# May 2009 Medicaid Bulletin

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


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

## *National Provider Identifier Guidelines for Community Care of North Carolina/Carolina ACCESS Providers*

Effective with date of processing May 1, 2009, the 7-digit Carolina ACCESS Medicaid provider referral number is no longer allowed on paper or electronic claims. To avoid denials, submit only the Carolina ACCESS National Provider Identifier (NPI) referral number in block 17b on the CMS-1500 claim form or on the left side of form locator 78 on the UB-04 claim form.

Tips on submitting claims for Carolina ACCESS recipients:

- A taxonomy code for the referring provider is never required.
- NPI is not used for Carolina ACCESS overrides. Providers must continue to submit the override number in block 17a on the CMS-1500 claim form or on the right side of form locator 78 on the UB-04 claim form. **Submit the appropriate qualifier when applicable: 1D on the CMS-1500 claim form and G2 on the UB-04 claim form.**

  **Note:** Qualifiers are required when billing paper claims. They are not required when using the NCECSWeb Tool. If you use a software vendor or clearinghouse, contact them to verify whether qualifiers are required.
- Block 17 (name) is not a required field on the CMS-1500 claim form.
- Refer to the recipient's Medicaid identification (MID) card or the Automated Voice Response (AVR) system to determine whether to obtain the group NPI or individual NPI for the Carolina ACCESS authorization. When calling the AVR system for primary care provider (PCP) information, select option 6 for eligibility, then option 2 for enrollment.
- After you obtain the Carolina ACCESS NPI from the PCP, verify that the NPI matches the provider name on the recipient's MID card and/or on the AVR system by using the NPI and Address database on DMA's website at http://www.ncdhhs.gov/dma/WebNPI/default.htm.

  **Note:** Coordination of care is a required component of CCNC/CA. PCPs are responsible for ensuring that they have provided their correct Carolina ACCESS NPI to the referring provider.

***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*

Even though providers cannot submit the Medicaid Provider Number (MPN) on claims after May 1, 2009 (unless the provider is atypical), claims will continue to be adjudicated based on the provider's MPN. The N.C. Medicaid Program has designed a mapping solution that crosswalks a provider's National Provider Identifier (NPI) to his or her MPN. Claims submitted by providers who have enumerated "one to many" (one NPI on file for multiple MPNs) or by providers who have enumerated incorrectly may be denied if the system cannot map the NPI to the correct MPN. These denied claims will be listed on the Unresolved Report, not the provider's Remittance and Status Report. The unresolved report is sent to providers who file their claims electronically and is sent to the address that is listed on the claim. The report includes instructions for required actions. Providers who file on paper will receive a letter stating that one or more claims were unresolved for the checkwrite date listed in the letter.

If a provider is enrolled with N.C. Medicaid in more than one provider type and specialty and has reported the same NPI for each type and specialty, the taxonomy code will be very important for NPI mapping. Refer to DMA's website at http://www.ncdhhs.gov/dma/NPI/taxonomy.htm for information on recommended taxonomy codes.

If a provider has enrolled more than one site and has reported the same NPI for each site, the site address ZIP code as well as the billing address ZIP code, are also very important for NPI mapping. Providers must ensure that information on file with DMA is correct. Refer to the NPI and Address database on DMA's website at http://www.ncdhhs.gov/dma/WebNPI/default.htm to verify that information on file with DMA is correct.

As of May 1, 2009, DMA will no longer 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. "Ready" will no longer be displayed under the provider number.

***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*

## *Medical Genetic Counseling*

Effective with date of processing April 1, 2009, DMA covers CPT procedure code 96040 (medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family) retroactive to date of service October 1, 2008, as outlined in Clinical Coverage Policy #1S-4, *Cytogenetic Studies* (http://www.ncdhhs.gov/dma/mp/. Providers who have received claim denials related to EOB 9 (service not covered by the Medicaid Program) for dates of service October 1, 2008, and after may resubmit the denied charges as new claims (not as adjustment requests) for processing.

**EDS, 1-800-688-6696 or 919-855-8888**

## *Attention: All Providers*

# *Clinical Coverage Policies*

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

- 1A-24, *Diabetes Outpatient Self-Management Education*
- 1G-2, *Bioengineered Skin*
- 1S-2, *HIV Tropism Assay*
- 2B-2, *Geropsychiatric Units in Nursing Facilities*
- 5B, *Orthotics & Prosthetics*
- 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*

# *Part D Drug Coverage Information*

Providers are reminded that with the inception of Medicare Part D on January 1, 2006, the N.C. Medicaid Program does not cover drugs that should be billed to Medicare Part D nor does it cover the costs associated with the administration of such drugs. Drugs covered by Part D that are not covered by Medicare Part B, such as Depo-Provera for contraception, should not be billed to Medicaid with a request to override Medicare. Providers should contact Medicare or the beneficiary's specific Part D plan for information about how to obtain and bill Part D drugs and how to bill the administration costs. If a Medicare beneficiary's Part D plan does not cover a particular drug, the beneficiary may appeal to the Part D plan.

