June 2008 Medicaid Bulletin

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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 a Medicaid Provider Number (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.

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

Medicare Crossover Claims

For crossover claims to process correctly, the National Provider Identifier (NPI) submitted on the Medicare claim must match the NPI on file with N.C. Medicaid. Claims submitted to Medicare with an NPI that is not on file with Medicaid will not cross over to Medicaid and cannot be processed.

Only one NPI number is collected for each Medicaid provider number. If a provider has multiple NPIs, but only one Medicaid provider number, the provider must select the NPI to be reported to Medicaid. All NPI changes must be submitted on the NPI and Address Verification-Correction Request Form. The form is accessible via the NPI and Address database located at http://www.ncdhhs.gov/dma/WebNPI/default.htm.

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

Attention: All Providers

National Provider Identifier Customer Support

N.C. Medicaid has taken proactive steps to ensure that when National Provider Identifiers (NPIs) are implemented on May 23, 2008, providers continue to receive reimbursement for services rendered to Medicaid recipients. DMA and EDS staff have received training to ensure they are able to address provider inquiries related to NPI. An NPI unit has been added to the EDS Provider Services team to handle NPI phone calls and research NPI issues. Callers will hear an option for the NPI Help Desk when contacting EDS Provider Services (1-800-688-6696 or 919-851-8888).

In addition, beginning June 9, 2008, the hours of operation for the EDS Provider Services Call Center will be extended to 5:30 p.m. This expansion of hours will be provided on a temporary basis to assist with additional NPI-related calls.

As a reminder, all providers (except pharmacies and atypical providers) should continue to submit claims with NPI, Medicaid Provider Number (MPN), and taxonomy code(s) until their Ready Letter arrives by mail. Continuing to submit the MPN in the meantime will avoid any potential interruption in payment.

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

Attention: All Providers

National Provider Identifier Provider Ready Letter

DMA encourages all providers (except pharmacies and atypical providers) to continue to submit their National Provider Identifier (NPI), Medicaid Provider Number (MPN), and taxonomy on all claims until they receive an NPI Provider Ready letter confirming that their claims are mapping correctly to the MPN submitted on the claim. DMA began mailing the NPI Provider Ready letters to providers on May 16, 2008. After receiving the letter, providers may begin submitting claims without their MPN.

Refer to future general Medicaid bulletins for additional information on the Provider Ready letters.

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

Attention: All Providers

How National Provider Identifier Implementation Will Affect Remittance and Status Reports

Beginning with the first checkwrite following the implementation of National Provider Identifiers (NPIs) on May 23, 2008, only the NPI will be reported on the 835 electronic remittance advice (ERA). Since Medicaid will still be processing and paying claims based on the Medicaid Provider Number (MPN), providers may receive multiple 835 ERAs, depending on the number of MPNs for which claims were processed. A separate 835 ERA will be sent for each MPN but only the NPI will be listed on the 835 ERA.

The paper RA was modified in January to include both the NPI and the MPN.

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

Attention: All Providers

Prior Approval Requests Using the Medicaid Provider Number

With the implementation of National Provider Identifiers (NPIs), there has been no change in the process for obtaining prior approval. At this time, N.C. Medicaid providers will continue to submit prior approval requests using their legacy Medicaid Provider Number (MPN). Providers should verify that the MPN under which prior approval was obtained is properly associated with the NPI to be billed on the claim. This can be verified by accessing the DMA NPI and Address Database at http://www.ncdhhs.gov/dma/WebNPI/default.htm.

Providers are also reminded to submit their claims using the site facility and/or billing address ZIP+4 code and the correct taxonomy code associated with the service(s) they provide. Accuracy of this information is vital in order to determine the correct MPN to be used for claim adjudication, especially if the NPI is enumerated as one-to-many.

Claims processing rules have not changed with the implementation of NPI.

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

Attention: All Providers

Individuals with Multiple Provider Numbers

DMA has identified a number of individual providers with more than one Medicaid Provider Number (MPN) for the specific service they are enrolled to provide. (For example, an individual physician employed by a physician group with more than one site using one Medicaid Provider Number to bill for services provided at one site and a second Medicaid Provider Number to bill for services provided at the second site.)

Effective August 1, 2008, all individual providers will be required to maintain one service-specific MPN to ensure that claims process correctly when billing with National Provider Identifiers. DMA will end-date all but one of the provider's MPNs.

