Number 5 *May 2006*

North Carolina Medicaid Bulletin

Visit DMA on the Web at: http://www.dhhs.state.nc.us/dma

In This Issue……Page #

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

Attention: All Providers

Carolina ACCESS Override Request Form Revised

The Carolina ACCESS Override form has been revised. The new form is designed to simplify the evaluation process and includes new field sin the "Is this claim due to?" portion of the form. The fax number for submitting Carolina ACCESS Override Requests has also changed. The new fax number is 919-816-4420. This fax line is dedicated to **Carolina ACCESS Override Requests only**.

A copy of the new form is available on the next page or from DMA's website at http://www.dhhs.state.nc.us/dma/forms.html. Providers who have already submitted a request to the old fax number (919-851-4014) or submitted a request by mail using the old form do not need to resubmit the request.

It is the responsibility of the treating provider to obtain authorization for treatment from the primary care provider (PCP) listed on the recipient's Medicaid identification care **prior** to rendering treatment. If authorization is requested **after** services have been rendered, the PCP may refuse to authorize treatment, which will result in a denied claim. No override request will result in a denied claim. No override request will be considered unless the PCP has been contacted and refused to authorize treatment.

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

Carolina ACCESS Override Request Form

Complete this form to request a Carolina ACCESS override when you have received a denial for EOB 270 or 286 **or** the Primary Care Provider (PCP) has refused to authorize treatment for **past** date(s) of service. The request must be submitted within six months of the date of service. Overrides will not be considered unless the PCP has been **contacted and refused** to authorized treatment. Attach any supporting documentation. Mail or fax completed form to EDS. EDS will telephone or fax your office **within 30 days** with a denial or, if approved, the override number to use for filing the claim. This form is also available in the Carolina ACCESS Primary Care Provider Manual and on DMA's website at http://www.dhhs.state.nc.us/dma.

Mail to: CA Override
EDS Provider Services
PO Box 300009
Raleigh, NC 27622

Fax: CA Override
919-816-4420

Recipient MID No. _____Recipient Name_____

Date of Birth_____ Date(s) of Service_____

Is this claim due to?

- o An Inpatient admission
- o An Inpatient admission via the ER
- o Current condition _____

PCP on recipient's Medicaid card _____

Name of person contacted at PCP's office _____Date contacted _____
Reason PCP stated he/she would not authorize treatment _____
_____

Reason recipient did not go to the PCP listed on his/her Medicaid card_____
_____

I am requesting an override due to:

- o Enrollee linked incorrectly to PCP. Please explain: _____
  _____
  Who is the correct PCP? _____
- o This child has been placed in foster care in another area : _____
- o This enrollee has moved to another county: _____
- o The provider listed on the enrollee's Medicaid card is different from PCP indicated by the AVR system (attach a copy of the Medicaid card with this form).
- o Unable to contact PCP. Please Explain: _____
- o Other. Please explain: _____

Provider Name _____Provider Number _____

Provider Contact _____Telephone No. _____Fax No. _____

Attention: All Providers

Clinical Coverage Policies

The following new or amended clinical coverage policies are now available on the Division of Medical Assistance's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm:

5A – Durable Medical Equipment
8D-1 – Psychiatric Residential Treatment Facilities for Children under the Age of 21
8D-2 – Residential Treatment Services
9 – Outpatient Pharmacy Program

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

Family Planning "Be Smart" May 2006 Special Bulletin

Effective May 1, 2006, the Family Planning Waiver "Be Smart" Special Bulletin has been updated. This special bulletin supersedes previously published polices and procedures. For your convenience, shading will indicate new information.

Providers may access the May 2006 Special Bulletin, *Medicaid Family Planning Waiver Program* from DMA's website at http://www.dhhs.state.nc.us/dma/bulletin.htm. Providers should contact EDS with any billing questions.

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

Attention: All Providers

Hepatitis A Vaccine, Pediatric/Adolescent Dosage – 2 Dose Schedule (CPT 90633)

Effective with date of service March 1, 2006, the N.C. Medicaid program recognizes pediatric hepatitis A vaccine as a covered vaccine in the Universal Childhood Vaccine Distribution Program (UCVDP)/Vaccines for Children (VFC) program. The UCVDP/VFC program provides all vaccines recommended by the Advisory Committee of Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC). Currently, there are two manufacturers for pediatric hepatitis A. Vaqta and Havarix are licensed for use in those persons age 12 months through 18 years of age.

