June 2007 Medicaid Bulletin

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Attention: All Providers

Revision to the NPI and New Claim Forms Implementation Changes Published in the May 2007 Medicaid General Bulletin

The Division of Medical Assistance (DMA) will not implement utilization of the National Provider Identifier (NPI) on the originally scheduled implementation date of May 18, 2007. Claims will continue to be adjudicated after the May 23rd date using the Medicaid Provider Number instead. The Center for Medicare and Medicaid Services (CMS) is concerned about the health care industry's state of readiness with regard to successful implementation of the NPI. CMS will focus on voluntary compliance and is allowing entities covered under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to employ a contingency plan after May 23, 2007. DMA's contingency plan is based on continued use of the Medicaid Provider Number. As a result, the date on which DMA will implement the NPI rule is yet to be determined.

Due to the delay in NPI implementation, claims submitted after May 18, 2007, without a Medicaid Provider Number will be denied.

Providers should be aware that voluntary compliance does not change the HIPAA requirement that health care providers obtain an NPI by May 23, 2007. DMA will continue to collect NPI information from providers, and N. C. Medicaid strongly encourages providers to immediately begin submitting claims that contain both their Medicaid Provider Number and their NPI.

In addition, N.C. Medicaid will no longer accept the old CMS-1500 (12/90) after **July 1, 2007**. Any CMS-1500 (12/90) old paper claim version sent after **July 1, 2007,** will be returned to providers. N.C. Medicaid requests that providers continue to send only the new paper claim versions of the UB-04 and ADA claim forms. Medicaid will publish in upcoming bulletin articles the final date that the old paper versions of the ADA form and the UB-92 will be accepted.

Additional information regarding the new NPI implementation date will be communicated when available. The quickest and easiest way for providers to obtain updated information regarding the NPI will be via e-mail from the NPI Electronic Mailing List. If you have not subscribed to the Electronic Mailing List, please do so immediately by visiting the DMA Web site at http://www.ncdhhs.gov/dma/NPI.htm. Click on the NPI Mailing List link highlighted in red at the top of the page to subscribe. In addition, NPI information will be communicated to providers via bulletins, remittance advice banner messages, and the DMA Web site.

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

NPI Reporting Tips

N.C. Medicaid requires all providers to report NPI(s) by using either the NPI Collection Spreadsheet (EDI) or the NPI Collection Form. Both the spreadsheet and the form are located on the DMA Website: www.ncdhhs.gov/dma/npi.htm. Over half of the N.C. Medicaid provider community still needs to report their NPI. Providers should report all NPIs to Medicaid as soon as possible. Some reported NPIs are being returned to the provider and not loaded into the provider database. The NPI cannot be loaded because of errors in the information being submitted. The following trends have been identified which result in NPI reporting errors:

Common Error	How to Avoid It
Reporting the same NPI for a group and individual provider	There are two different types of NPIs: Type I (individual) and Type II (organizational). The same NPI would never represent both an individual and a group. • Each individual provider must apply for and obtain a unique NPI. • Entities may apply for an organizational NPI to represent the group. • Also, providers do not need to "link" the individual's NPI to the group NPI. Do not submit a NPI collection spreadsheet or form for this reason. If a provider joins or leaves a group, submit a Provider Change Form. The provider change form is, located on the DMA Web site: at www.ncdhhs.gov/dma/forms.html.
Attempting to change an NPI using the NPI Collection Spreadsheet	A provider's whose NPI changes (for example, from one NPI for multiple Medicaid provider numbers and has now decided to subpart), must report the change on the **NPI Collection Form** and write the word **"UPDATE"** at the top. If changes are submitted via the NPI Collection Spreadsheet (EDI), the database will **not** be updated because an NPI will already be on file for the provider.
Submitting the word "pending" in the Medicaid Provider Number or NPI field, or leaving these fields blank	If all fields on either the NPI Collection Spreadsheet (EDI) or NPI Collection Form cannot be completed, do not attempt to report an NPI. New Medicaid providers do not need to submit an NPI Collection Spreadsheet (EDI) or NPI Collection Form. New providers are required to submit their NPI on the Medicaid Provider application.