Individual providers who have been identified as having more than one service-specific MPN will be notified by mail 30 days prior to this administrative action. The letter will inform the individual provider that all previously assigned MPNs will be end-dated and will identify the MPN that is assigned to the provider for the service he or she is enrolled to provide.

Please note that the requirement to maintain one MPN does not apply to an individual provider who is enrolled with Medicaid to provide services in more than one program area. (For example, a psychiatrist who is also enrolled as a licensed psychologist providing services as an outpatient mental health practitioner.) Nor does the requirement apply to group providers, such as a home health agency that is enrolled with N.C. Medicaid as a home health provider and a Community Alternatives Program provider. In these cases, the provider must maintain each MPN that is specific to the services they are enrolled to provide.

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

Attention: All Providers

National Provider Identifier Implementation

Effective May 23, 2008, all claims must contain a National Provider Identifier (NPI). N.C. Medicaid will no longer accept claims submitted without an NPI on or after 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.

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

Attention: All Providers

National Provider Identifier/Medicaid Provider Number Mismatch

Analysis has found that some providers are submitting a different National Provider Identifier (NPI) on claims than what was reported to DMA for their Medicaid Provider Number (MPN). Once providers no longer submit claims with the MPN, claims will process based on the NPI reported for the MPN(s) in the provider database. Therefore, it is imperative that providers use the same NPI on claims.

N.C. Medicaid is sending a letter to providers who are submitting claims using a different NPI. Each NPI/MPN mismatch is listed in the letter. Please note that only claims submitted with an NPI, MPN, and taxonomy code are eligible for this letter. In addition, providers will receive a letter if they submit a claim with an NPI that has not been reported to DMA. Letters are mailed out each checkwrite.

Tips to remember regarding mismatch letters:

1. Providers can report a maximum of one NPI per MPN. Multiple MPNs can be reported for one NPI, but the reverse situation is not allowed.
2. The mismatch letter IS NOT a claim denial. It is an informational letter. However, future claims may be affected if no action is taken.
3. If claims are automatically crossing over from Medicare, Medicaid must have the NPI submitted on the crossover claim on the DMA provider file.
4. There are two types of NPIs: organizational and individual. The same NPI cannot represent both an organization and an individual MPN.

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

To update or change an NPI on file with DMA, print the correction form from the NPI and Address Database (http://www.ncdhhs.gov/dma/WebNPI/default.htm), make the appropriate change, and fax the form to DMA Provider Services. Allow two weeks for updates to be processed.

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

Attention: All Providers

Clinical Coverage Policies

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

General Clinical Policy A2, Over-the-Counter Medications (5/9/08)

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

Electrocardiography, Echocardiography, and Intravascular Ultrasound

Effective with date of service March 1, 2008, electrocardiograms are covered up to four times per day. It is no longer necessary to bill CPT procedure codes 93000, 93005, and 93010 with modifiers 76 and 77 for more than one electrocardiogram provided on the same day per recipient.

Effective with date of service March 1, 2008, the following procedures must be billed with an approved primary ICD-9-CM diagnosis code to qualify for reimbursement.

- Microvolt T-wave alternans, CPT code 93025
- Holter monitoring, CPT codes 93224 through 93237
- Ambulatory cardiac event monitoring, CPT codes 93268 through 93272
- Signal-averaged electrocardiography, CPT code 93278
- Coronary intravascular ultrasound, CPT codes 92978 through 92979

Refer to Clinical Coverage Policy 1R-4, *Electrocardiography, Echocardiography, and Intravascular Ultrasound*, on DMA's website at http://www.ncdhhs.gov/dma/mp/mpindex.htm for the list of applicable primary diagnosis codes.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

HCPCS Procedure Code Changes for the Physician's Drug Program

The following changes have been made to comply with CMS HCPCS procedure code changes.

New HCPCS Procedure Codes

The following HCPCS procedure codes were added to the list of covered codes for the Physician's Drug Program effective with date of service April 1, 2008.

New HCPCS Code	Description	Unit
Q4096	Injection, von Willebrand factor complex, human, ristocetin cofactor (not otherwise specified), per I.U. vWF:RCO	Per IU
J7187	Injection, von Willebrand factor complex, (Humate-P), per I.U. vWF:RCO	Per IU

End-Dated Codes with Replacement Codes

The following HCPCS procedure codes were end-dated with date of service March 31, 2008, and replaced with new codes effective with date of service April 1, 2008. Claims submitted for dates of service on or after March 31, 2008, using the end-dated codes will be denied.