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

## *Attention: All Providers*

# *CSC Assumes N.C. Medicaid Provider Enrollment, Credentialing, and Verification Activities*

DMA is pleased to announce that as of April 20, 2009, Medicaid provider enrollment, credentialing, and verification functions have been transferred from DMA Provider Services to CSC.

Please note that EDS continues to serve as the N.C. Medicaid Program's fiscal agent and to perform all other provider support functions. Providers will continue to call EDS for claim status, checkwrite information, billing problems, etc., just as they do today. CSC has assumed only the provider enrollment, credentialing, and verification activities previously carried out by DMA Provider Services.

Providers should now mail all Medicaid enrollment forms including applications, agreements, Medicaid Provider Change Forms, and Carolina ACCESS applications and agreements to CSC at the address listed in the chart below. Providers accessing the DMA website for enrollment information will be redirected to the CSC website to obtain provider enrollment forms.

CSC has activated a dedicated Medicaid Provider Enrollment, Verification, and Credentialing (EVC) Call Center for providers to inquire on the status of their Medicaid applications or change requests. The EVC Call Center hours of operation are 8:00 a.m. to 5:00 p.m., Monday through Friday, except for State approved holidays. The toll-free CSC telephone and fax numbers are listed in the chart below.

CSC will soon initiate a 12-month process to verify information for enrolled Medicaid providers. In accordance with CMS requirements for Medicaid participation (42 CFR.455.100 – 106), CSC will initiate credentialing activities for those enrolled providers who have not been credentialed in the last 18 months. CSC will notify providers by mail when verification and credentialing activities will begin for their provider types. The notification packet will be mailed to the provider's billing/accounting address and will include a report of information currently on file with N.C. Medicaid plus several forms that must be completed by the provider. (Providers may verify their billing/accounting address via the DMA Provider Services NPI and Address Database at http://www.ncdhhs.gov/dma/WebNPI/default.htm or by calling the EVC Call Center.) Within 30 days from receipt of the notification packet, providers must verify their provider file data, update the forms, and return all information to CSC for processing. CSC will follow-up with notifications by mail and telephone to those providers who do respond within 30 days. Failure to respond to the notifications may result in termination of Medicaid participation.

DMA and CSC will continue to inform providers of various events and changes through the general Medicaid bulletin, the DMA website, and the CSC website.

**EVC Call Center Contact Information**

| | |
|---|---|
| **Enrollment, Verification, and Credentialing Call Center Toll-Free Number** | 866-844-1113 |
| **EVC Call Center Fax Number** | 866-844-1382 |
| **EVC Call Center E-Mail Address** | NCMedicaid@csc.com |
| **CSC Mailing Address** | N.C. Medicaid Provider Enrollment<br>CSC<br>PO Box 300020<br>Raleigh NC 27622-8020 |
| **CSC Site Address** | N.C. Medicaid Provider Enrollment<br>CSC<br>2610 Wycliff Road, Suite 102<br>Raleigh NC 27607-3073 |
| **CSC Website Address** | http://www.nctracks.nc.gov |

Refer to DMA's website at http://www.ncdhhs.gov/dma/provider/mmis.htm for more information about CSC and the development and implementation of the Replacement Medicaid Management Information System (MMIS).

**Linda Pruitt, DMA**
**919-855-4106**

## *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/.

With the implementation of standards for electronic transactions mandated by 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: All Providers*

# *HIV Tropism Assay*

Effective with date of service January 1, 2009, DMA covers HIV tropism assay as outlined in Clinical Coverage Policy #1S-2. The policy is available on DMA's website at http://www.ncdhhs.gov/dma/mp/.

Providers should bill CPT code 87999 (unlisted microbiology procedure) along with diagnosis codes 042 (human immunodeficiency virus [HIV] disease) **and** V09.90 (infection with drug-resistant microorganisms, unspecified; without mention of multiple drug resistance) **or** V09.91 (infection with drug-resistant microorganisms, unspecified; with multiple drug resistance).

Providers who received claim detail denials for dates of service January 1, 2009, and after may resubmit the denied charges as new claims (not as adjustment requests) for processing.

