# May 2008 Medicaid Bulletin

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## Attention: All Providers

## Medicare Crossovers and Medicare Adjusted Claims

Effective March 1, 2008, Medicare began denying claims that did not contain a National Provider Identifier (NPI). As a result, if a provider requests a Medicare adjustment on a claim that when originally adjudicated did not contain an NPI, Medicare will adjudicate the adjustment claim but will **not** automatically cross the claim over to Medicaid due to the claim's lack of an acceptable NPI. Medicare contractors will inform the providers via the customary special provider notification letters that Medicare could not cross the claims over due to lack of a valid NPI.

Therefore, if a Medicare adjustment for claims submitted with no NPI affects Medicaid adjudication, N.C. Medicaid providers will need to submit a replacement claim or a manual adjustment request to EDS.

***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: Pharmacists

## National Provider Identifier Update for Pharmacy Providers

Effective May 23, 2008, the National Provider Identifier (NPI) number will be required on pharmacy claims for the billing provider. Pharmacy providers are encouraged to submit the NPI number as the prescriber ID on pharmacy claims but may continue to submit the NPI number or the DEA number as the prescriber ID until further notice.

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

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


## Attention: All Providers

## National 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 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

## New EOB Codes for Claim Denials Related to National Provider Identifiers and Taxonomy Codes

Effective May 23, 2008, all claims must contain a National Provider Identifier (NPI) and a taxonomy code (except pharmacy claims, which require only an NPI). Claims will deny if they are

- Billed without an NPI and/or taxonomy (unless atypical)
- Billed with MPN only (unless atypical)

The following EOB codes indicate claim denials related to NPIs and taxonomy codes:

- **EOB 3091**
  Billing NPI and/or Billing Taxonomy is missing. Attending NPI and/or Attending Taxonomy, when required, is missing.
- **EOB 3092**
  Billing NPI and/or Billing Taxonomy is missing.
- **EOB 3093**
  Attending NPI and/or Attending Taxonomy, when required, is missing.
- **EOB 3094**
  Referring NPI is missing.
- **EOB 3101**
  Taxonomy code for attending provider is missing.
- **EOB 3102**
  Taxonomy code for billing provider is missing.
- **EOB 3208**
  Void or adjustment cannot be processed. Billing NPI does not match NPI on file for original provider.
- **EOB 3209**
  Void or adjustment cannot be processed. Billing NPI does not match NPI filed on original claim.

The following EOB codes indicate pharmacy claim denials related to NPI:

- **EOB 3106**
  The NPI submitted for the prescribing provider cannot be the same as the pharmacy's NPI.
- **EOB 1801**
  Service Provider ID Qualifier is not 01.
- **EOB 1802**
  Service Provider ID is not numeric.

The following EOB codes have been modified to include NPI-related claim denials:

- **EOB 270**

  Billing provider is not the recipient's Carolina Access PCP. Authorization is missing or unresolved. Contact PCP for authorization or EDS Provider Services if authorization is correct.

- **EOB 3007** (for Hospice)

  Patient facility identification is missing, invalid, or unresolved. Verify patient facility ID and resubmit as a new claim or contact EDS Provider Services if ID is correct.

- **EOB 8326**

  Attending provider ID is missing or unresolved. Attending provider is required. Verify attending provider ID and resubmit as a new claim or contact EDS Provider Services if ID is correct.

- **EOB 2270**

  Service must be referred by Carolina Access PCP, LME, or Medicaid enrolled psychiatrist. Enter referral # on claim or contact EDS Provider Services if referral # is correct.

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

## Attention: All Providers

## Baby Love Program Provider Application Available on the Internet

Baby Love Program services include Maternity Care Coordination, Child Service Coordination, Maternal Outreach Worker Services, Childbirth Education, Home Visit for Newborn Care and Assessment, Home Visit for Postnatal Assessment and Follow-up Care, Skilled Nurse Home Visit, and Health and Behavior Intervention.

The Medicaid provider enrollment application for Baby Love Program services and the instructions for completion are now available on DMA's Provider Enrollment web page at http://www.ncdhhs.gov/dma/provenroll.htm. Choose Maternity Care Coordination/Child Service Coordination from the drop-down menu.

Baby Love Program provider qualifications can be found in the clinical policies listed on the following web page: http://www.ncdhhs.gov/dma/babylove.html.

**Provider Enrollment**
**DMA, 919-855-4050**

## Attention: All Providers

# Changes to N.C. Health Choice Benefit Cards

Beginning May 1, 2008, as N.C. Health Choice (NCHC) recipients re-enroll in Health Choice, they will see two changes in their benefit cards.

- First, NCHC recipients' cards will no longer include a termination date. (The effective date will remain on the card.)
- Second, a disclaimer related to eligibility will be included on the back of the recipients' cards as a reminder to providers to check eligibility. The added disclaimer is **"Eligibility should be verified prior to providing services."**

The purpose of these two changes is to encourage providers to verify eligibility prior to rendering services rather than relying on the coverage end date currently on the front of the card. NCHC eligibility can be verified through the online mechanism currently in place through Blue Cross Blue Shield of North Carolina.

**Cinnamon Narron**
**N.C. Health Choice, 919-284-0373**

## Attention: All Providers

# National Drug Codes Required on Professional Crossover 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 claims.

Effective with date of processing July 1, 2008, the N.C. Medicaid Program will require providers to list the 11-digit National Drug Codes (NDC) in addition to the HCPCS codes and units on professional claims that crossover from Medicare for all drugs administered by providers in offices, clinics or outpatient facilities. Claims will continue to be reimbursed in the same manner.