Common Error	How to Avoid It
Deleting columns on the NPI Collection Spreadsheet	The spreadsheet is automated and all columns are required in order for the information to load into the database correctly.
Submitting taxonomy codes in the NPI field	Verify submitted information matches the column or field heading.
Failing to complete the submitter information	This information is required in case DMA needs to contact the provider regarding the information submitted.
Selecting the incorrect indicator from the drop down box on the NPI Collection Spreadsheet(EDI)	Group and individual NPIs may be reported using the same spreadsheet. Frequently the incorrect indicator is selected on the drop down box. It should be 'I' for individual or 'G' for group. This must be designated for each line on the spreadsheet.

Avoid these common errors when reporting your NPI. Submitting the information correctly will make the NPI reporting process quick, easy, and effective.

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

Breast Imaging Policy

Digital Mammography

Effective with date of service June 1, 2007, digital as well as film mammography will be covered by N.C. Medicaid. Film and digital mammography have the same criteria for coverage and the same rates for service. The codes are as follows:

Film Code	Description	Digital Code	Description
77055	Mammography; unilateral	G0206	Diagnostic mammography, producing direct digital image, unilateral, all views
77056	Mammography; bilateral	G0204	Diagnostic mammography, producing direct digital image, bilateral, all views
77057	Screening mammography; bilateral	G0202	Screening mammography, producing direct digital image, bilateral, all views

Screening Mammography

Effective with date of service June 1, 2007, Medicaid coverage for annual screening mammography is expanded to include female recipients between the ages of 20 and 39 years who have high-risk diagnoses. Providers must bill ICD-9-CM diagnosis code **V76.11** (screening mammogram for high-risk patient) as the primary diagnosis, with one of the following secondary diagnoses:

ICD-9-CM Code	Description
V10.3	Personal history of malignant neoplasm of the breast
V15.89	Other specified personal history presenting hazards to health
V16.3	Family history of malignant neoplasm of the breast
V76.19	Special screening for malignant neoplasms in the breast

For complete information, refer to Clinical Coverage Policy 1K-1, Breast Imaging, now posted on the Division of Medical Assistance Web site at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

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

Attention: All Providers

Clinical Coverage Policies

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

1H, Telemedicine and Telepsychiatry
1K-1, Breast Imaging
5A, Durable Medical Equipment
8C, Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers

The following policies were revised as of May 1. These changes are in addition to the global changes made to all affected policies:
3J, Personal Care Services–Plus
7, Hearing Aid Services
9, Pharmacy
General Clinical Policy A-2, Over-the-Counter Medications

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

Delayed Implementation/Training Cancellation for the New Medicaid Uniform Screening Tool

The Medicaid Uniform Screening Tool (MUST), introduced in the May 2007 Medicaid general bulletin (pp. 17–20), will **not** be implemented on October 1 as expected. An implementation plan will be announced at a later date.

As a result of this delay and of the need to incorporate North Carolina Identification Program (NCID) into program software—which is required for access to all State-sponsored Web portals—the training sessions on the new Medicaid Uniform Screening Tool **have been cancelled.** The rescheduled training sessions will be posted in future Medicaid bulletins.

MUST, when implemented, will replace several existing prior authorization processes for the nursing home level of care and allow local screeners to use the Web to determine the "best fit" Medicaid service and any alternate option(s) for the individual screened. The screener and the individual will discuss the option(s), select one, and generate a referral to a provider of the recipient's choice.

Facility and Community Care Section
DMA, 919-855-4360

Attention: All Providers

North Carolina Electronic Claims Submission Web-Based Tool (NCECS Webtool) Seminars:

NCECS Webtool seminars are being held during the months of July and August 2007. Seminars are intended to educate providers on the basics of Webtool billing.

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

Providers may register for the NCECS Webtool seminars by completing and submitting the following registration form or online at http://www.ncdhhs.gov/dma/semreg/webtool.html.

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

Providers must print the PDF version of the 2007 NCECS Webtool Billing Guide, which will be available July, 2007 from the DMA's website and bring it to the seminar.

Tuesday, July 24, 2007 Jane S. McKimmon Center 1101 Gorman Street Raleigh, N.C.	**Wednesday, July 25, 2007** Crowne Plaza Hotel One Resort Plaza Asheville, N.C.
Tuesday, July 31, 2007 Hilton Hotel 207 Greenville Blvd Greenville, N.C.	**Thursday, August 2, 2007** Holiday Inn Greensboro-Airport Burnt Poplar Road Greensboro, N.C.