State-supplied hepatitis A vaccine is available for any Medicaid-enrolled child 12 months (one year) through 18 years of age. For a complete list of recommendations, please see the Advisory Committee on Immunization Practices (ACIP) website at http://www.cdc.gov/nip/recs/provisional_recs/hepA_child.pdf.

For children 12 months through 18 years of age, Medicaid does not reimburse for the actual vaccine because state-supplied pediatric hepatitis A vaccine is available to all providers enrolled in the UCVDP/VFC program. As with other injectable vaccines covered in this program, Medicaid will reimburse an administration fee, if applicable. When state-supplied pediatric hepatitis A vaccine is administered, ICD-9-CM diagnosis code V05.3 should be indicated on the claim (see billing guidelines below). Medicaid does not reimburse for hepatitis A vaccine, CPT code 90633, for those recipients over 18 years of age.

Billing Guidelines:

- The procedure code for billing hepatitis A vaccine is CPT 90633.
- Effective with date of service March 1, 2006, bill the vaccine code, CPT 90633, with no modifier, at a charge of $0.00, for vaccine that was state-supplied and administered to a Medicaid recipient 12 months through 18 years of age. An administration fee may be billed to Medicaid, if appropriate.
- ICD-9-CM diagnosis code V05.3 should be used when billing for 90633.

Health Check providers should refer to the April 2006 Special Bulletin, *Health Check Special Billing Guide 2006*, for additional billing information on billing Medicaid for vaccines for Medicaid recipients.

Providers should also refer to the article titled, *CPT Codes 90465 and 90466 – New Immunization Administration Codes for Recipients under Eight Years of Age*, in the July 2005 general Medicaid bulletin.

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

Attention: All Providers

Medicaid Crossover Claims Billed with Incorrect Medicaid Provider Numbers

Effective May 1, 2006, the coinsurance and deductible paid by Medicaid for claims submitted to Medicare for reimbursement of services for dually eligible recipients will be paid at $0.00 if:

- The provider type/specialty combination associated with the Medicare provider number crosses over to a Medicaid provider type/specialty that is not eligible to bill Medicare for the service. For example, if Medicaid durable medical equipment (DME) provider bills Medicare for a service, and the claim crosses over to a home infusion therapy (HIT) provider number, the claim will pay at $0.00 because Medicare does not pay for HIT services. If the provider is actually billing Medicare for DME services, the provider should refile the claim to Medicaid using his DME provider number.

- The provider is billing the claim on a CMS-1500 claim form or electronic equivalent, but that provider type/specialty combination should bill the service or procedure on the UB-92 claim form or electronic equivalent. Because UB-92 claims are processed using a different payment methodology, these claims do not cross over to Medicaid automatically; they must be reformatted and resubmitted to Medicaid as a secondary filing.

Crossover claims for dates of service May 1, 2006 and after that were paid at $0.00 because they were billed to Medicare with a provider number that did not cross over to an appropriate Medicaid provider number may be resubmitted electronically to Medicaid as an 837 void transaction and a new day claim or resubmitted as a manual adjustment using the Medicaid Claim Adjustment form. The correct Medicaid provider number must be entered in the group number block on the claim form. Claims that are eligible for reprocessing will appear in the paid crossover section the Remittance and Status Advice (RA) with a pay amount of $0.00.

Providers may verify that their Medicare provider number is cross-referenced to their Medicaid provider number by contacting EDS Provider Services at 1-800-688-6696 or 919-851-8888. If your Medicare provider number is not cross-referenced to your Medicaid provider number or to the correct Medicaid provider number, you must complete and submit the Medicare Crossover Reference Request form by fax or mail to EDS at the address indicated on the form. Both forms are available on DMA's website at http://www.dhhs.state.nc.us/dma/forms.html.

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

Attention: All Providers

Part B Reimbursement Percentages Update

Effective with date of service May 1, 2006, the percentage applied to coinsurance and deductible paid by Medicaid for providers who file on CMS-1500 claim form has been updated to reflect current aggregate Medicaid pricing.