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.

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

## Attention: All Providers

# National Drug Codes Required 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 claims.

Effective with date of processing July 1, 2008, the N.C. Medicaid Program will require providers to list the 11-digit National Drug Code (NDC) in addition to the HCPCS codes and units on all outpatient institutional claims billed with Revenue Codes 25X, 634, 635, and 636 for all drugs administered by physicians.

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.

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.

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

## Attention: All Providers

# Mammography Updates

Clinical Coverage Policy #1K-1, *Breast Imaging Procedures*, was published on June 1, 2007. At that time, new claims payment system audits were introduced. Issues with the system audits that were incorrectly causing claims to deny have been identified and corrected. Providers who received claim denials for the following codes with the following EOBs may resubmit new claims (not adjustments) for processing effective with date of service June 1, 2007.

| EOB | Description | Codes Involved |
|---|---|---|
| 714 | Routine, annual or screening mammography non-covered. | 77055 and 77056 billed with ICD-9-CM diagnosis codes 793.80 and 793.82 through 793.89. |
| 773 | Exceeds limit per 365 days. | RC403 billed with 2 units. |
| 5223 | No payment for add-on code allowed if primary code in series is not paid for the same date of service, same provider. | G0204 and G0206 billed with 77051, and G0202 billed with 77052. |

Refer to DMA's website at http://www.ncdhhs.gov/dma/mp/mpindex.htm for a copy of Clinical Coverage Policy #1K-1.

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

## Attention: All Providers

# Community Care of North Carolina/Carolina ACCESS Override Policy

Community Care of North Carolina/Carolina ACCESS (CCNC/CA) override numbers are emergency authorization numbers issued by EDS for CCNC/CA-enrolled recipients that allow providers to receive reimbursement for medical services without authorization from the primary care provider (PCP). Override requests are considered only if extenuating circumstances beyond the control of the responsible parties affect access to medical care. The override request must come from the provider who rendered the service. Overrides will not be given to a Medicaid recipient.

The following steps must be followed before requesting an override:

- The PCP must be contacted for authorization of a service before requesting an override. Override requests for past dates of service are considered only when the request is mailed or faxed to EDS using the Override Request Form. The form can be accessed from the DMA website at http://www.ncdhhs.gov/dma/formsca.html.
- If the patient is present in the office and asking for services and the PCP has refused authorization, the provider may call EDS at 1-800-688-6696 to request an override.
- Override requests will not be considered if the date of service is more than six months from the date of the override request.
- The Override Request Form must be completed in its entirety or it will be returned to the provider requesting the override. The provider may resubmit the request when all information is provided.
- All requests for overrides must be made to EDS. Providers should not contact DMA to request an override.

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

## Attention: All Providers

# Independent Practitioner Program Seminars

Independent Practitioner Program seminars are scheduled to be held in several locations throughout the State during the month of July 2008. The seminars are intended to educate providers on the basics of Medicaid billing for Independent Practitioner Program services.

The seminar sites and dates will be announced in the June 2008 general Medicaid Bulletin on DMA's website at http://www.ncdhhs.gov/dma/bulletin.htm. Preregistration will be required and will be limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

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

## 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: 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:
4A, Dental Services

These policies supersede previously published policies and procedures. Providers may contact EDS at 1-800-688-6696 or 919-851-8888 with billing questions.

**Clinical Policy and Programs**
**DMA, 919-855-4260**

## Attention: All Providers

# Town Hall Meetings: Community Alternatives Program for Disabled Adults

The Community Alternatives Program for Disabled Adults (CAP/DA) is a federal Medicaid waiver program that provides home and community-based services as an alternative to nursing home placement for Medicaid clients 18 years of age and older. CAP/DA waiver services, which are offered in all 100 counties in the State, include case management, adult day health, in-home aides, home-delivered meals, waiver supplies, in-home and institutional respite care, and home mobility aids.

This month, DMA is hosting five town hall meetings across the State to

- Inform providers and consumers about the CAP/DA waiver
- Evaluate the current CAP/DA policy and services and consider changes to improve the program
- Facilitate local conversation and collaboration among CAP/DA agencies and providers

Anyone is welcome to attend. We particularly encourage participation by CAP/DA lead agencies, CAP/DA consumers and caregivers, Medicaid providers, public officials, consumer advocates, and long-term care providers.

**Preregistration for the meetings is not required.** Sign-in for the meetings will begin at 9:00 a.m., and the meetings will run from 9:30 a.m. until 12:30 p.m. **Because meeting room temperatures vary, please dress in layers to ensure your personal comfort.** For more information, contact Michelle C. Wilder, DMA CAP/DA Consultant (919-855-4371 or michelle.wilder@ncmail.net).