Directions to the North Carolina Electronic Claims Submission (NCECS) Seminars

Crowne Plaza – Asheville

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

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

Holiday Inn- Greensboro-(TRIAD INTL. ARPT)

On I-40 Take Exit 211**(If traveling east, turn left, if traveling west, turn right).** Then turn left onto Burnt Poplar Rd. The Hotel is on the right.

Hilton – Greenville

Traveling East: - take 64 east to 264 east. Follow 264 east to Greenville. Turn right on Allen Rd. once you enter Greenville. Go approx. 2 miles and Allen Rd. turns into Greenville Blvd/Alternate 264. Follow Greenville Blvd. for 2 1/2 miles, the Hilton Greenville is located on the right.

Traveling South: Take 64 to US-13 S/NC-11 S. Continue to follow NC-11 S. Turn left onto US-Greenville Blvd. The hotel is on the left.

Traveling North: Take NC Highway 11 North to Greenville. Turn right onto Greenville Blvd. Hotel is approximately one mile ahead on the right.

Jane S. McKimmon Center l - Raleigh

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

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

North Carolina Electronic Claims Submission (NCECS) Medicaid Seminar Registration Form

July-August 2007 NCECS Medicaid Seminar
Registration Form:
(No fee)

Provider Name _____

Medicaid Provider Number_____ NPI Number_____

Mailing Address_____

City, Zip Code_____ County_____

Contact Person_____ E-mail_____

Telephone Number (____) _____ Fax Number_____

(1) or (**2**) person(s) will attend the seminar at_____ on _____
(circle one) (location) (date)

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

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

Attention: Adult Care Home and Hospice Providers

Adult Care Home Payment When a Recipient Chooses Their Hospice Benefit

Effective with date of service, July 1, 2007 Adult Care Home Providers will be reimbursed for Basic and /or Enhanced Personal Care Services provided by the Adult Care Home to a recipient who is also receiving Hospice services. Such service must be specified in the Hospice plan of care and may not be a duplication of service provided by the Hospice Agency. This change in reimbursement policy does not affect any resident in a Special Care Unit for those with Alzheimer's and Related Disorders.

Facility and Community Care Section
Charles Jackson, 919-855-4346
Candace Stancil, 919-855-4369

Attention: AQUIP Users and CAP/DA Lead Agencies

Quarterly Automated Quality and Utilization Improvement Program Training Seminar

The Carolinas Center for Medical Excellence (CCME; www.thecarolinascenter.org) announces continued quarterly training for new AQUIP users in CAP/DA lead agencies. The second quarterly training session this year will be held on June 26, 2007, at the Shell Island Resort in Wrightsville Beach. Attendance at this meeting is of the utmost importance for new AQUIP users. CAP/DA lead agency contacts have been informed via e-mail of any identified new users in their counties who should attend this session. We recommend that all attendees read and become familiar with the AQUIP User Manual, which can be accessed by going to the AQUIP Web site (https://www2.mrnc.org/aquip) and clicking on Downloads, prior to the training session. Current users who would like to attend the session may do so if space permits. However, the information presented will be designed for new users.

The seminar is scheduled to begin at 9:00 a.m. and end at 3:00 p.m. The session will focus on Resource Utilization Group (RUG) scores, acquiring adequate knowledge, understanding how to accurately complete the three parts of the AQUIP tool (the Client Information Sheet, Data Set Assessment, and Plan of Care), and resolving common data entry errors.

Pre-registration is required. Contact your CAP/DA lead agency to verify if your name is on the required attendance list. You may register for the seminar online, beginning June 1, 2007, by going to https://www2.mrnc.org/aquip and clicking on Registrations. You will receive a computer-generated confirmation number, which you should bring to the seminar. Check-in will be from 8:30 until 9:00 a.m. on the day of the seminar; lunch will be on your own.