**EDS, 1-800-688-6696 or 919-855-8888**

## *Attention: Orthotics and Prosthetics Providers*

# *Coverage for Prosthetic Devices*

Effective with date of service May 1, 2009, lifetime expectancies and quantity limitations have been reduced for 75 prosthetic codes. Refer to Attachment E in Clinical Coverage Policy 5B, *Orthotics and Prosthetics*, to view the new lifetime expectancies and quantity limitations for these 75 codes. The specific changes are documented in Section 8 of the policy, which is available on DMA's website at http://www.ncdhhs.gov/dma/mp/.

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

## *Attention: All Providers*

## *Denials for CPT Procedure Code 96372 with an FP Modifier*

CPT procedure code 96372 (therapeutic, prophylactic, or diagnostic injection; subcutaneous or intramuscular) was a new code effective with date of service January 1, 2009. The FP (family planning) modifier is allowed with this code. However, some claims have been denied with EOB 1609 (Claim includes family planning diagnosis and no family planning procedure. Please resubmit with family planning procedure/modifier or correct the diagnosis.).

If you received a denial with EOB 1609 when billing for 96372 with the FP modifier for dates of service January 1, 2009, and after please resubmit the denied charges as a new claim (not as an adjustment request) for processing.

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

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

## *Recipient Enrollment by Primary Care Providers*

Primary care providers are encouraged to start the enrollment process for their Medicaid patients who are eligible to be enrolled in Community Care of North Carolina/Carolina ACCESS (CCNC/CA). (Refer to the *Basic Medicaid Billing Guide* on DMA's website at http://www.ncdhhs.gov/dma/basicmed/ for information on recipients who are exempt from CCNC/CA.) Procedures are:

- Use the Carolina ACCESS Member Handbook to explain the benefits of being a member of CCNC/CA.
- Give the recipient a copy of the Carolina ACCESS Member Handbook. The handbook, which is available in both English and Spanish, can be obtained by
  - ♦ e-mail to Adrienne.Frederick@ncmail.net
  - ♦ online at http://www.ncdhhs.gov/dma/ca/
  - ♦ fax at 919-715-0844 or 919-715-5235
- Inform recipients that they have freedom to choose their primary care provider and that they can choose to change primary care providers at any time. If recipients request to change from your practice, refer them to a caseworker at their local county department of social services, which maintains a directory of providers serving that county.
- Provide information about any extended office hours, after-hours policy, the hospital where the doctor has admitting privileges and any other pertinent information regarding office protocols and services.

The office staff completing the enrollment form should send it to the local DSS in the county in which the patient resides. The enrollment form for providers and instructions for completing the form can be found on the DMA website at http://www.ncdhhs.gov/dma/ca/ccncproviderinfo.htm.

**Managed Care**
**DMA, 919-855-4780**

## *Attention: Hospice Service Providers*

## *Billing for Revenue Codes 651, 652, 655, and 656*

Effective January 1, 2009, hospice providers are required to include the Core Based Statistical Area (CBSA) code for the location where the hospice care was provided (e.g., patient's residence, nursing home, assisted living facility, hospital unit) in the Value Code Amount field on all claims submitted for reimbursement of revenue codes 651, 652, 655, or 656. A value code of 61 or G8, as applicable, must be entered in the Value Code field. The ZIP code for the location where the service was rendered **must** be entered in the Facility Location field (FL1 on the UB-04 claim form for paper submission). During claims processing, the CBSA code entered in the Value Code Amount field is compared to the ZIP code for the recipient's location (in the Facility Location field) for verification of the rate of reimbursement.

Providers submitting claims through the NCECSWeb Tool should contact the EDS Electronic Commerce Services (ECS) Unit for information on the field location for the Facility Location. If submitting claims through other electronic commerce services, contact the service vendor for the information. Claims submitted without entering the information in these fields will be denied. Contact EDS Provider Services at 1-800-688-6696 or 919-851-8888 if there are questions on this process.

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

## *Attention: CAP/C Case Managers*

## *Medically Necessary Oral Nutrition Products for Recipients under the Age of 21*

Effective June 30, 2009, oral nutrition products will no longer be available as a waiver service for children under the age of 21. Medically necessary oral nutrition products for recipients under the age of 21 are now covered as a Medicaid State Plan service. Coverage is through the Durable Medical Equipment Program (DME). Effective immediately, CAP/C case managers should revise CAP/C cost summaries to reflect this change and should begin following the process for obtaining the products according to the guidelines in Clinical Coverage Policy 5A, *Durable Medical Equipment* (http://www.ncdhhs.gov/dma/mp/).

Under the new DME policy, oral nutrition products require a prescription along with completion of two forms to establish medical necessity: the regular Certificate of Medical Necessity/Prior Approval form and a new Oral Nutrition Product Request form (http://www.ncdhhs.gov/dma/provider/forms.htm).

All recipients who are enrolled in or eligible for Women, Infants, and Children Special Supplemental Nutrition Program (WIC) assistance must continue to obtain their oral nutrition products from WIC.