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|---|---|
| **Statesville**<br>**Tuesday, May 6**<br>Iredell County Department of Social Services<br>549 Eastside Drive<br>Statesville, NC 28625<br>704-873-5631 | **Asheville**<br>**Wednesday, May 7**<br>Mountain Area Health and Education Center<br>501 Biltmore Avenue<br>Asheville, NC 28801<br>828-257-4400 |
| **Wilmington**<br>**Friday, May 9**<br>Department of Aging<br>2222 S. College Road<br>Wilmington, NC 28403<br>910-798-6400 | **Winterville**<br>**Thursday, May 15**<br>Pitt Community College<br>Fulford Building, Room 153<br>1986 Pitt Tech Road<br>Winterville, NC 28590<br>252-493-7200 |
| **Raleigh**<br>**Friday, May 16**<br>Wake County Commons Building, Room B and C<br>4011 Carya Drive<br>Raleigh, NC 27610<br>919-250-1000 | |

## Directions to the Town Hall Meetings

### ASHEVILLE

***Mountain Area Health and Education Center***

Traveling East on I-40

Take I-40 East to exit 50. Turn onto Hendersonville Road. Stay in the right-hand lane through five traffic lights. At the 6th traffic light, turn left into the Mission Hospitals emergency entrance. Take the first right and then another immediate right into the parking deck.

Traveling West on I-40

Take I-40 West to exit 50B onto Hendersonville Road. Stay in the right-hand lane through five traffic lights. At the 6th traffic light, turn left into the Mission Hospitals emergency entrance. Take the first right and then another immediate right into the parking deck.

Traveling East on I-26

Take I-26 to 240 East to exit 5B for Charlotte Street. Exit right onto Charlotte Street. At the 4th traffic light, turn left onto Biltmore Avenue. Proceed through three traffic lights. At the 4th light, turn right into the Mission Hospitals emergency entrance. Take the first right and then another immediate right into the parking deck.

### RALEIGH

***Wake County Commons Building***

Traveling on I-40

Take I-40 to the I-440 Outer Beltline. Take exit 15 onto Poole Road. Turn right and travel approximately 0.5 miles. Turn left into the Wake County Office Park. Follow the winding road to the bottom of the hill – there are small directional signs along the way. The Commons Building is next to the last building in the park with a tall flagpole in front. Parking is available across the street or on the left of the facility.

Traveling West on Hwy 64

Take Hwy 64 West to the I-440 Inner Beltline. Take exit 15 onto Poole Road. Turn left and travel approximately 0.5 miles. Turn left into the Wake County Office Park. Follow the winding road to the bottom of the hill – there are small directional signs along the way. The Commons Building is next to the last building in the park with a tall flagpole in front. Parking is available across the street or on the left of the facility.

### STATESVILLE

***Iredell County Department of Social Services***

Traveling South on I-77

Take 1-77 South to exit 50. Turn left onto E. Broad Street. Travel approximately 0.3 miles. Turn right onto Eastside Drive. Travel approximately 0.6 miles. The Iredell County Department of Social Services in located on the left.

Traveling North on I-77

Take I-77 North to exit 50. Turn right onto E. Broad Street. Travel approximately 0.3 miles. Turn right onto Eastside Drive. Travel approximately 0.6 miles. The Iredell County Department of Social Services in located on the left.

Traveling on I-40

Take 1-40 to exit 152A for I-77 South. Take 1-77 South to exit 50. Turn left onto E. Broad Street. Travel approximately 0.3 miles. Turn right onto Eastside Drive. Travel approximately 0.6 miles. The Iredell County Department of Social Services in located on the left.

**WILMINGTON**
***Department of Aging***
Take I-40 East to Wilmington. I-40 becomes US 117 South (N. College Road). Travel approximately 5.3 miles. The Department of Aging is located on the right.

**WINTERVILLE**
***Fulford Building, Room 153***
***Pitt Community College***
Traveling West on Hwy 264
Take Hwy 264 West to Greenville. When you reach Greenville, exit to Hwy 11 South. Follow Hwy 11 South for approximately 5.0 miles. Pitt Community College is located on the right.

Traveling East on Hwy 264
Take Hwy 264 East (Stantonsburg Rd.) straight toward downtown Greenville. (DO NOT take exit 73B to Washington.) When you arrive in Greenville, turn right onto Arlington Boulevard. Follow Arlington Boulevard until you reach the stoplight at the intersection of Arlington Boulevard and Memorial Drive. Turn right onto Memorial Drive/Hwy 11 South. Travel approximately 3.0 miles. Pitt Community College is located on the right.

**Michelle Wilder, CAP/DA Program**
**DMA, 919-855-4371**

## Attention: All Providers

## Updated EOB Code Crosswalk to HIPAA 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 DMA's website at http://www.ncdhhs.gov/dma/hipaa.htm.

With the implementation of standards for electronic transactions mandated by the 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 crosswalk is current as of the date of publication. Providers will be notified of changes to the crosswalk through future general Medicaid Bulletins.

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

## Attention: CAP/MR-DD Service Providers and Residential Treatment Facility Providers

# Change to Cost Reporting Requirements

In an effort to consolidate and decrease the number of cost reports required of a single provider, DMA now includes the cost reporting requirements for Residential Treatment Facility providers and CAP/MR-DD service providers within the 2007 Mental Health Cost Report administered by the Department of Health and Human Services (DHHS) Office of the Controller. A **separate cost report** in addition to the 2007 Mental Health Cost Report is **no longer required**.

Any CAP/MR-DD provider who rendered **only** CAP/MR-DD waiver services since filing the 2007 CAP/MR-DD Cost Report (due September 2007) and has a fiscal year end between July 1, 2007 and January 1, 2008 must file **either** the **2007 CAP/MR-DD Closeout Cost Report**, administered by DMA, **or** the **2007 Mental Health Cost Report**, administered by the DHHS Office of the Controller. Both the **2007 CAP/MR-DD Closeout Cost Report** and the **2007 Mental Health Cost Report** should be submitted to the DHHS Office of the Controller.