End-Dated HCPCS Code	Description	Unit	New HCPCS Code	Description	Unit
J1751	Injection, iron dextran, 165	50 mg	Q4098	Injection, iron dextran	50 mg
J1752	Injection, iron dextran, 267	50 mg	Q4098	Injection, iron dextran	50 mg

New Code Previously Billed with the Miscellaneous Drug Code J3590

Effective with date of service April 1, 2008, the N.C. Medicaid program covers Privigen with the individual HCPCS procedure code listed in the following table. Claims submitted for dates of service on or after March 31, 2008, using the unlisted biologics code (J3590) for this immune globulin will be denied. An invoice is not required. The 11-digit NDCs code(s) are required.

Old HCPCS Code	Description	Old Unit	New HCPCS Code	Description	New Unit
J3590	Injection, immune globulin (Privigen), intravenous non-lyophilized (e.g., liquid)	500 mg	Q4097	Injection, immune globulin (Privigen), intravenous, non-lyophilized, (e.g., liquid)	500 mg

Refer to the fee schedule for the Physician's Drug Program on DMA's website at http://www.ncdhhs.gov/dma/fee/fee.htm for the latest available fees.

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

Attention: All Providers

Independent Practitioner Program Seminar Update

To allow staff to focus on customer support for the implementation of the National Provider Identifiers on May 23, 2008, the Independent Practitioner Program seminars announced in the May 2008 general Medicaid Bulletin have been cancelled.

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

Attention: All Providers

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

The 14 regional training sessions scheduled for May 26, 2008 through July 11, 2008, on the new Uniform Screening Program (USP) and the N.C. Medicaid Uniform Screening Tool (MUST) have been **cancelled.** DMA has delayed implementation and statewide rollout of the full MUST, but will continue to develop options for referrals to Medicaid long-term care programs and services. Following a pilot project, training will be provided throughout the state on the full MUST and the revised procedures for making Medicaid referrals.

Please note that the PASARR-only screen **WILL BE** implemented as planned in September 2008. Six regional training programs that will address the use of the MUST for PASARR will be scheduled; details will be announced at a later date.

For additional information regarding new implementation plans, as well as information regarding the regional training sessions for PASARR, please visit http://www.ncmust.com or refer to future general Medicaid bulletins.

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. The DRA 2005 does not exclude 340B providers; therefore, 340B providers must also meet these requirements.

Effective with date of processing July 1, 2008, for claims with dates of service on or after December 28, 2007, 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 (5/20/08) of the October 2007 Special Bulletin, *National Drug Code Implementation* (http://www.ncdhhs.gov/dma/bulletinspecial.htm), and the November 2007 National Drug Code seminar presentation (http://www.ncdhhs.gov/dma/services/physiciandrug.html) for additional information.

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

Attention: Institutional (UB-04) Claim Filers

UB-04 Bill Type Code Changes

Effective with date of processing April 25, 2008, psychiatric hospital lower level of care beds should use Bill Type **66X** for services previously billed under bill type 17X or 18X. This change is being implemented due to a definition change in the *UB-04 Manual.* Claims submitted with Bill Type 17X or 18X will deny after April 25, 2008.

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

Attention: CAP/DA Lead Agencies

Automated Quality and Utilization Improvement Program Quarterly Training Seminar

The Carolinas Center for Medical Excellence (CCME) (http://www.thecarolinascenter.org) announces continued quarterly training for new users of the Automated Quality and Utilization Improvement Program (AQUIP) by CAP/DA lead agencies.

The second quarterly training session this year will be held on June 24, 2008, at the Days Inn in Southern Pines. 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 new users in their counties who should attend this session. We recommend that all attendees read and become familiar with the AQUIP User Manual prior to the training session. The manual is available on the AQUIP website (https://www2.mrnc.org/aquip) under "Downloads." Current users who would like to attend the session may do so if space is available. However, the information presented is intended for new users.

The seminar is scheduled to begin at 9:00 a.m. and end at 3:00 p.m. The session will provide information on Resource Utilization Group (RUG) scores, and will focus on accurately completing the three parts of the AQUIP tool (client information sheet, data set assessment, and plan of care), and resolving common data entry errors. The session will end with an overview of Health Check/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for Medicaid eligible recipients under the age of 21.