Facility and Community Care Section
CCME, 1-800-682-2650

Attention: Children's Developmental Service Agencies, Home Health Providers, Hospital Outpatient Clinics, Independent Practitioners, Local Health Departments, Local Management Entities and Physicians

Outpatient Specialized Therapies Prior Authorization Process – Post Payment Validation

Beginning in August 2007, The Carolinas Center for Medical Excellence (CCME) will implement post-payment validation on therapy authorizations. Each month, a sample will be drawn from authorizations with an end date six months prior to that month. (For this first sample, the included authorizations will be those with an end date in February 2007.) Providers will be notified of clients selected in the sample; and documentation such as the therapy order, evaluation, and progress notes will be requested. This documentation will be validated against the information submitted with the prior authorization request for the same dates of service.

Additional details will be available in future bulletin articles and on CCME's prior authorization Web site, https://www2.mrnc.org/priorauth/pages/Home.aspx.

CCME, 1-800-682-2650

Attention: CMS-1500 Billers

Electronic Adjustments (Replacement Claims)

With the implementation of HIPAA compliant claim formats, adjustments can be filed electronically, regardless of claim type and original claim format. Filing adjustments electronically results in quicker resolution and correct payment. Electronic adjustments are submitted in the form of claim voids and replacements:

Professional (CMS-1500) replacement claims are filed using the Claim Submission Reason Indicator. A value of 7 indicates a replacement claim.

Note: Providers are reminded to bill their usual and customary charges rather than the Medicaid rate.

Listed below is an example of a replacement claim that may be submitted:

Replacement Claim
When filing a replacement claim, include Claim Submission Reason Indicator 7, the original ICN of the previously processed claim, and corrected claim information. The claim associated with the original ICN

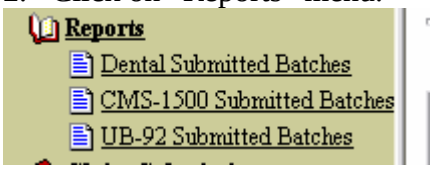
will be recouped and the corrected claim will be processed in its place. If for any reason the corrected claim denies, the previously processed claim will not be recouped.

Example: A provider bills for one 15 minute unit of therapy when 1 hour of therapy (four 15 minute units) should have been billed. Medicaid processes and pays the original claim for one 15 minute unit. The provider notices the billing error when the RA is received and shows payment made for one 15 minute unit. If the provider billed for the balance of the missing units, the claim would likely deny as a duplicate. Instead, a corrected claim for the entire four 15 minute units can be submitted, with Submission Reason code 7 and the ICN from the original claim. The system will recoup the original claim and process the correct claim for four units.

Reminder: Replacement claims can only be performed on paid claims.

How to file a Replacement Claim on NCECS Webtool

1. Log into NCECS Webtool.
2. Click on "Reports" menu.



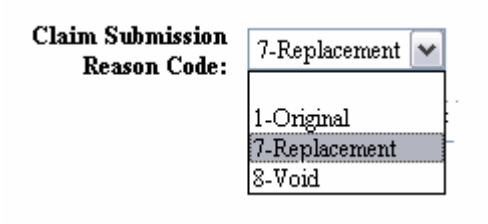
3. Click on "CMS-1500 Submitted Batches." Select the appropriate batch.
4. Click on the "Copy" button at the top of the screen. This will automatically pull all the claims in the selected Batch to the "Claims Entry" screen. 

5. Once the "Claims Entry" screen is accessed, click on the circle button next to the individual claim you would like to replace. 
6. Click "Edit." 

7. You will see all the previous submitted claim information on the screen. Scroll about mid-way down underneath the "Miscellaneous Claim Information" section.

8. There is a box titled "Original ICN." In this box, type in the claim number from the original paid claim. This can be found on your Remittance and Status report from Medicaid. Type in the 15 digit number without the NCXIX at the end.

9. In the box directly to the right of "Original ICN," you will see a drop down menu titled "Claim Submission Reason Code." Select option 7 for "replacement."



10. If there are any changes that need to be made to the body of the claim, those may be edited as well. If there are no changes to be made, scroll to the top of the page and click "Save." This will bring you back again to the "Claims Entry" screen, and you can repeat the steps for other claims in the copied batch. 

Questions regarding these types of adjustment can be addressed by EDS Provider Services at 1-800-688-6696, select option 3 from the menu.