**Example**: A CAP/MR-DD provider renders only CAP/MR-DD services and has a December 31, 2007 fiscal year end. The provider must file an annual cost report but has the choice of filing **either** the 2007 CAP/MR-DD Closeout Cost Report **or** the 2007 Mental Health Cost Report using their cost data for the period January 1, 2007 through December 31, 2007.

Beginning with cost reporting periods ending on or after January 1, 2008 all Residential Treatment Facility providers and CAP/MR-DD service providers are required to file the **2008 Mental Health Cost Report**. Effective January 1, 2008, the CAP/MR-DD Cost Report and the Residential Treatment Cost Report were discontinued.

Providers **will no longer be granted exemptions** based on the amount of Medicaid revenue received and number of months in business. If a provider has received an exemption for a current cost report period, the exemption will be allowed for that cost report period only. The Residential Treatment Cost Reports scheduled to be received at DMA by May 31, 2008 are still required as previously published.

Training sessions have been scheduled to familiarize providers with the instructions and data requirements needed to complete the Mental Health Cost Report. Refer to the CAP/MR-DD and Residential Providers Mental Health Cost Report Training Memo for information on the training sessions, including dates, times, locations, and registration information. The memo is available on the DHHS Office of the Controller's website at http://www.ncdhhs.gov/control/amh/amhauth.htm.

**Contact Information**
For all questions related to the Mental Health Cost Report, contact Susan Kesler at Susan.Kesler@ncmail.net or 919-855-3680.

For all questions related to the 2007 CAP/MR-DD Closeout Cost Report, contact Mishawn Davis at Mishawn.Davis@ncmail.net or 919-855-4200.

**Rate Setting**
**DMA, 919-855-4200**

## Attention: Community Care of North Carolina/Carolina ACCESS Primary Care Providers

# Community Care of North Carolina/Carolina ACCESS Management Reports

In order to assist providers enrolled in Community Care of North Carolina/Carolina ACCESS (CCNC/CA) with managing and coordinating care for their Carolina ACCESS patients, DMA provides four management reports. Primary care providers are strongly encouraged to review these reports each month.

| Report Name | Purpose |
|---|---|
| Monthly Carolina ACCESS Enrollment Report | Provides names and information about the recipients who are newly enrolled, currently enrolled, and no longer enrolled, effective the month the report is received. |
| Monthly Emergency Room Management Report | Provides names, diagnoses, and the cost of care for recipients who went to the emergency room for services. The reason for the visit is divided into emergency diagnoses and non-emergency diagnoses as defined by DMA. The data is based on claims processed during the previous month. |
| Monthly Referral Report | Provides the names of recipients who have seen another medical provider during the previous month. Providers can use this report to see where their patients obtained care and if they authorized the care. This also lets the provider know when an override is approved for services by another provider. |
| Quarterly Utilization Report | Shows providers the utilization and cost of recipients linked to their practice. Information is categorized by PCP office visits, ER/urgent care, pharmacy, hospital inpatient, inpatient and outpatient mental health, specialist referrals, labs, x-rays, and outpatient ambulatory. Information is based on date of payment. Provides comparison with PCP peer group. |

These reports are mailed to each CCNC/CA practice. Providers can also view and download the reports from a confidential website; however, the **Provider Confidential and Security Agreement** with an original signature must be on file with DMA in order for providers to access the website. Providers may complete and submit the security agreement to DMA. When the security agreement is received, EDS will assign a log-on and password to the practice. For more information about the Provider Confidential and Security Agreement required for accessing these management reports online, go to the DMA website at http://www.ncdhhs/dma/caenroll.htm.

**Betty West, Managed Care**
**DMA, 919-647-8000**

## Attention: Dental Providers and Health Department Dental Centers

## New Covered Service D0145 for Recipients Under the Age of 3

Effective with date of service January 1, 2008, the following dental procedure code has been added for the N.C. Medicaid Dental Program. This addition is a result of a recent policy change.

| CDT 2007/2008 Code | Description | Reimbursement Rate |
|---|---|---|
| D0145 | **Oral evaluation for a patient under three years of age and counseling with primary caregiver**<br>* evaluation includes recording the oral and physical health history, evaluation of caries susceptibility, development of an appropriate preventive oral health regimen, and communication with and counseling of the child's parent, legal guardian and/or primary caregiver<br>* the first oral evaluation for a patient under three years of age must be at least six (6) calendar months after the comprehensive oral evaluation (D0150) or at least six (6) calendar months after a periodic oral evaluation (D0120) for the same provider<br>* allowed once per six (6) calendar month period for the same provider (for example, a patient under three years of age seen for an oral evaluation on any date in January would be eligible for the next such oral evaluation on any date in July.)<br>* allowed on recipients under age 3<br>* service must be provided in conjunction with topical fluoride varnish (D1206) | $38.07 |

In an effort to promote the establishment of a "dental home" for Medicaid recipients under the age of 3, DMA has adopted CDT procedure code D0145 at an enhanced reimbursement in comparison to the rate paid for D0120 (periodic oral evaluation). Providers will now have the flexibility to choose from three different non-emergent care diagnostic procedure codes for recipients under the age of 3: D0150, D0120, and D0145. Procedure code D0150 (comprehensive oral evaluation) continues to be the most appropriate service to render at the initial visit for all patients under the age of 3. For subsequent periodic visits, providers may choose from either D0120 or D0145.