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

## *Attention: Enhanced Behavioral Health Service Providers and Local Management Entities*

## *Revised Effective Date for ACTT Service Rate Change*

The effective date for the following rate decrease that was published in the October 2008 bulletin has been changed from January 1, 2009, to July 1, 2009.

| Service Code | Service Description | Service Unit | Current Rate | New Rate |
|---|---|---|---|---|
| H0040 | Assertive Community Treatment Team | per event, maximum 4 per month | $323.98 | $301.35 |

Fee schedules are available on DMA's website at http://www.ncdhhs.gov/dma/fee/. Providers must always bill their usual and customary charges.

**Rate Setting**
**DMA, 919-647-8170**

## *Attention: Institutional Claim (UB-04/837I) Billers*

## *Medicare Health Maintenance Organization – Institutional Services*

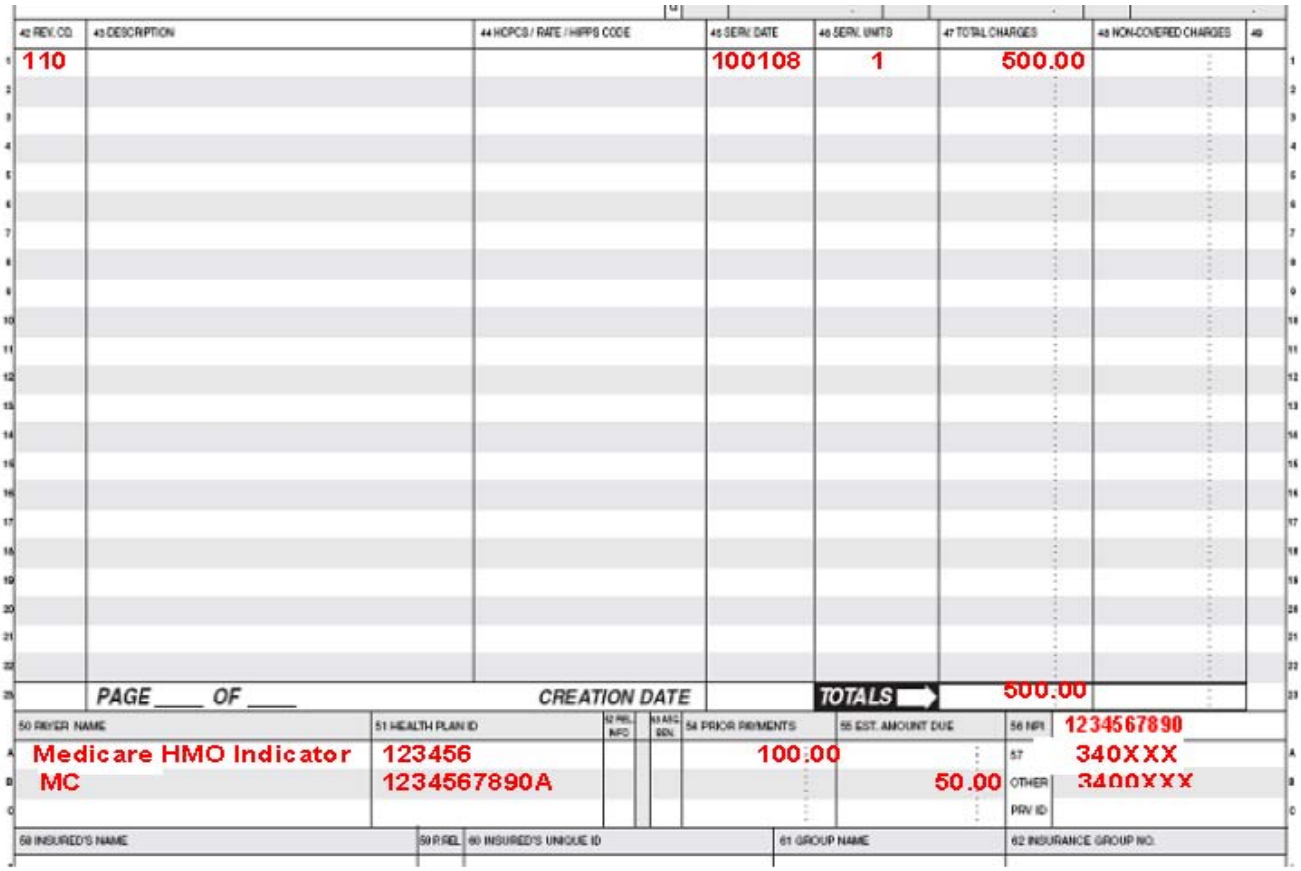
In order for Medicaid to consider payment for Medicare HMO, providers are requested to bill all institutional charges on the UB-04 claim form. The claims should not be altered for processing purposes. **The claim should be billed to Medicaid as it was billed to Medicare HMO. Medicaid liability is only for the Medicare HMO cost share, which includes copayment, coinsurance, and/or deductible.** The following information is required for claim processing:

- The claims must be submitted with a Medicare EOB attached to the claim. If the EOB is on multiple pages, please submit all of the pages of the EOB with the claim.
- All charges should be reflected on the UB-04 claim form. Do not combine or destroy the integrity of the claim by "rolling up" the charges into one revenue code.
- If the recipient has patient monthly liability or deductible, the information should be reflected on inpatient stays, if applicable.
- **Form locator 47 (Total Charges) and form locator 56 (Estimated Amount Due) should reflect the Medicare HMO cost share amount only.**
- Indicate in form locator 80 that "This is a Medicare HMO claim."
- The Medicaid Provider Number (MPN) will continue to be required when submitting a UB-04 Medicare HMO claim even after May 1, 2009, along with the NPI of the Billing Provider. Enter the MPN in form locator 57 on the UB-04 claim form.

Mail the UB-04 claim form and Medicare HMO EOB to:

DMA/Third Party Recovery
2508 Mail Service Center
Raleigh, NC 27699-2508

**Example of a UB-04 HMO Claim Form:**



| 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49 |
|---|---|---|---|---|---|---|---|
| 110 | | | 100108 | 1 | 500.00 | | |
| | PAGE ____ OF ____ | CREATION DATE | | TOTALS | 500.00 | | |

| 50 PAYER NAME | 51 HEALTH PLAN ID | 52 REL. INFO | 53 ASG. BEN. | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 NPI | 1234567890 |
|---|---|---|---|---|---|---|---|
| Medicare HMO Indicator | 123456 | | | 100.00 | | 57 | 340XXX |
| MC | 1234567890A | | | | 50.00 | OTHER PRV ID | 340XXX |

| 58 INSURED'S NAME | 59 P REL | 60 INSURED'S UNIQUE ID | 61 GROUP NAME | 62 INSURANCE GROUP NO. |
|---|---|---|---|---|

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

## *Attention: Independent Diagnostic Testing Facility Providers*

## *Billing for Independent Diagnostic Testing Facility Services*

Independent diagnostic testing facility (IDTF) providers enrolled in N.C. Medicaid are approved to bill only the following CPT codes:

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 76536 | 76645 | 76700 | 76705 | 76770 | 76775 | 76800 | 76801 | 76802 | 76805 | 76810 | 76811 |
| 76812 | 76813 | 76814 | 76815 | 76818 | 76825 | 76827 | 76830 | 76831 | 76856 | 76857 | 76870 |
| 76872 | 76880 | 76977 | 77051 | 77052 | 77055 | 77056 | 77057 | 93303 | 93304 | 93307 | 93308 |
| 93320 | 93321 | 93325 | 93350 | 93875 | 93880 | 93922 | 93923 | 93925 | 93930 | 93965 | 93970 |
| 93971 | 93975 | 93978 | 93990 | G0202 | G0204 | G0206 | | | | | |

IDTF providers must bill these codes with a modifier TC (technical component). The IDTF cannot bill the global procedure. In addition to modifier TC, providers may bill with modifiers 53, 59, 76, or 77 when appropriate.

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

## *Attention: Professional Claim (CMS-1500/837P) Billers*

## *Medicare Health Maintenance Organization – Professional Services*

In order for Medicaid to consider payment for Medicare HMO, providers are requested to bill only the **cost share**, which includes the copayment, coinsurance, and/or deductible amount shown on the Medicare EOB. **Medicaid liability is only for the Medicare HMO cost share.** If there is no qualifying cost share amount, then Medicaid is not liable for payment. HMO claims must be filed on paper.