The Medicaid Crossover Percentage Payment Schedule is available on DMA's website at http://www.dhhs.state.nc.us/dma/fee/fee.htm.

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

Attention: All Providers

Updated EOB Crosswalk to HIPPA Standard Codes

The list of standard national codes used on the Electronic Remittance Advice (ERA) has been cross-walked to EOB codes as an informational aid to adjudicated claims listed on the Remittance and Status Report (RA). An updated version of the list is available on the Division of Medical Assistance's website at http://www.dhhs.state.nc.us/dma/prov.htm.

With the implementation of standards for electronic transactions mandated by the Health Insurance Portability and Accountability Act (HIPAA), providers now have the option to receive an ERA in addition to the paper version of the RA.

The EOB codes that providers currently receive on a paper RA are not used on the ERA. Because the EOB codes on the paper RA provide a greater level of detail on claim denials, all providers will continue to receive the paper version of the RA, even if they choose to receive the ERA transaction. The list is current as of the date of publication. Providers will be notified of changes to the list through the general Medicaid bulletin.

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

Attention: All Providers

Tetanus, Diphtheria Toxoids and Acellular Pertussis Vaccine (Tdap), for Intramuscular Use, (CPT 90715)

Effective with date of service March 1, 2006, the N.C. Medicaid program recognizes tetanus, diphtheria toxoids, and acellular pertussis (Tdap) as a covered vaccine in the Universal Childhood Vaccine Distribution Program (UCVDP)/Vaccines for Children (VFC) program. The UCVDP/VFC program provides all vaccines recommended by the Advisory Committee of Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC). Currently, there are two Tdap products, Adacel and Boostrix.

State-supplied Tdap vaccine is available for any Medicaid-enrolled child 11 through 18 years of age who meets the recommendations listed by the Advisory Committee on Immunization Practices (ACIP) found at http://www.cdc.gov/nip/pr/pr_tdap_jun2005.htm. ACIP does not recommend Tdap vaccine for individuals under the age of 11 and it is, therefore, not available through the UCVDP/VFC vaccine program.

For children 11 through 18 years of age, Medicaid does not reimburse for the actual vaccine because state-supplied Tdap vaccine is available to all providers enrolled in the UCVDP/VFC program. As with other injectable vaccines covered in this program, Medicaid will reimburse an administration fee, if applicable. When state-supplied Tdap vaccine is administered, ICD-9-CM diagnosis code V06.1 should be indicated on the claim when appropriate.

Medicaid reimburses for Tdap for recipients over the age of 18 who meet the ACIP recommendations. Medicaid may reimburse an administration fee, if applicable.

Billing Guidelines:

- The procedure code for billing Tdap is CPT 90715.
- Effective with date of service March 1, 2006, report the vaccine CPT code 90715 with no modifier at a charge of $0.00 for vaccine that was state-supplied and administered to a Medicaid recipient 11 through 18 years of age. An administration fee may be billed to Medicaid, if appropriate.
- Effective with date of service March 1, 2006, bill CPT 90715 with no modifier for vaccine given to those Medicaid recipients 19 through 64 years of age. Bill the usual and customary charge. An administration fee may be billed to Medicaid, if appropriate.
- ICD-9-CM diagnosis code V06.1 should be used when billing for Tdap.

Providers should refer to the April 2006 Special Bulletin, *Health Check Special Billing Guide 2006*, for guidance on how to bill for immunizations.

The maximum reimbursement rate for Tdap provided to recipients over the age of 18 is $19.35. The fee schedule for the Physician's Drug Program is found on DMA's website at http://www.dhhs.state.nc.us/dma/fee/fee.htm.

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

Attention: Ambulatory Surgery Centers and Physicians

Update to Approved Procedures for Ambulatory Surgery Centers and Physicians

CPT procedure codes, *15822 (blepharoplasty, upper eyelid)* and *15823, (blepharoplasty, upper eyelid, with excessive skin weighting lid)* have been added to the list of approved procedures for an ambulatory surgery center. These codes require prior approval. Ambulatory surgery centers should verify that the physician performing the procedure(s) has obtained prior approval before scheduling the surgery in their facility to prevent denial of claims for lack of prior approval.