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

Attention: Durable Medical Equipment Providers

Change in Requests for Prior Approval for Pediatric Mobility Devices

Effective with date of request July 1, 2007, Children's Special Health Services will no longer be reviewing requests for prior approval for pediatric mobility devices on behalf of DMA. On that date, EDS will begin the review for prior approval of these devices. Please see Clinical Coverage Policy 5A, Durable Medical Equipment, located on DMA's Web site at www.ncdhhs.gov/dma/dme/dmepdf.pdf and refer to **Attachment B, How a Recipient Obtains Durable Medical Equipment and Supplies,** for detailed instructions regarding submission of prior approval requests.

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

Attention: Durable Medical Equipment Providers

HCPCS Code Changes for Wheelchair Accessories (Power Seating System Tilt and Recline)

Effective with date of service **May 31**, **2007** the following codes were end-dated and removed from the DME fee schedule:

W4146	**W4147**

Effective with date of service of **June 1, 2007,** the following codes were added to the DME fee schedule:

New Code	Description	Lifetime Expectancy/Quantity Limitations
E1002*	Wheelchair accessory, power seating system, tilt only	5 years
E1003*	Wheelchair accessory, power seating system, recline only, without shear reduction	5 years
E1004*	Wheelchair accessory, power seating system, recline only, with mechanical shear reduction	5 years
E1005*	Wheelchair accessory, power seating system, recline only, with power shear reduction	5 years
E1006*	Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction	5 years

New Code	Description	Lifetime Expectancy/Quantity Limitations
E1007*	Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction	5 years
E1008*	Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction	5 years

Note: In the tables above, HCPCS codes with an asterisk (*) require prior approval; bold type indicates the item is covered by Medicare. A Certificate of Medical Necessity and Prior Approval (CMN/PA) form must be completed for all items, regardless of whether prior approval is required. The coverage criteria for these items have not changed. Refer to Clinical Coverage Policy #5, Durable Medical Equipment, on DMA's Web site at www.ncdhhs.gov/dma for detailed coverage information. For the maximum allowable reimbursement please refer to the DME Fee schedule also found on DMA's Web site.

Clinical Policy
DMA, 919-855-4316

Attention: Durable Medical Equipment Providers

Reimbursement for Accessory Equipment for Use with Continuous Positive Airway Pressure and Respiratory Assist Devices

Effective with date of service April 24, 2007, N.C. Medicaid will allow for the reimbursement of the accessory equipment associated with the use of Continuous Positive Airway Pressure (CPAP) devices and Respiratory Assist Devices (RAD). This is the only exception to the policy for rental equipment in which reimbursement for rental items includes service, delivery, assembly, set-up, repairs and supplies. Please refer to the DME fee schedule and Clinical Coverage Policy #5A, Durable Medical Equipment, on DMA's Web site at www.ncdhhs.gov/dma for more detailed coverage information.

Clinical Policy
DMA, 919-855-4316

Attention: Maternity Care Coordination Providers

New Intake Screening and Pregnancy Outcome Summary Forms

The implementation date for the mandatory completion of the Maternity Care Coordination Intake Screening, DHHS T1513, and the Pregnancy Outcome Summary, DHHS T1514, has been changed from May 15, 2007 to June 1, 2007. Maternity Care Coordination Program (MCCP) providers may continue to complete the current Pregnancy Outcome Summary/Report (DMA-3002) until May 31, 2007. HSIS users may also continue to enter/close out Pregnancy Outcome Summaries using the current pregnancy outcome data entry screens until 5:00pm on May 31st, 2007. Effective June 1, 2007 all MCCP providers will be required to complete the new Pregnancy Outcome Summary, DHHS T1514. In addition, beginning June 1, 2007 Maternity Care Coordinators must complete the new MCCP-IS form, DHHS T1513, for all new clients who enroll in MCCP. For HSIS users, the MCCP-IS form must also be completed and entered into HSIS for all MCCP clients who are currently enrolled between June 1 and July 1, 2007. Non-Local Health Department (LHD) provider agencies that are not HSIS users must send completed forms to the Division of Public Health for data entry.

Forms must be submitted to:
The Baby Love Program, Division of Public Health,
Women's Health Branch,
1929 Mail Service Center,
Raleigh, NC 27699-1929.

Non-LHDs will not be penalized for delays resulting from an alternative data entry system. Training materials and handouts on using the new forms are available at http://www2.sph.unc.edu/hipaa/updates.htm.

