digit NDC codes. Refer to the revised version (3/3/08) of the October 2007 Special Bulletin, *National Drug Code Implementation* (http://www.ncdhhs.gov/dma/bulletinspecial.htm) for instructions.
- 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/fee.htm.

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

Attention: Nurse Practitioners and Physicians

Immune Globulin, Non-lyophilized Intravenous (Privigen, J3590) – Billing Guidelines

Effective with date of service January 1, 2008, the N.C. Medicaid program covers the non-lyophilized immune globulin, Privigen, for use in the Physician's Drug Program when billed with HCPCS procedure code J3590 (unclassified biologic). Privigen is indicated for treatment of primary immunodeficiency and chronic immune thrombocytopenic purpura. Privigen is the first and only proline-stabilized intravenous immune globulin that is ready for immediate use, requiring no refrigeration or reconstitution. Privigen is distributed as a 10% solution in 50-, 100- and 200-ml vials.

The recommended dose of Privigen varies by condition. For recipients with primary immunodeficiency, 200 to 800 mg/kg should be administered intravenously every 3 to 4 weeks. Initially, the infusion rate should be 0.5 mg/kg/min (0.005 ml/kg/min) but may be gradually increased to 8 mg/kg/min (0.08 ml/kg/min) if well tolerated. For recipients with chronic immune thrombocytopenic purpura, 1 g/kg should be administered intravenously daily for 2 consecutive days for a total of 2 g/kg. The initial infusion rate should be 0.5 mg/kg/min (0.005 ml/kg/min) and may be gradually increased to 4 mg/kg/min (0.04 ml/kg/min) if well tolerated.

For Medicaid Billing:

- Privigen is not restricted based on the ICD-9-CM diagnosis code; however, all codes should be supported with adequate documentation in the medical record. Acceptable ICD-9-CM diagnosis codes are as follows:

279.00	Hypogammaglobulinemia, unspecified
279.01	Selective IgA immunodeficiency
279.02	Selective IgM immunodeficiency
279.03	Other selective immunoglobulin deficiencies
279.04	Congenital hypogammaglobulinemia
279.06	Common variable immunodeficiency
279.12	Wiskott-Aldrich syndrome
279.2	Combined immunity deficiency

- One Medicaid unit of coverage is 500 mg.
- Providers should bill for Privigen with HCPCS code J3590 (unclassified biologic). An invoice is not required, as the claim can be submitted electronically; however, the 11-digit National Drug Code (NDC) and the NDC units (quantity) must be included.
- When billing for single-dose vials, providers may bill for the amount wasted from the vial in addition to the amount actually administered to the recipient. When billing multidose vials, bill only the amount actually administered to the recipient.
- When billing on paper, providers must indicate the number of units given in block 24G on the CMS-1500 claim form.
- For dates of service on and after Dec. 28, 2007, providers must bill with the 11-digit NDC codes. Refer to the revised version (3/3/08) of the October 2007 Special Bulletin, *National Drug Code Implementation* (http://www.ncdhhs.gov/dma/bulletinspecial.htm) for instructions.
- 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/fee.htm.

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

Attention: Nurse Practitioners and Physicians

Ixabepilone Kit for Injection (Ixempra, HCPCS Procedure Code J3490) – Billing Guidelines

Effective with date of service October 1, 2007, the N.C. Medicaid program covers ixabepilone kit for injection (Ixempra) for use in the Physician's Drug Program when billed with HCPCS procedure code J3490 (unclassified drug). Ixempra is indicated in combination with capecitabine for the treatment of patients with metastatic or locally advanced breast cancer resistant to treatment with an anthracycline and a taxane, or whose cancer is taxane-resistant and for whom further anthracycline therapy is contraindicated. (Anthracycline resistance is defined as progression while on therapy or within 6 months in the adjuvant setting or 3 months in the metastatic setting. Taxane resistance is defined as progression while on therapy or within 12 months in the adjuvant setting or 4 months in the metastatic setting.) Ixempra is also indicated as monotherapy for the treatment of metastatic or locally advanced breast cancer in patients with tumors that are resistant or refractory to anthracyclines, taxanes and capecitabine.