Pre-registration is required. New AQUIP users should contact their CAP/DA lead agency to verify that their names are on the required attendance list. Online registration for the seminar will be available beginning June 2, 2008 and can be accessed by going to https://www2.mrnc.org/aquip and clicking on "Training Sessions." Attendees will receive a computer-generated confirmation number, which they should bring to the seminar. Check-in will be from 8:30 a.m. until 9:00 a.m. on the day of the seminar; lunch will be on your own.

CCME, 1-800-682-2650

Attention: CAP/MR-DD Service Providers

Clarification of Cost Reporting Requirements for CAP/MR-DD Service Providers

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 CAP/MR-DD providers within the 2008 Mental Health Cost Report administered by the Department of Health and Human Services (DHHS) Office of the Controller and will no longer require a **separate** cost report after the FY 2007 reporting cycle. The current 2007 CAP/MR-DD Closeout Cost Report or the 2007 Mental Health Report are still required to be submitted by the September 30, 2008 due date. However, providers must submit the cost report to the DHHS Office of the Controller instead of DMA.

For example, providers who provided **only** CAP/MR-DD services and whose fiscal year ended on December 31, 2007, are required to file an annual cost report **but have the choice** of filing **either** the 2007 CAP/MR-DD **Closeout** Cost Report **or** the 2007 Mental Health Cost Report using their January 1, 2007 through December 31, 2007 cost data.

Exemptions for CAP/MR-DD providers with service revenue of less than $500,000 will remain in place for the current FY 2007 reporting cycle, and will also apply to those providers who are currently in the middle of their fiscal year. For any fiscal years starting on or after July 1, 2008, the exemptions will no longer apply and all CAP/MR-DD providers will be required to file the Mental Health Cost Report with the DHHS Office of the Controller.

Training sessions have been scheduled to familiarize providers with the instructions and data requirements needed to complete the Mental Health Cost Report. To find out about training session locations, times, and registration, please go to the DHHS Office of the Controller's website at http://www.ncdhhs.gov/control/amh/amhauth.htm and read the CAP/MR-DD & Residential Treatment Providers Mental Health Cost Report Training Memo.

Contact Information

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

For all questions relating 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: Children's Developmental Service Agencies, Health Departments, Home Health Agencies, Independent Practitioners, Local Management Entities, Outpatient Hospital Clinics, and Physicians

Prior Authorization of Outpatient Specialized Therapies: Survey Results

In March 2008, providers were asked by The Carolinas Center for Medical Excellence (CCME) to complete a survey on the outpatient specialized therapies prior authorization process. We would like to take this opportunity to thank you for making the survey such a success! CCME received 328 responses from providers across the state who provided feedback regarding the prior authorization process and improvements they would like to see in the future. The results of the survey, along with answers to some of the most frequently asked questions, are now available on CCME's prior authorization website at https://www2.mrnc.org/priorauth/ and can be accessed via the "Resources" link on the home page. CCME is taking this valuable information and working to make the prior authorization process even more user-friendly for the future.

CCME, 1-800-228-3365

Attention: Community Care of North Carolina/Carolina ACCESS Providers, Direct-enrolled Mental Health Practitioners, Local Management Entities, and Psychiatrists

Community Care of North Carolina/Carolina ACCESS Override for Mental Health Services Performed by a Direct-enrolled Mental Health Practitioner

Direct-enrolled mental health practitioners who provide services to a Community Care of North Carolina/Carolina ACCESS (CCNC/CA) enrollees under the age of 21 years must have a referral from the CCNC/CA primary care provider, a Medicaid-enrolled psychiatrist or the Local Management Entity (LME). When the service is provided without an appropriate referral, an override cannot be given by CCNC/CA.

It is the responsibility of the direct-enrolled mental health provider to make sure he or she has a referral before services are rendered. If treatment is provided without a referral from one of these three entities, the service provider's claim will be denied with EOB 2270, which states: "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."