Clinical Policy
DMA, 919-855-4320

Attention: Mental Health Service Providers

Correction to Expansion of Billing Codes Published in the May 2007 General Medicaid Bulletin

Certified Clinical Supervisors were incorrectly listed to bill CPT codes. Licensed Clinical Addiction Specialists may bill the following CPT codes:

90801	90802	90804	90806	90808	90810	90812	90814	90846	90847
90849	90853	90857	90816	90818	90821	90823	90826	90828	

This is in addition to the codes they now bill, H0001, H0005, H0031 and H0004 (with or without one of the following modifiers, as appropriate: HQ, HR, or HS).

Certified Clinical Supervisors may bill H0001, H0005, H0031 and H0004 (with or without one of the following modifiers, as appropriate: HQ, HR, or HS).

Behavioral Health Services
DMA, 919-855-4290

Attention: Personal Care Services and CAP-DA Providers

2006 PCS Cost Report Trainings

The Division of Medical Assistance (DMA) will be conducting training for the 2006 Personal Care Services Cost Report. The new training registration form; 2006 PCS Cost Report; schedule; instruction manual; and other related materials are located on DMA's Web site (http://www.ncdhhs.gov./dma/costreport.html). The due date for the 2006 PCS Cost Report is July 27, 2007.

Pre-registration is required due to limited space availability. Your registration form needs to be received and confirmed at least 5 business days prior to the training class you wish to take. Please go to the DMA Web-site and complete the registration form, choosing the training date and time that is most convenient for you. Seating availability will be based on a first-come, first- served basis. The training site is able to accommodate 60 participants. A confirmation of your registration will be sent to you via e-mail.

Training sessions are scheduled to be held at the NCDOT Training Center, 313 Chapanoke Road, (Room #s 203 &204) Raleigh, NC 27603.

June 7, 2007, Thursday	☐ ***TIME: 9:00 AM to 12:00 PM***	☐ ***TIME: 1:30 PM to 04:30 PM***
June 8, 2007, Friday	☐ ***TIME: 9:00 AM to 12:00 PM***	☐ ***TIME: 1:30 PM to 04:30 PM***
June 27, 2007, Wednesday	☐ ***TIME: 9:00 AM to 12:00 PM***	☐ ***TIME: 1:30 PM to 04:30 PM***
June 28, 2007, Thursday	☐ ***TIME: 9:00 AM to 12:00 PM***	☐ ***TIME: 1:30 PM to 04:30 PM***

Rate Setting
DMA, 919-855-4200

Attention: Pharmacists

Billing for MiraLax

MiraLax is now available as an over-the-counter (OTC) medication. MiraLax is not included on the list of drugs covered under the N.C. Medicaid OTC program. Pharmacists should not bill claims for OTC MiraLax under prescription-only NDCs for this medication. This practice is considered fraudulent and can lead to increased disputes in the Medicaid drug rebate program.

EDS, 1-800-688-666 or 919-851-8888

Attention: Pharmacists

Joint Statement from the N.C. Board of Pharmacy and the N.C. Division of Medical Assistance

The N.C. General Assembly mandates that pharmacists participating in the Medicaid program substitute generic drugs for brand name drugs unless the prescriber indicates "medically necessary" on the face of prescriptions for brand name drugs. In support of this mandate, the N.C. Board of Pharmacy and the N.C. Division of Medical Assistance would like to notify pharmacists that prescriptions for brand name Prilosec 40 mg may be substituted with the equivalent dose of generic omeprazole 20 mg.

Pharmacists should consult with their Medicaid patients that they are receiving an appropriate, generically equivalent medication and should also take care to consult these patients on the appropriate use of the medication.

EDS, 1-800-688-666 or 919-851-8888

Attention: Prescribers and Pharmacists

New Pharmacy Prior Authorization Program for Proton Pump Inhibitors

The N.C. Medicaid Outpatient Pharmacy Program will implement a new prior authorization (PA) program for brand name proton pump inhibitors on June 1, 2007. On this date, pharmacists will begin receiving a point-of-sale message that PA is required for brand name prescription medications in this drug class. 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:

1. "Failed omeprazole 40 mg for 30 days"
2. "Esophagitis Grade C" – for esomeprazole magnesium (Nexium) 40 mg prescriptions only
3. "Esophagitis Grade D" – for esomeprazole magnesium (Nexium) 40 mg prescriptions only
4. "Cannot swallow tablets"
5. "Cannot swallow capsules"

If the brand name proton pump inhibitor medication 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.