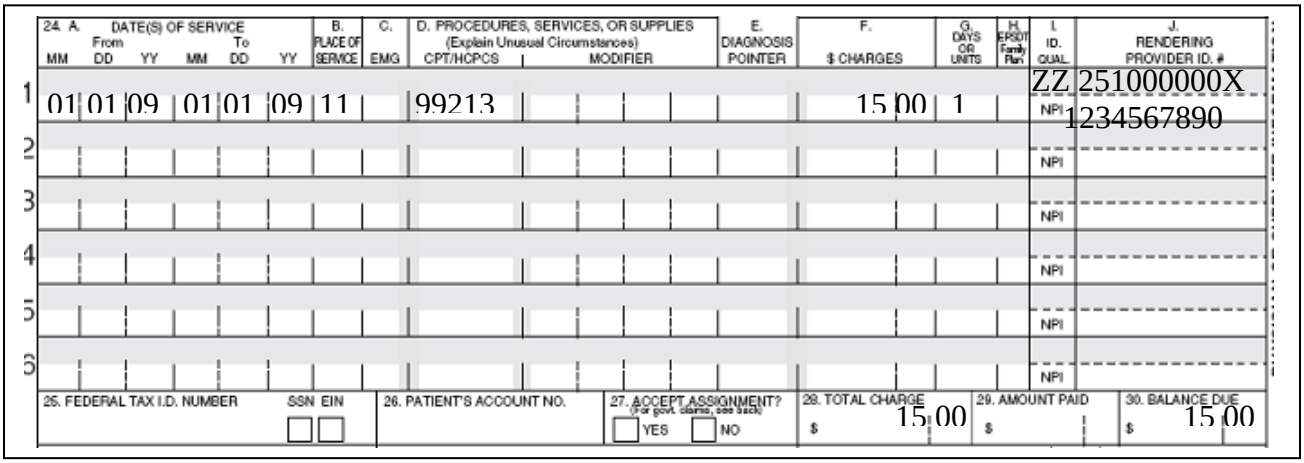
Providers filing on the CMS-1500 claim form must complete specific blocks following these instructions:

- Blocks 24F, 28, and 30 should reflect the Medicare HMO cost share amount only. If blocks 24F, 28, and 30 do not reflect the Medicare HMO cost share amount, the claim will be returned to the provider for correction.
- Block 29 should reflect third-party insurance payments only. Providers are not to indicate the Medicare HMO payment in this block. If the recipient does not have a third-party insurance payment, the block should be left blank. If the Medicare HMO payment is indicated in block 29, the claim will be returned to the provider for correction.

All CMS-1500 Medicare HMO claims should be submitted with the Medicaid Resolution Inquiry Form (http://www.ncdhhs.gov/dma/provider/forms.htm) indicating that the claim attached is a Medicare HMO. The Medicaid Resolution Inquiry Form, as well as the CMS-1500 claim form and Medicare HMO EOB, should be mailed to

EDS
Attn: Medicare HMO Claims
PO Box 300009
Raleigh NC 27622

**Example of CMS-1500 HMO Claim Form**



| 24. A. DATE(S) OF SERVICE From MM | DD | YY | To MM | DD | YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 01 | 01 | 09 | 01 | 01 | 09 | 11 | | 99213 | | | 15 00 | 1 | | NPI | ZZ 251000000X 1234567890 |
| 2 | | | | | | | | | | | | | | NPI | |
| 3 | | | | | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | | | | | NPI | |

| 25. FEDERAL TAX I.D. NUMBER | SSN EIN | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO | 28. TOTAL CHARGE $ 15 00 | 29. AMOUNT PAID $ | 30. BALANCE DUE $ 15 00 |
|---|---|---|---|---|---|---|

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

## *Attention: Nurse Practitioners and Physicians*

## *Oxaliplatin (Eloxatin, HCPCS Procedure Code J9263) – Additional Diagnosis Codes*

Effective with date of service March 1, 2009, Medicaid covers oxaliplatin (Eloxatin) for the treatment of carcinoma of the small intestines or gall bladder. This is in addition to coverage for the treatment of patients with metastatic carcinoma of the colon or rectum whose disease has recurred or progressed during, or within six months of completion of, first-line therapy with the combination regimen of 5-fluorouracil, leucovorin, and irinotecan. Medicaid also covers Eloxatin for the treatment of carcinoma of the pancreas, esophagus and stomach.

**For Medicaid Billing**
The ICD-9-CM diagnosis codes required for billing Eloxatin are

- V58.11 (encounter for antineoplastic chemotherapy)
  **AND one** of the following:
- 153 through 153.9 (malignant neoplasm of colon)
  **OR**
- 154.0 through 154.9 (malignant neoplasm of rectum, rectosigmoid junction, and anus)
  **OR**
- 157.0 through 157.9 (malignant neoplasm of pancreas)
- **OR**
- 150.0 through 150.9 (malignant neoplasm of esophagus)
- **OR**
- 151.0 through 151.9 (malignant neoplasm of stomach)
- **OR**
- 152.0 through 152.9 (malignant neoplasm of small intestine, including duodenum)
- **OR**
- 156.0 through 156.9 (malignant neoplasm of gallbladder and extrahepatic bile ducts)

Providers who received claim detail denials related to the diagnosis of malignant neoplasm of the small intestine or gall bladder for dates of service March 1, 2009, and after may resubmit the denied charges as new claims (not as adjustment requests) for processing.