Managed Care
DMA, 919-647-8170

Attention: Nurse Practitioners and Physicians

Bendamustine Hydrochloride (Treanda, J9999) – Billing Guidelines

Effective with date of service March 1, 2008, the N.C. Medicaid program covers bendamustine hydrochloride, lyophilized powder, 100 mg/20 mL single-use vials (Treanda) for use in the Physician's Drug Program when billed with HCPCS code J9999 (chemotherapy, unspecified product). Treanda is indicated for the treatment of patients with chronic lymphocytic leukemia (CLL).

Treanda should be administered as a 100 mg/m^2 IV infusion over 30 minutes on days one and two of a 28-day cycle for up to six cycles.

For Medicaid Billing

- The ICD-9-CM diagnosis codes required for billing Treanda are
  - ♦ 204.10 (Lymphoid leukemia, chronic, without mention of remission)

    OR
  - ♦ 204.11 (Lymphoid leukemia, chronic, in remission)

    AND
  - ♦ V58.11 (Admission or encounter for chemotherapy)
- Providers should bill Treanda with HCPCS code J9999 (chemotherapy, unspecified product).
- One Medicaid unit of coverage is one single-use vial, 100 mg. Treanda is supplied as a single-use vial; therefore, billing of a whole vial, including wastage, is permitted.
- Providers must bill with the 11-digit NDC code; a paper invoice is not required. The NDC units must also be indicated. When calculating the NDC units used, the drug in its original state must be considered, NOT the reconstituted amount. Refer to the revised version (5/20/08) of the October 2007 Special Bulletin, *National Drug Code Implementation* (http://www.ncdhhs.gov/dma/bulletinspecial.htm), for instructions.
- Providers must indicate the number of HCPCS units used in block 24G on the CMS-1500 claim form.
- Providers must bill their usual and customary charge.

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

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

Attention: Health Departments

Reimbursement of Immunization Administration Codes for the Health Check Population

Effective with date of service July 1, 2008, the N.C. Medicaid Program covers an immunization administration fee for each vaccine provided to Health Check recipients ages 0 through 20 years, when the immunizations are not provided as part of a Health Check screening visit.

For dates of service prior to July 1, 2008, immunization administration fees are billed with only one code (CPT procedure code 90465 EP when physician counseling was performed or 90471 EP when no physician counseling was performed) and are reimbursed at one rate regardless of the total number of injectable immunization administrations performed. A single intranasal/oral immunization given in the same encounter is reimbursed in addition to the injectable vaccines.

The immunization administration codes affected by this change on July 1, 2008, are as follows:

CPT Code	Definitions
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) Note: This add-on code is used when the physician counsels the patient/family.
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous or intramuscular injections); one vaccine (single or combination vaccine/toxoid)
90472	Each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure)

An immunization administration fee may not be billed if the immunization(s) is provided in addition to a Health Check screening visit. The immunization administration CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473 or 90474 with the EP modifier may be billed if immunizations are the only services provided that day or if any immunizations are provided in conjunction with an **office visit.**

- Administration of one injectable vaccine is billed with CPT code 90471 (one unit) or 90465 (one unit) with the **EP** modifier.
- Additional injectable immunization administrations are billed with CPT code 90472 or 90466 with the **EP** modifier. The appropriate number of units must be billed for each additional immunization administration CPT procedure code, and the total charge for all units must be reflected on the detail.
- Administration of **one vaccine that is an intranasal/oral immunization** is billed with the administration CPT code 90467 with the EP modifier or with 90473 with the EP modifier.

  Note: CPT codes 90467 or 90473 may be billed only if the intranasal/oral vaccine is the only immunization provided on that date of service. Neither code may be billed with another immunization administration code on that date of service. (See next paragraph for further clarification.) A second intranasal/oral immunization may not be billed at this time.

- Administration of an intranasal/oral immunization vaccine provided in addition to one or more injectable immunization administrations is billed with CPT code 90468 or 90474 with the EP modifier.
- CPT vaccine codes for the vaccines administered must be reported or billed, as appropriate, even if the administration codes are not being billed.

Please refer to the *2008 Health Check Billing Guide* at http://www.ncdhhs.gov/dma/healthcheck.htm for detailed billing instructions. No additional changes are being made at this time regarding other immunization administration codes or for recipients over 20 years of age.

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

Attention: Pharmacists and Prescribers

New Prior Authorization Program for Brand-name Narcotics

On August 4, 2008, the N.C. Medicaid Outpatient Pharmacy program will implement a new prior authorization (PA) program for brand-name schedule II (CII) narcotics. On this date, pharmacists may receive a point-of-sale message that PA is required for brand-name prescriptions in this drug class. Brand-name short-acting and long-acting CII narcotics will require PA. This PA program will replace the current Oxycontin PA program. PA will not be required for recipients with a diagnosis of pain secondary to cancer.