PA will not be required for recipients who are pregnant, breastfeeding, or less than six years old. For recipients with a pink Medicaid identification card (MPW coverage), the eligibility file will automatically exempt prescription claims for these medications from the PA requirement. For recipients with a blue Medicaid identification card, the pharmacist may indicate pregnancy and/or breastfeeding on the claim in one of the following ways:

- Enter a "2" in the pregnancy indicator field (335-2C)
- Enter a diagnosis of "V22" or "V23" in the diagnosis field (424-DO)

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

There are some forms being developed by the Community Care of North Carolina network to assist physicians in this process that can also serve as a prescription. These forms are not required for this program. If you do receive these forms, please make sure that all of the necessary information required in the prescriber's own handwriting is present on the form prior to dispensing a brand name proton pump inhibitor medication.

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

Attention: Prescribers and Pharmacists

Change in Policy on Proton Pump Inhibitors

Effective June 1, 2007, brand name proton pump inhibitors (PPIs) will require prior authorization. Please refer to the N.C. Medicaid Enhanced Pharmacy Program Web site at http://www.ncmedicaidpbm.com for additional information on this program. Due to the change in policy for PPIs, patients may require a physician visit for evaluation of their PPI therapy. Providers who receive a denial because a recipient has reached the 24 visit limit for the fiscal year ending June 30, 2007 may send DMA their remittance advice showing the denial. Also send a claim including the appropriate ambulatory visit code and diagnosis code V82.9 and a brief explanation for the reason the visit was needed. The request will be processed for payment.

Please mail claim information to:
Division of Medical Assistance
Pharmacy and Ancillary Services Section
2501 Mail Service Center
Raleigh, NC 27699-2501

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

Attention: Physicians and Nurse Practitioners

Eculizumab, 300mg/30ml single-use vial (Soliris, J3590) Billing Guidelines

Effective with date of service April 1, 2007, the N.C. Medicaid program covers eculizumab (Soliris) for use in the Physician's Drug Program when billed with HCPCS procedure code J3590 *(unclassified biologics).* Soliris is indicated for treatment of paroxysmal nocturnal hemoglobinuria (PNH) and is the first drug to be approved to treat this rare blood disorder. Soliris is a monoclonal antibody that decreases the body's immune response in destroying abnormal red blood cells.

The recommended dose of Soliris is a 600-mg intravenous infusion administered over 35 minutes every 7 days for the first 4 weeks. The fifth dose of 900 mg is administered 7 days later and additional doses of 900 mg are administered every 14 days thereafter.

For Medicaid Billing:

- The ICD-9-CM diagnosis code required for billing Soliris is 283.2 *(Hemoglobinuria due to hemolysis from external causes)*
- Providers must bill Soliris with HCPCS procedure code J3590 *(unclassified biologics),* with the original invoice or copy of the original invoice attached to the CMS-1500 claim form. **An invoice must be submitted with each claim.** The paper invoice must include the recipient's name and Medicaid identification number, the name of the medication, the dosage given, the National Drug Code (NDC) number from the vial(s) used, the number of vials used, and the cost per dose.
- Providers must indicate the number of units given in block 24G on the CMS-1500 claim form.
- Providers must bill their usual and customary charge.

One unit of coverage is 300 mg (one 300-mg/30-ml single-use vial). The maximum reimbursement rate per unit is $5,616.00.

The new fee schedule for the Physician's Drug Program is available on DMA's Web site at http://www.ncdhhs.gov/dma/fee/fee.htm.

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

Attention: Physicians and Nurse Practitioners

Hydroxocobalamin, 5 gram kit (Cyanokit, J3490) Billing Guidelines

Effective with date of service April 1, 2007, the N.C. Medicaid program covers hydroxocobalamin (Cyanokit) for use in the Physician's Drug Program when billed with HCPCS procedure code J3490 *(unclassified drugs)*. Cyanokit is indicated for treatment of known or suspected cyanide poisoning. Cyanokit works by binding with the cyanide ions and then excreting them out through the urine.