General information regarding the prior approval process can be found in the *Basic Medicaid Billing Guide* on DMA's website at http://www.dhhs.state.nc.state.us/dma/medbillcaguide.htm.

CPT code 15822 is assigned to payment group 3 and CPT code 15823 is assigned to payment group 5. The fee schedule for Ambulatory Surgical Centers can be found on the DMA website at http://www.dhhs.state.nc.us/dma/fee/fee.htm.

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

Attention: Durable Medical Equipment Providers, Home Health Providers, Private Duty Nursing Providers

Medicare Part D Coverage of Supplies for Delivery of Insulin

Effective January 1, 2006, Medicaid no longer covers prescriptions for recipients who are covered by both Medicaid and Medicare (dually eligible) with a few exceptions. Dually eligible recipients now receive their drug coverage from a Medicare approved Prescription Drug Plan (PDP). This is called Medicare Part D. In addition to prescriptions, Part D also covers certain medical supplies associated with the injection of insulin (syringes, needles, alcohol swabs, and gauze).

Therefore, the N. C. Medicaid program must not be billed for these supplies for recipients who are eligible for both Medicare and Medicaid services. Providers must bill the recipient's PDP for these supplies. If you have any questions, please call 1-800-Medicare (1-800-633-4227).

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

Attention: Health Department

Training for Local Health Departments on Health Check Requirements and Billing

A training session is scheduled for local health department staff from 10:00 a.m. through 1:00 p.m. on May 31, 2006 via the Public Health Training and Information Network (PHTIN). Attendance at these seminars is very important. The seminars will focus on Early and Periodic Screening, Diagnostic, and Treatment, Prior Approval, requesting non-covered services, Due Process (appeal rights), and Health Check billing requirements, as well as vision and hearing assessments and developmental screening requirements for the Health Check Program.

Registration information is listed below. The target audience for this session is both clinical staff who perform the Health Check screenings and billing staff. Providers may register by completing the form or by registering online at http://www.dhhs.state.nc.us/dma/prov.htm.

The April 2006 Special Bulletin, Health Check Billing Guide 2006, is the primary handout for this session. Attendees must access and print the PDF version of this special bulletin from the Division of Medical Assistance's website at http://www.dhhs.state.nc.us/dma/healthcheck.htm. Copies of this handout will not be provided onsite.

(cut and return the registration form only)

Local Health Department Teleconference Registration Form

(No Fee)

Provider Name _____ Provider Number _____

Address _____

City, Zip Code _____ County _____

Contact Person _____ E-mail Address _____

Telephone Number (____) _____ Fax Number (____) _____

I will be joining in the teleconference _____ on May 31, 2006

(location)

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

Attention: Orthotic and Prosthetic Providers

Medicaid Crossover Claims Billed by Attending Providers

Effective May 1, 2006, the coinsurance and deductible paid by Medicaid for claims submitted to Medicare for reimbursement of orthotic and prosthetic devices for dually eligible recipients will pay at $0.00 by Medicaid if the claim crosses over to Medicaid with the provider's attending number listed on the claim as the billing provider number.

Crossover claims for dates of service May 1, 2006 and after that were paid at $0.00 because they were billed to Medicare with the attending number listed as the billing number may be submitted to Medicaid as an 837 void transaction and resubmitted as a new day claim or as a manual adjustment using the Medicaid Claim Adjustment form. The correct billing provider number must be entered in the group block on the claim form. Claims that are eligible for reprocessing will appear in the paid crossover section of the RA with a pay amount of $0.00.

If your Medicaid and Medicare provider numbers are not cross-referenced or not cross-referenced correctly, please complete and submit the Medicare Crossover Reference Request form by fax or mail to EDS at the address indicated on the form. Both forms are available on DMA's website at http://www.dhhs.state.nc.us/dma/forms.html.