If a pharmacy provider receives a point-of-sale message that PA is required, the prescriber may 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 brand-name narcotics will be available on the N.C. Medicaid Enhanced Pharmacy Program website at http://www.ncmedicaidpbm.com.

If the PA is approved and a brand-name narcotic medication is dispensed when a generic version is available, "medically necessary" must be written on the face of the prescription in the prescriber's own handwriting.

Prescribing clinicians are encouraged to review the N.C. Medical Board's statement on use of controlled substances for the treatment of pain when prescribing narcotics. This statement may be found at http://www.ncmedboard.org/Clients/NCBOM/Public/NewsandForum/mgmt.htm.

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

Attention: Pharmacists

Maintaining Hard Copies of Prescriptions

Many pharmacies are moving toward the use of systems that allow prescriptions to be scanned into a computer. The N.C. Medicaid Program requires that hard copies of prescriptions must be retained as stated in DMA's Medicaid Participation Agreement. From Section A.5, "The aforementioned provider agrees to participate in the North Carolina Medicaid Program and agrees to abide by the following terms and conditions: . . . Maintain for a period of five (5) years from the date of service: (a) accounting records in accordance with generally accepted accounting principles and Medicaid recordkeeping requirements; and (b) other records as necessary to disclose and document fully the nature and extent of services provided and billed to the Medicaid Program. For providers who are required to submit annual cost reports, 'records' include, but are not limited to, invoices, checks, ledgers, contracts, personnel records, worksheets, schedules, etc. Such records are subject to audit and review by Federal and State representatives."

Additionally, Section C of the Participation Agreement states that all pharmacy providers are required to "file prescriptions numerically and in chronological order, either in normally occurring order with other prescriptions filled by the provider or in a separate file."

Furthermore, important legislation was passed by Congress in May 2007 requiring prescriptions for all Medicaid outpatient drugs to be written on tamper-resistant prescription pads. This requirement was included in a provision in Section 7002(b) of the US Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007. States have been charged with implementation and monitoring of this federal requisite in order to be eligible for federal reimbursement. In order to fully assess providers' compliance with this federal mandate, it is reasonable to conclude that there are instances in which auditors, investigators or entities working on behalf of DMA would need access to the original hard copies of prescriptions. It is the position of DMA that all hard copies of prescriptions should be maintained on-site and readily retrievable for a period of not less than five years from the date of service.

Krista Kness, RPh, Program Integrity Pharmacy Review Section
DMA, 919-647-8000

Attention: Pharmacists

Pharmacy Audits

Pursuant to federal regulations regarding utilization of Medicaid services, DMA is authorized by Section 1902 (a)(27) of the Social Security Act and Federal Regulation 42 CFR 431.107 to access patient prescriptions for purposes directly related to the administration of the Medicaid program. Therefore, special permission from the recipient is not necessary for releasing this information. In addition, when applying for Medicaid benefits, each recipient signs a release, which authorizes access to his or her Medicaid records by the appropriate authorities.

The N.C. Medicaid Program is not required to give advance notice of intent to audit. Section B.5 of the Medicaid Participation Agreement states that the provider understands and agrees "That Federal and/or State officials and their contractual agents may make certification and compliance surveys, inspections, medical and professional reviews, and audit of costs and data relating to service to Medicaid patients as may be necessary under Federal and State statutes, rules and regulations. Such visits must be allowed at any time during hours of operation, including unannounced visits. All such surveys, inspections, reviews and audits will be in keeping with both legal and ethical practice governing patient confidentiality."

Section B.10 further states that "DMA may terminate this agreement upon giving written notice or refuse to enter into an agreement when: (a) The provider fails to meet conditions for participation, including licensure, certification or other terms and conditions stated in the provider agreement."

Section A.5 states that the provider must "maintain for a period of five (5) years from the date of service: (a) accounting records in accordance with generally accepted accounting principles and Medicaid recordkeeping requirements; and (b) other records as necessary to disclose and document fully the nature and extent of services provided and billed to the Medicaid Program. . . . Such records are subject to audit and review by Federal and State representatives."