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

## *Attention: Behavioral Health Providers, Board-eligible Professional Counselors, Local Management Entities, Marriage and Family Therapists in the Associate Licensure Status, Physicians, Provisionally Licensed Psychologists, Provisionally Licensed Social Workers, and Provisionally Licensed Clinical Addiction Specialists*

## *Behavioral Health Services Provided by Provisionally Licensed Professionals in Physician Offices*

Please refer to the March 2009 general Medicaid Bulletin for detailed information on behavioral health services provided by provisionally licensed professionals in physician offices. The prior approval guidelines pertaining to the SC modifier published in this May 2009 Medicaid Bulletin supersede the prior approval guidelines pertaining to the SC modifier published in the March 2009 Medicaid Bulletin.

### Prior Approval

Those providers listed above who have received prior approval from ValueOptions for dates of service July 1, 2008, to May 1, 2009, for H0001, H0004, H0005, and H0031 **will not** be required to request a new prior approval using CPT codes for dates of service provided prior to May 1, 2009.

The March 2009 Medicaid Bulletin directed providers to submit new requests for prior authorization for dates of service effective May 1, 2009, and forward using CPT codes and the SC modifier. In order to make the process more streamlined for providers, this requirement has been modified. Providers are required to submit a new request for prior approval to ValueOptions using CPT codes for service dates effective May 1, 2009, and forward. **However, providers should not include the SC modifier on the service request form.**

Providers may submit one authorization request per recipient for services provided by both the physician and the provisionally licensed professional.

**Note: For dates of services May 1, 2009, all providers must bill for services provided by provisionally licensed professionals "incident to" the physician using the CPT codes with the SC modifier.**

**Catharine Goldsmith, Behavioral Health Section**
**DMA, 919-855-4290**

## *Attention: Hospice Service Providers*

# *Registration for Hospice Seminars*

Seminars for hospice services are scheduled for June 2009. These seminars will review the current hospice policies and procedures as well as claim submission instructions.

Registration information, a list of dates, and site locations for the seminars are listed below. The hospice seminars will begin at 11:00 a.m. and will end at 12:30 p.m. Providers are encouraged to arrive by 10:45 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. Pre-registration 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/provider/seminars.htm. Providers may also complete the seminar registration form on the following page and fax it to the number listed on the form. Please indicate on the registration form which session you plan to attend.

Clinical Coverage Policy #3D, *Hospice Services,* will be used as the primary training document for the seminar. Please review and print the policy and bring it to the seminar. It is available on DMA's website at http://www.ncdhhs.gov/dma/mp/.

**Asheville**
**June 18, 2009**
Asheville-Buncombe Technical Community College
Ferguson Building
340 Victoria Road
Asheville NC 28801

**Wilmington**
**June 23, 2009**
Holiday Inn Wilmington
5032 Market Street
Wilmington NC 28405

**Raleigh**
**June 25, 2009**
Wake Technical Community College
Student Services Building
9101 Fayetteville Road
Raleigh NC 27603

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

**Hospice Seminars**
**June 2009 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**

## *Attention: Home Health Service Providers*

# *Registration for Home Health Seminars*

Seminars for home health services are scheduled for June 2009. These seminars will review the current home health policies and procedures for Medicare-certified home health agencies as well as claim submission instructions.

Registration information, a list of dates, and site locations for the seminars are listed below. The home health seminars will begin at 9:00 a.m. and will end at 10:30 a.m. 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. Pre-registration 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/provider/seminars.htm. Providers may also complete the seminar registration form on the following page and fax it to the number listed on the form. Please indicate on the registration form which session you plan to attend.

Clinical Coverage Policy #3A, *Home Health Services*, be used as the primary training document for the seminar. Please review and print the policy and bring it to the seminar. It is available on DMA's website at http://www.ncdhhs.gov/dma/mp/.

**Asheville**
**June 18, 2009**
Asheville-Buncombe Technical Community College
Ferguson Building
340 Victoria Road
Asheville NC 28801

**Wilmington**
**June 23, 2009**
Holiday Inn Wilmington
5032 Market Street
Wilmington NC 28405

**Raleigh**
**June 25, 2009**
Wake Technical Community College
Student Services Building
9101 Fayetteville Road
Raleigh NC 27603

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

**Home Health Seminars**
**June 2009 Seminar Registration Form**
*(No Fee)*

Provider Name _____

Medicaid Provider Number _____ NPI Number _____

Mailing Address _____

City, Zip Code _____ County _____

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**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**

# Directions to the Home Health Seminars and the Hospice Seminars

**ASHEVILLE**

***Asheville-Buncombe Technical College, Ferguson Building***

**Traveling West on I-40:** Take I-40 to Exit 50B (Biltmore Avenue/US 25 North). At the end of the exit ramp, turn right. Turn left at the 7th traffic light onto Victoria Road, which brings you onto the campus. Turn right after the Holly Building, just before the Simpson Building. The Ferguson Auditorium is located in the Ferguson Building just behind the Holly Building.