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

Attention: Physicians and Nurse Practioners

Aminolevulinic Acid HCl for Topical Administration, 20%, Single Unit Dosage Form (Levulan Kerastick, J7308) – Billing Guidelines

Effective with date of service January 1, 2006, the N.C. Medicaid program covers aminolevulinic acid HCl (Levulan Kerastick) topical solution for use in the Physician's Drug Program for the diagnosis of actinic keratoses only. Levulan Kerastick plus blue light illumination using the BLU-U Blue Light Photodynamic Therapy Illuminator is indicated for the treatment of minimally to moderately thick actinic keratoses (Grade 1 or 2) of the face and scalp. Levulan Kerastick is intended for direct application to individual lesions diagnosed as actinic keratoses and not to perilesional skin. Application should involve either scalp or face lesions, but not both simultaneously. The recommended treatment frequency is one application of the Levulan Kerastick topical solution to the target lesions, followed 14 to 18 hours later by one dose of illumination (with blue light using the BLU-U Blue Light Photodynamic Therapy Illuminator, CPT code 96567) per treatment site. Treated lesions that have not completely resolved after eight weeks may be treated a second time.

For Medicaid billing:

- ICD-9-CM diagnosis code 702.0 (actinic keratosis) is required when billing for Levulan Kerastick.
- Providers must use HCPCS code J7308 to bill for Levulan Kerastick.
- Providers must indicate the number of units given in block 24G on the CMS-1500 claim form.
- Providers should bill their usual and customary charge.
- For Medicaid billing, 1 unit of coverage is 1 single unit dose of Levulan Kerastick.

The maximum reimbursement rate per unit is $101.83. The fee schedule for the Physician's Drug Program is available on DMA's website at http://www.dhhs.state.nc.us/dma/fee/fee.htm.

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

Attention: Physicians and Nurse Practioners

Daptomycin Injection, 1 mg (Cubicin, K0878) – Billing Guidelines

Effective with date of service January 1, 2006, the N.C. Medicaid program covers daptomycin for injection (Cubicin) for use in the Physician's Drug Program, when billed with HCPCS code J0878. Cubicin is an antibacterial agent of a new class of antibiotics, the cyclic lipopeptides. The FDA approved indication for Cubicin is the treatment of **complicated skin and skin structure infections** caused by susceptible strains of the following Gram-positive microorganisms:

- *Staphylococcus aureus* (including methicillin-resistant strains)
- *Streptococcus pyogenes*
- *Streptococcus agalactiae*
- *Streptococcus dysgalactiae* subsp. e*quisimilis*
- *Enterococcus faecalis* (vancomycin-susceptible strains only)

Combination therapy may be clinically indicated if the documented or presumed pathogens include Gram-negative or anaerobic organisms. **Cubicin is not recommended for the treatment of pneumonia.**

The FDA indicates that the usual adult dose is 4 mg/kg administered over a 30-minute period by IV infusion in 0.9% sodium chloride injection once every 24 hours for 7 to 14 days. Doses of Cubicin higher than 4 mg/kg/day have not been studied in Phase 3 controlled clinical trials. Cubicin should not be dosed more frequently than once a day.

One of the following ICD-9-CM **diagnosis codes** is **required** when billing for Cubicin**:**

035	373.13	376.01
380.10 through 380.16	528.5	608.4
616.4	680.0 through 680.9	681.0 through 681.9
682.0 through 682.9	685.0	686.00 through 686.09
686.1 through 686.9		

Billing Requirements:

- Use the CMS-1500 claim form.
- Enter the appropriate ICD-9-CM diagnosis code in block 21.
- Enter the date of service in block 24A.
- Enter the place of service in block 24B.
- Enter HCPCS code J0878 in block 24D.
- Enter the usual and customary charge in block 24F.
- Enter the units given in block 24G (1mg = 1 unit).

Example:

21 Diagnosis	**24A Date(s) of Service**	**24B Place of Service**	**24D Procedures, Services or Supplies**	**24F Charges**	**24G Days or Units**
035	02012006	11	J0878	$	

For Medicaid billing, one unit of coverage is 1 mg. The maximum reimbursement rate per unit is $0.29. The fee schedule for the Physician's Drug Program is available on DMA's website at http://www.dhhs.state.nc.us/dma/fee/fee.htm.