It is important to remember that D0145 must be provided on the same date of service and billed in conjunction with D1206 (topical fluoride varnish; therapeutic application for moderate to high caries risk patients) to receive payment for any claim including D0145. In addition, other dental services (except D0120, D0140, D0150, D0160, D0170, and D1203) may be provided on the same date of service as the D0145 and D1206 diagnostic/preventive oral health service package. Evidence-based research has demonstrated that topical fluoride varnish is the safest and most effective means of preventing caries in preschool children at risk for early childhood caries. If providers do not wish to apply topical fluoride varnish (D1206) to a patient under 3 years of age at a periodic visit, they may still use procedure code D0120 to report and receive reimbursement for the periodic oral evaluation rendered on that date of service.

**Sample**

**Periodicity Schedule for Diagnostic and Preventive Services for Preschool Recipients**

| Age (months) | Procedures Performed |
|---|---|
| 6 | D0150, D1206 |
| 12 | D0145, D1206 |
| 18 | D0145, D1206 |
| 24 | D0145, D1206 |
| 30 | D0145, D1206 |
| Before 36 | D0145, D1206 |
| 42 or older | D0120, D1206 |

Providers are reminded to bill their usual and customary charges rather than the Medicaid rate. For complete coverage criteria and additional billing guidelines, please refer to Clinical Coverage Policy 4A, *Dental Services*, on the DMA website at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

**Dental Program**
**DMA, 919-855-4280**

## Attention: Dental Providers and Health Department Dental Centers

## Orthodontic Records Must Be of Acceptable Diagnostic Quality

When providers submit orthodontic records for prior approval review by the EDS orthodontic consultants, all models must be of acceptable diagnostic quality and properly trimmed. In addition, all radiographs (panoramic and cephalometric films) must be of acceptable diagnostic quality.

Records found to be below clinically acceptable standards will be returned to the provider. Claims for records with non-diagnostic films and unacceptable models will not be paid until diagnostic radiographs and models are resubmitted to EDS.

**Dental Program**
**DMA, 919-855-4280**

## Attention: Health Departments

# Oral Contraceptives Provided in Local Health Departments (HCPCS Procedure Code S4993)

Effective with date of service January 1, 2008, DMA reimburses local health departments for oral contraceptives (birth control pills) when billed through the Physician's Drug Program. HCPCS procedure code S4993 (contraceptive pills for birth control) with the FP modifier appended to the code (S4993 FP) must be used when requesting reimbursement. One of the following ICD-9-CM diagnosis codes must also appear on the claim: V25.01 (prescription of oral contraceptives) or V25.41 (contraceptive pill). The reimbursement rate is $3.35 per pack.

The N.C. Medicaid Program covers one pack of oral contraceptives per 28 days for a maximum of 14 packs per 365 days for female recipients ages 11 through 55 for every program category except the Family Planning Waiver (MAF-D). Providers must follow the guidelines established in the May 2006 Special Bulletin, *Family Planning Waiver* (available online at http://www.ncdhhs.gov/dma/bulletinspecial.htm) when dispensing birth control to Family Planning Waiver recipients.

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

## Attention: Institutional (UB-04) Claim Billers

# Billing Instructions for Form Locators 14 and 15

Effective with date of processing July 1, 2008, providers submitting inpatient or outpatient institutional claims will be required to complete FL14, Priority of Visit, and FL15, Point of Origin for Admission or Visit, according to the instructions documented in the *UB-04 Data Specifications Manual*.

If code 4, Newborn, is used, providers must also enter one of the codes listed in the *UB-04 Manual* from the Code Structure for Newborn in FL15. This requirement applies to all claim formats (paper, 837I, and NCECSWeb claims).

Inpatient and outpatient claims will be denied with EOB 1808 or EOB 319 if these fields are not completed according to the instructions in the *UB-04 Manual*. Refer to the *UB-04 Manual* for guidelines on coding FL14 and FL15 and resubmit the claim for processing.

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

## Attention: Orthotic and Prosthetic Providers

# Orthotic and Prosthetic Fee Schedule Update and Prior Approval Changes

Effective with date of service May 1, 2008, the Orthotic and Prosthetic Fee Schedule was updated to reflect the annual increase to the maximum allowable rates. In addition to the annual rate update, the rates for the codes listed in the following table were changed from manual pricing to an established Medicare rate. The requirement for prior approval was also end-dated effective with date of service April 30, 2008 for the HCPCS codes in the following table that are listed without an asterisk after the code.

| Code | Description |
|---|---|
| **L3806** | WHFO, includes one or more non-torsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, custom fabricated, includes fitting and adjustment |
| **L3808** | WHFO, rigid without joints, may include soft interface material; straps, custom fabricated, includes fitting and adjustment |
| **L3915** | WH orthosis, includes one or more non-torsion joint(s),elastic bands, turnbuckles, may include soft interface, straps, prefabricated, includes fitting and adjustment |
| **L3925** | Finger orthosis, proximal interphalangeal (PIP)/distal interphalangeal (DIP), non-torsion joint/spring, extension/flexion, may include soft interface material, prefabricated, includes fitting and adjustment. |
| **L3929** | Hand finger orthosis, includes one or more non-torsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, prefabricated, includes fitting and adjustment. |
| **L3931** | Wrist hand finger orthosis, includes one or more non-torsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, prefabricated, includes fitting and adjustment. |
| **L6624*** | UE addition, flexion/extension and rotation wrist unit |
| **L6639*** | UE addition, heavy-duty feature, any elbow |

**Note:** An asterisk (*) after the code indicates that prior approval is required. **Bold type** indicates that the item is covered by Medicare.