Ixempra is administered as an intravenous infusion of 40 mg/m^2 over 3 hours every 3 weeks. Doses for patients with body surface area greater than 2.2 m^2 should be calculated based on 2.2 m^2.

For Medicaid Billing:

- The ICD-9-CM diagnosis codes required for billing Ixabepilone are
  175.0 through **175.9** (Malignant neoplasm of the breast)
  AND
  V58.11 (Admission or encounter for chemotherapy)
- Providers must bill Ixempra with HCPCS procedure code J3490 (unclassified drug).
- One Medicaid unit of coverage is 1 mg.
- For dates of service prior to December 28, 2007, the original invoice or a copy of the original invoice must be 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 11-digit National Drug Code (NDC) number from the vial(s) used, the number of vial(s) used, and the cost per dose. Ixempra is supplied in 15- and 45-mg single-use vials; therefore, billing of a whole vial is permitted, including wastage.
- For dates of service on and after December 28, 2007, providers must bill with the 11-digit NDC codes; a paper invoice is not required. Refer to the revised version (3/03/08) of the October 2007 Special Bulletin, *National Drug Code Implementation* (http://www.ncdhhs.gov/dma/bulletinspecial.htm) for instructions.
- Regardless of the date of service, providers must indicate the number of units given 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/fee.htm.

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

Attention: Nurse Practitioners and Physicians

Lanreotide Injection (Somatuline Depot, HCPCS Procedure Code J3490) – Billing Guidelines

Effective with date of service October 1, 2007, the N.C. Medicaid program covers lanreotide injection (Somatuline Depot) for use in the Physician's Drug Program when billed with HCPCS procedure code J3490 (unclassified drug). Somatuline Depot is indicated for the long-term treatment of acromegaly in patients who have had an inadequate response to surgery and/or radiotherapy or for whom surgery and/or radiotherapy is not an option.

Somatuline Depot is administered via the deep subcutaneous route. Treatment should begin with 90 mg given at 4-week intervals for 3 months. After 3 months, the dosage may be adjusted.

For Medicaid Billing:

- The ICD-9-CM diagnosis code required for billing Somatuline Depot is **253.0** (Acromegaly and gigantism).
- Providers must bill Somatuline Depot with HCPCS procedure code J3490 (unclassified drug).
- One Medicaid unit of coverage is 1 mg.
- For dates of service prior to December 28, 2007, the original invoice or a copy of the original invoice must be 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 11-digit National Drug Code (NDC) number from the vial(s) used, the number of vial(s) used, and the cost per dose.
- For dates of service on and after December 28, 2007, providers must bill with the 11-digit NDC codes; a paper invoice is not required. Refer to the revised version (3/03/08) of the October 2007 Special Bulletin, *National Drug Code Implementation* (http://www.ncdhhs.gov/dma/bulletinspecial.htm) for instructions.
- Regardless of the date of service, providers must indicate the number of units given 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/fee.htm.

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

Early and Periodic Screening, Diagnostic 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/medbillcaguide.htm.
- *Health Check Billing Guide:* http://www.ncdhhs.gov/dma/healthcheck.htm.
- EPSDT provider information: http://www.ncdhhs.gov/dma/EPSDTprovider.htm.

Proposed Clinical Coverage Policies

In accordance with NCGS §108A-54.2, proposed new or amended Medicaid clinical coverage policies are available for review and comment on DMA's website at http://www.ncdhhs.gov/dma/mp/proposedmp.htm. To submit a comment related to a policy, refer to the instructions on the website. Providers without Internet access can submit written comments to the address listed below.

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

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

2008 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
April	04/03/08	04/08/08
	04/10/08	04/15/08
	04/17/08	04/24/08
May	05/01/08	05/06/08
	05/08/08	05/13/08
	05/15/08	05/20/08
	05/22/08	05/29/08

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

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

Cheryll Collier
Executive Director
EDS