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

Attention: Physicians and Nurse Practioners

Peinterferon Alfa- 2a, 180 mcg/ml (Pegasys, J3490 and S0145) – Billing Guidelines

Effective with date of service June 1, 2005, the N.C. Medicaid program covers peginterferon alfa-2a (Pegasys) for use in the Physician's Drug Program when billed with HCPCS code J3490. Pegasys is a covalent conjugate of recombinant alfa-2a interferon with a polyethylene glycol (PEG) chain. The FDA approved indications for Pegasys are:

- Alone or in combination with Copegus (ribavirin) for the treatment of adults with chronic hepatitis C virus infection who have compensated liver disease and have not been previously treated with interferon alpha. Patients in whom efficacy was demonstrated included patients with compensated liver disease and histological evidence of cirrhosis (Child-Pugh class A) and patients with HIV disease that is clinically stable (e.g., antiretroviral therapy not required or receiving stable antiretroviral therapy).
- For the treatment of adult patients with HBeAg positive and HBeAg negative chronic hepatitis B who have compensated liver disease and evidence of viral replication and liver inflammation.

The recommended dosing schedules are provided below.

For Patients with Chronic Hepatitis C:

Pegasys monotherapy: 180 mcg SQ once weekly for 48 weeks

Pegasys and Copegus combination therapy:

Viral Genotype	Pegasys Dose (SQ once weekly)	Copegus Dose (PO daily in 2 divided doses)	Duration
Genotypes 1, 4	180 mcg	<75 kg = 1000 mg ≥75 kg = 1200 mg	48 weeks 48 weeks
Genotypes 2, 3	180 mcg	800 mg	24 weeks

For Patients with Chronic Hepatitis C and HIV Coinfection:

Pegasys monotherapy: 180 mcg SQ once weekly for 48 weeks

Pegasys and Copegus combination therapy: Regardless of genotype Pegasys 180 mg SQ once weekly for 48 weeks

Copegus 800 mg PO daily (in 2 divided doses) for 48 weeks

For Patients with Chronic Hepatitis B:

Pegasys monotherapy: 180 mcg SQ once weekly for 48 weeks

One of the following diagnosis codes must be billed with Pegasys:

- **070.54** (chronic hepatitis C without mention of hepatic coma)
- **070.32** (chronic hepatitis B without mention of hepatic delta)

Billing Requirements for June 1, 2005 through June 30, 2005:

- Providers must indicate 1 unit in block 24G of the CMS-1500 claim form.
- The original invoice or 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 National Drug Code (NDC) number from the vial(s) used, the number of vials used, and the cost per dose.

- Providers must indicate 1 unit in block 24G on the CMS-1500 claim form.
- Providers must bill their usual and customary charge.
- For Medicaid billing, one unit of coverage is 180 mcg/ml.
- The maximum reimbursement rate per unit is $301.85.

Billing Requirements for Dates of Service July 1, 2005 and after:

- Providers must indicate 1 unit in block 24G on the CMS-1500 claim form.
- Providers must bill HCPCS code **S0145** for Pegasys.
- Providers must bill their usual and customary charge. No invoice is required.
- For Medicaid billing, one unit of coverage is 180 mcg/ml.
- For dates of service on and after January 1, 2006, the maximum reimbursement rate is $317.73.

Refer to the fee schedule for the Physician's Drug Program on DMA's website at http://www.dhhs.state.nc.us/dma/fee/fee.htm.

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

NCLeads Update

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

NCLeads Provider Relations
Office of MMIS Services
919-647-8315

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 website at http://www.dhhs.state.nc.us/dma/prov.htm. To submit a comment related to a policy, refer to the instructions on the website. Providers without Internet access can submit written comments to the address listed below.

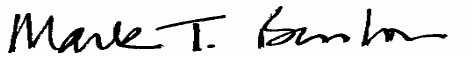
Gina Rutherford
Division of Medical Assistance
Clinical Policy Section
2501 Mail Service Center
Raleigh, NC 27699-2501

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

2006 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
May	04/28/06	05/02/06
	05/05/06	05/09/06
	05/12/06	05/16/06
	05/19/06	05/25/06
June	06/02/06	06/06/06
	06/09/06	06/13/06
	06/16/06	06/22/06
	06/30/06	07/06/06
July	07/07/06	07/11/06
	07/14/06	07/18/06
	07/21/06	07/27/06

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



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

Cheryll Collier
Executive Director
EDS