Please refer to the online fee schedule located at http://www.ncdhhs.gov/dma/fee/fee.htm. Providers are reminded to bill their usual and customary charges rather than the Medicaid rate.

A Certificate of Medical Necessity and Prior Approval (CMN/PA) must be completed for all items, regardless of the requirement for prior approval. The coverage criteria for these items have not changed. Refer to the Clinical Coverage Policy 5B, *Orthotics and Prosthetics* on the DMA website at http://www.ncdhhs.gov/dma/mp/mpindex.htm for detailed coverage information.

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

## Attention: Durable Medical Equipment Providers

# Change in Requests for Prior Approval of Oral Nutrition Products

Effective with date of request July 1, 2008, Children's Special Health Services will no longer review requests on behalf of DMA for prior approval of oral nutrition products, including formulas and supplies for oral feedings, for recipients ages birth through 20 years of age. Requests for these products will be considered by DMA on a case-by-case basis. Providers must submit requests for these products using the Non-Covered Services Request Form. The form and instructions for completing and submitting the form are available on DMA's website at http://www.ncdhhs.gov/dma/formsprov.htm.

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

## Attention: CAP/DA Service Providers and Personal Care Service Providers

# Personal Care Services 2007 Cost Report Trainings

Personal Care Services Cost Report training for the 2007 cost reports are scheduled for June 2008. The sessions are intended to provide instructions on the completion of the cost report, which is due by July 25, 2008. The registration form, the 2007 PCS Cost Report schedule, an instruction manual, and other related materials for the training will be available on DMA's website (http://www.ncdhhs.gov/dma/costreport.htm) by May 14, 2008.

Because the training site can accommodate only 60 to 70 participants per session, preregistration is required. Registration forms will be processed on a first-come, first-served basis. Registration forms must be received and confirmed at least five business days prior to the date of the training class you select. The registration form may be submitted by e-mail or by mail to the address listed on the form. A confirmation of your registration will be sent to you via e-mail.

All of the training sessions will be held at the following location:

**N.C. Department of Transportation Training Center**
**313 Chapanoke Road**
**Garner, NC 27603**

The dates and times are listed below. Participants may register for either the morning session or the afternoon session. Please choose the training date and time that is most convenient for you.

| Training Dates | Session Time | Session Time |
|---|---|---|
| Tuesday, June 10, 2008 | 9:00 a.m. to 12:00 noon | 1:30 p.m. to 4:30 p.m. |
| Thursday, June 19, 2008 | 9:00 a.m. to 12:00 noon | 1:30 p.m. to 4:30 p.m. |
| Friday, June 20, 2008 | 9:00 a.m. to 12:00 noon | 1:30 p.m. to 4:30 p.m. |

**Rate Setting**
**DMA, 919-855-4200**

## Attention: Durable Medical Equipment Providers

## Change in Requests for Prior Approval of Augmentative and Alternative Communication Devices

Effective with date of request July 1, 2008, Children's Special Health Services will no longer review requests on behalf of DMA for prior approval of augmentative and alternative communication devices for recipients ages birth through 20 years of age. Requests for these devices will be considered by DMA on a case-by-case basis. Providers must submit requests for these devices using the Non-Covered Services Request Form. The form and instructions for completing and submitting the form are available on DMA's website at http://www.ncdhhs.gov/dma/formsprov.htm.

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

## Attention: Personal Care Services and Personal Care Services–Plus Providers

## Personal Care Services Provider Training Sessions

The Carolinas Center for Medical Excellence (CCME; http://www2.thecarolinascenter.org/ccme/) announces continuing provider training for Personal Care Services (PCS) as approved by DMA.

The 2nd calendar quarter training sessions (PCS Provider Training Session VIII) of 2008 are scheduled for June 2008. The training is recommended for registered nurses, agency administrators, and agency owners who have a working knowledge of the PCS program and applicable DMA policies. This training allows CCME to offer 4.25 Continuing Nursing Education (CNE) contact hours to all nurses at no cost to the participants.

Preregistration is required and space is limited to 150 participants at each session. Registration will be provided online or by fax. **To register online,** visit CCME's website and click on the appropriate link in Upcoming Events. When you have completed the online registration, you will receive a computer-generated number to confirm your registration. Bring the number with you to the session.

**To register by fax,** complete the form on page 22 and fax it to the attention of Alisha Brister at 919-380-9457. A member of the PCS team will contact you with a registration number, which you should bring with you to the session.

If you need to **cancel** at any time, please contact Alisha Brister 919-380-9860 (x2018) to allow others to register. Please e-mail Alisha Brister at CCME (abrister@thecarolinascenter.org) for further information on registering.