Our audits, investigations, and inspections are health oversight activities and are subject to the oversight Fraud and Abuse exemption of HIPAA. These disclosures are required by law, and are not subject to minimum necessary 45 CFR 164.502(b)(2)(v). Any disclosures beyond that clearly allowed are considered incidental exposures and are permitted under 45 CFR 164.502(a)(1)(iii). Additionally, 45 CFR 164.506(a) and 45 CFR 164.512(k) support DMA's right to request private health information.

Impeding or refusing a N.C. Medicaid audit may result in DMA implementing sanctions including, but not limited to, permanent or temporary termination of participation and/or recoupments.

Ann Slade, RPh, Program Integrity Pharmacy Review Section Chief
DMA, 919-647-8000

Krista Kness, RPh, Program Integrity Pharmacy Review Section
DMA, 919-647-8000

Attention: Pharmacists and Prescribers

Updated Prescription Advantage List

The Prescription Advantage List (PAL) has been updated and now includes an interactive tool and PAL Pocket Card. The PAL includes some of the most costly medications covered by the N.C. Medicaid Outpatient Pharmacy program. The medications in each drug class listed on the PAL are ranked in order from least to most expensive and placed in a tier. The tier that a drug is placed in is based on an evaluation of the net cost per unit of the medication, including rebates. The tiers are calculated on a quartile distribution system utilizing all medications' net cost per unit in the drug class. The lowest cost medications are tier 1 medications and the most expensive medications are tier 4 medications. The PAL is intended as an educational tool based on cost alone; no judgment as to the efficacy is implied.

Medications listed on the PAL Pocket Card were identified using more stringent criteria than the tier methodology. The following criteria had to be met for the drug to be on the PAL Pocket Card:

- The drug was identified as a drug or drug class commonly prescribed by N.C. Medicaid prescribers.
- The drugs are in a drug class with a significant price differential between drugs based on cost analysis from the most recent quarter available and a review of 6 to 9 months of prior data.
- Evidence exists to compare efficacy and safety between the drugs in the class, as well as in clinical trials, with head-to-head comparisons of drugs within the class when available.

The PAL and the PAL Pocket Card can be found on DMA's website at http://www.ncdhhs.gov/dma/pharmacy.htm and on the N.C. Physicians Advisory Group website at http://www.ncpag.org.

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

Attention: Physicians

Endoscopic Retrograde Cholangiopancreatography

Effective with date of service January 1, 2007, Medicaid covers endoscopic retrograde cholangiopancreatography; with endoscopic retrograde destruction, lithotripsy of calculus/calculi, any method when billed with CPT code 43265.

Providers with denied claims for dates of service January 1, 2007, and after may resubmit these claims as new claims. Claims must be submitted within 18 months of the denial.

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

Attention: Residential Treatment Facility Providers

Clarification of Cost Reporting Requirements for Residential Treatment Facility Providers

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 within the 2008 Mental Health Cost Report administered by the Department of Health and Human Services (DHHS) Office of the Controller, and will no longer require a **separate** cost report after the FY 2007 reporting cycle. The current 2008 Residential Treatment Cost Reports are still required to have been submitted to DMA by the May 31, 2008 due date.

Exemptions for residential treatment providers with service revenue of less than $230,000 will remain in place for the current FY 2007 reporting cycle, and will also apply to those providers who are currently in the middle of their fiscal year. For any fiscal years starting on or after July 1, 2008, the exemptions will no longer apply and all residential treatment providers will be required to file the Mental Health Cost Report with the DHHS Office of the Controller.

Training sessions have been scheduled to familiarize providers with the instructions and data requirements needed to complete the Mental Health Cost Report. To find out about training session locations, times, and registration, please go to the DHHS Office of the Controller's website at http://www.ncdhhs.gov/control/amh/amhauth.htm and read the CAP/MR-DD & Residential Treatment Providers Mental Health Cost Report Training Memo.

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

For all questions relating to the 2008 Residential Treatment Cost Report, contact Elizabeth John at Elizabeth.John@ncmail.net or 919-855-4200.

Rate Setting
DMA, 919-855-4200

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
June	06/05/08	06/10/08
	06/12/08	06/17/08
	06/19/08	06/26/08
July	07/03/08	07/08/08
	07/10/08	07/15/08
	07/17/08	07/22/08
	07/24/08	07/30/08

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