**Traveling East on I-40:** Take I-40 to Exit 50A (Biltmore Avenue/US 25 North). At the end of the exit ramp, turn left. Turn left at the 7th traffic light onto Victoria Road, which brings you onto the campus. Turn right after the Holly Building, just before the Simpson Building. The Ferguson Auditorium is located in the Ferguson Building just behind the Holly Building.

**Traveling North on I-26:** Take I-26 to the I-40 junction. Stay in the center lane for I-240 to Asheville. Take the exit for Amboy Road. At the "T" intersection, turn right. At the next traffic light onto Victoria Road, which brings you onto the campus. Turn right after the Holly Building, just before the Simpson Building. The Ferguson Auditorium is located in the Ferguson Building just behind the Holly Building.

**WILMINGTON**

***Holiday Inn Wilmington***

**Traveling East on I-40:** Take Exit 8 (Market Street). Turn left at the light. The hotel is located on the left, 0.5 mile from the intersection.

**Traveling South on US-17:** Follow US-17 South into Wilmington. The hotel is located on the left 0.5 mile from the intersection of US-17 and I-40.

**Traveling North on US-17/East on NC-74/76:** Follow US-17 North into Wilmington. The hotel is located on the right approximately 4 miles after entering Wilmington.

**RALEIGH**

***Wake Technical Community College, Student Services Building***

Take I-440 to US-401 South/S. Saunders Street (Exit 298). Stay to the right to continue on US-401 South/Fayetteville Road. Continue to travel on US-401 South/Fayetteville Street through Fuquay-Varina. The college is located on the left approximately 1 mile from the intersection with NC 1010. Turn left onto Chandler Ridge Circle. Visitor parking is on the left.

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

# *Personal Care Services 2008 Cost Report*

Each year, DMA requests cost data from personal care service providers in accordance with their Medicaid Participation Agreement. This year's cost report is **due on July 24, 2009.** If the cost report is not completed and **received** at DMA by July 24, 2009, DMA will withhold **20%** of future payments until the cost report is filed and complete with the financial statements and appropriate signatures. The cost report package is available online at http://www.ncdhhs.gov/dma/cost/pcsreports.htm.

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

## *Attention: Personal Care Service and Personal Care Service–Plus Providers*

# *Personal Care Services Provider Training Sessions*

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

The 2nd calendar quarter training sessions (PCS Provider Training Session 12) of 2009 is scheduled for June 2009. 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.

Dates and locations will be posted on CCME's website under "Upcoming Events." Pre-registration is required and space is limited. 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 and submitted it, you will see a computer-generated number to confirm your registration. Bring the number with you to the session.

**To register by fax,** complete the form following this announcement 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.

Detailed information regarding times and session content will be posted on CCME's website.

**CCME, 919-380-9860**

The Carolinas Center *for* Medical Excellence

**CCME PCS Provider Training Session 12**
**June 2009**
**Registration Form**

Location requested: _____ Location Date: _____

First Name: _____

Last Name: _____

Credentials: _____ First time to attend training? _____

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 website?
please check: ☐ Yes ☐ No

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

## *Early and Periodic Screening, Diagnosis 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/basicmed/
- *Health Check Billing Guide:* http://www.ncdhhs.gov/dma/healthcheck/
- EPSDT provider information: http://www.ncdhhs.gov/dma/epsdt/.

## *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/mpproposed/. 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.

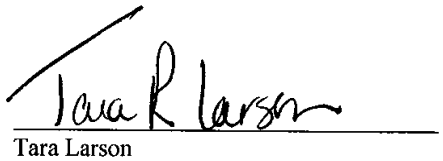
Loretta Bohn
Division of Medical Assistance
Clinical Policy Section
2501 Mail Service Center
Raleigh NC 27699-2501

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.

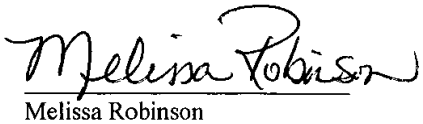
## *2009 Checkwrite Schedule*

| Month | Electronic Cut-Off Date | Checkwrite Date |
|---|---|---|
| **May** | 5/7/09 | 5/12/09 |
| | 5/14/09 | 5/19/09 |
| | 5/21/09 | 5/28/09 |
| **June** | 6/4/09 | 6/9/09 |
| | 6/11/09 | 6/16/09 |
| | 6/18/09 | 6/25/09 |

***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.***



Tara Larson
Acting Director
Division of Medical Assistance
Department of Health and Human Services



Melissa Robinson
Executive Director
EDS, an HP Company