Sign-in will start at 8:00 a.m. at each location. The presentations will begin at 9:00 a.m. and run through 1:30 p.m., with one or two 15-minute breaks. Please plan ahead for the late lunch hour, as coffee, hot tea, and water will be the only refreshments provided. **Considering the variability in meeting room temperature, please dress in layers to ensure your personal comfort.**

| | |
|---|---|
| **Greenville**<br>**Monday, June 2**<br>Hilton Greenville<br>207 SW Greenville Boulevard<br>Greenville, NC 27834<br>252-355-5099 | **Fayetteville**<br>**Tuesday, June 3**<br>Holiday Inn<br>1944 Cedar Creek Road at I-95 and NC 53<br>Fayetteville, NC 28302<br>910-323-1600 |
| **Cary**<br>**Wednesday, June 4**<br>Embassy Suites<br>201 Harrison Oaks Boulevard<br>Cary, NC 27513<br>919-677-1840 | **Winston-Salem**<br>**Thursday, June 12**<br>Hawthorne Inn<br>420 High Street<br>Winston-Salem, NC 27101<br>336-777-3000 |
| **Hickory**<br>**Friday, June 13**<br>Park Inn Gateway Conference Center<br>909 US 70 SW<br>Hickory, NC 28602<br>828-328-5101 or toll-free 888-201-1801 | |

## Directions to the Personal Care Services Provider Training Sessions

### CARY

***Embassy Suites***

Traveling East on I-40

Take I-40 East into Raleigh to exit 287 for Harrison Avenue. At the end of the exit ramp, turn right onto Harrison Avenue. Stay in the right-hand lane. Turn right after the traffic light onto Harrison Oaks Boulevard. The hotel is located on the right approximately 3/10 of a mile from the turn.

Traveling West on I-40

Take I-40 West (toward Raleigh-Durham International Airport) to exit 287 for Harrison Avenue. At the end of the exit ramp, turn left onto Harrison Avenue. Stay in the right-hand lane. Turn right after the traffic light onto Harrison Oaks Boulevard. The hotel is located on the right approximately 3/10 of a mile from the turn.
http://www.embassyraleighdurham.com/home.aspx

### FAYETTEVILLE

***Holiday Inn***

Take I-95 to exit 49. The hotel is visible from the exit ramp.
http://www.ichotelsgroup.com/h/d/hi/1/en/hotel/fayso/transportation?rpb=hotel&crUrl=/h/d/hi/1/en/mapsearchresults

## 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.

http://www1.hilton.com/en_US/hi/hotel/PGVNCHF-Hilton-Greenville-North-Carolina/index.do

## 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.

http://www.parkinn.com/hickorync

## WINSTON-SALEM

***Hawthorne Inn***

Traveling East on I-40

Take I-40 East to I-40 Business into downtown Winston-Salem. Take exit 5C for Cherry Street and turn onto High Street. The front entrance of the hotel is immediately on your right.

Traveling West on I-40

Take I-40 West to the I-40 Business split (Exit 206) into downtown Winston-Salem. Take exit 5C for Cherry Street. Turn left onto First Street at the first traffic light. Turn left at the next traffic light onto Marshall Street. Cross over I-40 Business and travel through the next traffic light. The hotel's rear parking entrance is located on the right as you head downhill. Turn into the parking lot and drive around the building to the hotel's front entrance.

Traveling North/South on I-85

Travel on I-85. Exit onto Highway 52 North. Take the exit for I-40 Business West (exit 109B). Take exit 5C for Cherry Street. Turn left onto First Street at the first traffic light. Turn left at the next traffic light onto Marshall Street. Cross over I-40 Business and travel through the next traffic light. The hotel's rear parking entrance is located on the right as you head downhill. Turn into the parking lot and drive around the building to the hotel's front entrance.

http://www.hawthorneinn.com/

**CCME, 919-380-9860**

The Carolinas Center *for* Medical Excellence

**CCME PCS Provider training session 8**
**June 2008**
**Registration form**

Location requested: _____ Location Date: _____

First Name: _____

Last Name: _____

Credentials: _____

Position: _____

Organization: _____

Facility: _____

Address: _____

City: _____, NC Zip: _____

County: _____

UPIN/Provider #: _____

Phone #: _____ Ext: _____

Fax #: _____

Email: _____

Referred by/How did you hear about this event?

_____

_____

May we send you e-mail updates on new information, features, and tools on the CCME web site?

please check: ☐ Yes ☐ No

**Please fax completed form to the attention of**
**Alisha Brister at 919-380-9457**

## Attention: Pharmacists and Prescribers

# New Pharmacy Prior Authorization Program for Second Generation Antihistamines – Update to Implementation

The planned implementation date of the second generation antihistamines prior authorization program has been delayed to May 5, 2008.

On May 5, 2008, the N.C. Medicaid Outpatient Pharmacy Program will implement a new prior authorization program for second generation antihistamines. Medications that will require prior authorization 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 prior authorization. Pharmacists will receive 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 that the PA criteria have been met by writing one of the following phrases on the face of the prescription in his or her own handwriting, 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 Program Integrity.

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 are available on the N.C. Medicaid Enhanced Pharmacy Program website at http://www.ncmedicaidpbm.com. If the PA is approved by ACS, the POS override codes will not be needed.

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

## Attention: Pharmacists

# Calling the Prescriber on a Non-Compliant Prescription

In the event that a pharmacist is presented with a prescription that does not meet the tamper-resistant prescription pad requirements and elects to call the prescriber to verify the prescription by telephone, the pharmacist must document the following information on the prescription:

1. initials of pharmacy staff verifying the prescription
2. date the prescription was verified
3. first and last name of the individual (representing the prescriber) who verified the prescription

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

## Attention: Physicians

# Use of *Locum Tenens* When Called to Active Duty in the Armed Forces

The Centers for Medicare and Medicaid Services (CMS) has announced an exception to the 60-day limit on *locum tenens* billing for physician members of a reserve component of the Armed Forces who are called to active duty. CMS implemented this exception in accordance with section 116 of the Medicare, Medicaid, and SCHIP Extension Act of 2007, enacted on December 29, 2007.