Each kit contains two vials, each with 2.5 g of lyophilized hydroxocobalamin dark red crystalline powder for injection. After reconstitution, each 2.5 g vial contains 100 ml hydroxocobalamin for injection, 25 mg/ml.

The recommended dose starting dose of Cyanokit for adults is 5g (two 2.5 g vials) administered by intravenous infusion over 15 minutes. Depending on severity of the poisoning and the clinical response, a second dose of 5 g may be administered for a total dose of 10 g.

For Medicaid Billing:

- The ICD-9-CM diagnosis codes required for billing Cyanokit are
  - 989.0 *(Toxic effects of hydrocyanic acid and cyanides)*
    OR
  - 987.7 *(Toxic effects of hydrocyanic acid gas)*
- Providers must bill Cyanokit with HCPCS procedure code J3490 *(unclassified drugs),* with the original invoice or copy of the original invoice attached to the CMS-1500 claim form. **An invoice must be submitted with each claim.** The paper invoice must include the recipient's name and Medicaid identification number, the name of the medication, the dosage given, the National Drug Code (NDC) number from the kit(s) used, the number of kits used, and the cost per dose.
- Providers must indicate the number of units given in block 24G on the CMS-1500 claim form.
- Providers must bill their usual and customary charge.

One unit of coverage is 5 g (one kit). The maximum reimbursement rate per unit is $731.25.

The new fee schedule for the Physician's Drug Program is available on DMA's Web site at http://www.ncdhhs.gov/dma/fee/fee.htm.

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

Attention: Physicians, Nurse Midwives, Nurse Practitioners, FQHCs and RHCs

Change in Reimbursement Rates for Injectable Immunization Administration Codes

Effective with date of service January 1, 2007, the reimbursement rates for the following CPT codes were adjusted - 90465, 90466, 90471 and 90472. The definitions of these codes are as follows:

- 90465 – Immunization administration younger than 8 years of age (includes percutaneous, intradermal, subcutaneous or intramuscular injections) when the physician counsels the patient/family; first injection (single or combination vaccine/toxoid), per day.
- 90466 – each additional injection (single or combination vaccine/toxoid), per day (List separately in addition to code for primary procedure)
- 90471 – Immunization administration (includes percutaneous, intradermal, subcutaneous or intramuscular injections); one vaccine (single or combination vaccine/toxoid).
- 90472 - each additional injection (single or combination vaccine/toxoid), per day (List separately in addition to code for primary procedure)

In the near future, when billing claims for Health Check recipient's ages 0 through 20 with the EP modifier, private providers will be able to bill for all of the additional vaccine administrations provided on one date of service. There will be a future bulletin article explaining how to bill for the additional units and stating when claims may be submitted for reimbursement. Currently, providers have been instructed to bill only one "add-on" administration code 90472EP or 90466EP, regardless of the number of administrations performed. **Providers should continue to bill according to these guidelines until instructed to do so otherwise.**

In the future, providers will be receiving additional reimbursement for the "add-on" codes 90472EP and 90466EP for Health Check recipients retroactively back to January 1, 2007 date of service. Please watch for a future bulletin article stating when this should occur.

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

Attention: Psychosocial Rehabilitation (PSR) Providers

Rate Change for Psychosocial Rehabilitation

Medicaid providers enrolled to offer the service of **Psychosocial Rehabilitation**, please note the following rate change:

Service Code	Old Rate	New Rate
H2017	$2.34/unit	$2.90/unit

This rate is effective as of July 1, 2007.

Rate Setting
DMA, 919-855-4200

Proposed Clinical Coverage Policies

In accordance with Session Law 2005-276, proposed new or amended Medicaid clinical coverage policies are available for review and comment on DMA's Web site at http://www.ncdhhs.gov/dma/prov.htm. To submit a comment related to a policy, refer to the instructions on the Web site. Providers without Internet access can submit written comments to the address listed below.

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

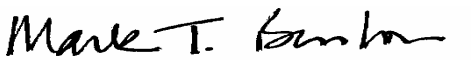
The initial comment period for each proposed policy is 45 days. An additional 15-day comment period will follow if a proposed policy is revised as a result of the initial comment period.

2007 Checkwrite Schedule

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

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

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



Mark T. Benton, Director
Division of Medical Assistance
Department of Health and Human Services

Cheryll Collier
Executive Director
EDS