DMA has adopted this exception for dates of service January 1, 2008 through June 30, 2008. Physicians may bill for services provided in their offices by a *locum tenens* physician using modifier Q6 appended to the procedure code.

*Locum tenens* services meeting the following requirements are identified by appending modifier Q6 to the procedure code:

- The *locum tenens* physician is not an employee of the regular physician.
- The regular physician is unavailable to provide the visit services.
- The recipient has arranged or seeks to receive the visit services from the regular physician.
- The regular physician pays the *locum tenens* for his/her services on a per diem basis or a similar fee-for-time basis.
- The medical record for each recipient clearly identifies the actual provider of the services.

If an extension of this exception is approved, providers will be notified through a future general Medicaid Bulletin article.

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

## Attention: Nurse Practitioners and Physicians

# Natalizumab (Tysabri, HCPCS Procedure Code J2323) – Update to Billing Guidelines

Effective with date of service February 14, 2008, the N.C. Medicaid program added the FDA-approved diagnosis of Crohn's disease to the required list of diagnoses for natalizumab (Tysabri) when billed through the Physician's Drug Program. Tysabri is also covered for a diagnosis of multiple sclerosis.

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

| ICD-9-CM Diagnosis Code | Description |
|---|---|
| 340 | multiple sclerosis |
| 555.0, 555.1, 555.2, or 555.9 | Crohn's disease |

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

## Attention: Private Duty Nursing Providers

# Private Duty Nursing Services

Medically necessary private duty nursing (PDN) services, as defined by the Code of Federal Regulations (42CFR440.80) the North Carolina Administrative Code (10A NCAC 220.0122) and the Medicaid State Plan may be provided when prescribed by a physician and prior approved by DMA. The care must be medically necessary and require a licensed nurse to provide substantial, complex, and continuous nursing care.

A Medicaid recipient with a medical condition that necessitates PDN services normally is unable to leave the home without being accompanied by a licensed nurse because leaving the home requires a considerable and taxing effort. The nurse may accompany the recipient outside of his or her residence during those approved hours when the recipient's normal life activities take the recipient out of the home. During activities that occur outside of the recipient's residence, the licensed nurse **may not** provide transportation. (Recipients may contact their local department of social services for medically related transportation options.)

The need for nursing care to participate in activities outside of the home is not a basis for authorizing PDN services. It is the responsibility of the provider to ensure there is a continuous need for nursing care, and to report significant changes in the recipient's condition that might indicate a need to discontinue services when the recipient's condition improves to a level that no longer supports the need for continuous nursing care. The agency is responsible for providing a factual "Medical Update" with each 60-day certification period that summarizes the performance and frequency of nursing assessments and interventions based on the required physician's orders. DMA may request nursing documentation or additional information to support the request for ongoing PDN services.

**Home Care Initiatives**
**DMA, 919-855-4390**

## Attention: Pharmacists

# Synagis Pharmacy Claims for 2007/2008 RSV Season

The last date of service that will be covered for Synagis pharmacy claims according to the 2007/2008 Synagis policy is March 31, 2008. Synagis claims processing for the 2007/2008 RSV season began on October 10, 2007. All Synagis requests must be completed on the criterion-specific forms found on DMA's website at http://www.ncdhhs.gov/dma/synagis.html.

No more than five monthly doses of Synagis can be obtained using these forms. Copies of the submitted N.C. Medicaid Synagis for RSV Prophylaxis forms should be mailed by pharmacy distributors to DMA. Please mail the forms to:

N.C. Division of Medical Assistance
Pharmacy Program
2501 Mail Service Center
Raleigh, NC 27699-2501

Pharmacy distributors with a large volume of Synagis claims should submit scanned copies of the N.C. Medicaid Synagis for RSV Prophylaxis forms on a diskette. All diskettes must be sent to DMA by May 31, 2008. Please call Charlene Sampson at 919-855-4306 if you need assistance with the coordination of this process or if you have any questions.

A Notice of Approval of Service Request letter was provided by DMA for Early Periodic Screening, Diagnostic and Treatment (EPSDT) requests for Synagis. These would include requests for a sixth dose in March or an April dose of Synagis. A copy of the Notice of Approval of Service Request letter should be maintained on file at the pharmacy.

The N.C. Medicaid program should not be billed for Synagis unless one of the following items is on file at the pharmacy:

- An accurate and complete Synagis for RSV Prophylaxis form
- A copy of an approval letter by DMA from the Request for Medical Review for Synagis Outside of Criteria form
- A Notice of Approval of Service Request letter from an EPSDT request for Synagis

Payment of Synagis claims will be reviewed and may be subject to recoupment by DMA Program Integrity if the appropriate forms or approval letters are not on file.

**Charlene Sampson, Pharmacy Program**
**DMA, 919-855-4306**

## 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 |
|---|---|---|
| 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 |
| June | 06/05/08 | 06/10/08 |
| | 06/12/08 | 06/17/08 |
| | 06/19/08 | 06/26/08 |

*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**

**Melissa Robinson**
**Executive Director**
**EDS**