



June 2009 Medicaid Bulletin

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**Providers are responsible for informing their billing agency of information in this bulletin.
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All rights reserved. Applicable FARS/DFARS apply.**

Attention: All Providers***E*lectronic Claims Submission and Fund Transfers**

As a cost saving measure and to increase efficiency, the N.C. Medicaid Program will require all providers to file claims and receive payments electronically. The date for the implementation of this requirement and further instructions including a list of exceptions for electronic claims submission will be published in the July General Medicaid Bulletin. This bulletin serves as a preliminary notice so that providers may begin to make the necessary business changes to accommodate this requirement. If you are already filing claims and receiving payments electronically, no further action is needed.

Electronic Claims Submission

Providers who did not complete an Electronic Claims Submission Agreement at the time of their enrollment must now complete and submit an Electronic Claims Submission Agreement. The Electronic Claims Agreement must be submitted and approved prior to submitting claims electronically regardless of whether you are submitting your claims through a clearinghouse, with software obtained from an approved vendor, or through the NCECSWeb Tool. Once notification of approval is received, providers must contact the EDS Electronic Commerce Services Unit (1-800-688-6696 or 919-851-8888, option 1) to obtain a logon ID and password for electronic claims submission.

Group providers must submit the name and Medicaid Provider Number for each individual provider affiliated with their group for whom they will be submitting claims using their group provider number. This is required even if there is only one provider in the group. The Electronic Claims Submission Agreement for the group must be signed by each individual provider, which authorizes the group to use the individual's National Provider Identifier to bill Medicaid for services provided.

To obtain a copy of this agreement for either a group or an individual, visit CSC's website at <http://www.nctracks.nc.gov/provider/forms/>.

Providers and clearinghouses that bill HIPAA-compliant transactions directly to N.C. Medicaid are required to complete and submit a Trading Partner Agreement (TPA) to N.C. Medicaid. The TPA stipulates the general terms and conditions by which the partners agree to exchange information electronically. The form is available on DMA's website at <http://www.ncdhhs.gov/dma/provider/forms.htm>.

Submitting claims electronically offers providers a low-cost, highly reliable alternative to paper claim submission. Claims submitted electronically are processed faster than paper claims, so payments are received more quickly. Claims submitted electronically by 5:00 p.m. on the cut-off date are processed on the following checkwrite.

Providers have many options for submitting claims electronically.

- Billing with the NCECSWeb Tool
- Billing with software obtained from a vendor
- Billing with software written by your office or company
- Billing through a clearinghouse

Additional information regarding billing claims electronically is available in the Basic Medicaid Billing Guide on DMA's website at <http://www.ncdhhs.gov/dma/basicmed/> or by calling the EDS Electronic Commerce Services Unit at 1-800-688-6696 or 919-851-8888, option 1.

Electronic Funds Transfer (Automatic Deposit)

To initiate the automatic deposit process, providers must complete and return the Electronic Funds Transfer Authorization Agreement for Automatic Deposit form and attach a voided check to confirm the provider's account number and bank transit number. A separate EFT form must be submitted for each provider number. Providers must submit a new EFT form if they change banks or bank accounts. A copy of the form can be obtained on DMA's website at <http://www.ncdhhs.gov/dma/provider/forms.htm>.

Completed forms can be returned by fax to the EDS financial unit at 919-816-3186 or by e-mail to EFT@ncxix.hcg.eds.com. Providers will continue to receive paper checks for two checkwrite periods before automatic deposits begin or resume to a new bank account. Providers can verify that the EFT process for automatic deposits has been completed by checking the top left corner of the last page of their RA, which will indicate **EFT number** rather than **check number**.

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

Attention: All Providers

CPT Procedure Codes 93307, 93320, 93321, and 93325

According to the CPT 2009, procedure codes 93320, 93321, and 93325 **can** be provided with procedure code 93351 (echocardiography, transthoracic, real-time with image documentation, includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision). These changes are effective with date of service January 1, 2009.

Providers who received denials with the following EOB codes for the CPT procedure codes listed below when billed with procedure code 93351 for dates of service on January 1, 2009, and after may resubmit new claims (not adjustments) for processing.

CPT Code	Description	EOB	Description
93320	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; complete	1478	Doppler echocardiography, pulsed wave; complete must bill with related procedure
93321	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; follow-up or limited study	1479	Doppler echocardiography, pulsed wave; follow up must bill with related procedure
93325	Doppler echocardiography color flow velocity mapping	1483	Doppler color flow velocity mapping must bill with related procedure

Also according to CPT 2009, procedure code 93307 (echocardiography, transthoracic, real-time with image documentation [2D], includes M-mode recording, when performed, complete without spectral or color Doppler echocardiography) **cannot** be provided with procedure codes 93320, 93321, and 93325 effective with date of service January 1, 2009.

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

Attention: All Providers***D*enials of CPT Procedure Code 29873 with Modifier 51**

Billing of CPT procedure code 29873 (arthroscopy, knee, surgical; with lateral release) with modifier 51 (multiple procedures) was end-dated effective with date of service October 1, 2006, in compliance with a directive from CMS.

Providers who received a denial for CPT procedure code 29873 with EOB 7996 (Only one surgical code per day is allowed as the primary procedure. Another code has already been billed as primary for this DOS. Correct detail by appending 51 and rebill.), for dates of service since October 1, 2006, and after may resubmit new claims (not adjustments) for processing following time limit procedures.

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

Attention: All Providers***D*enials of CPT Procedure Codes 96360, 96365, 96374, and 96375**

CPT procedure codes listed in the Hydration, Therapeutic, Prophylactic, Diagnostic Injections, and Infusions section of CPT 2008 were end-dated and replaced with new codes effective with date of service January 1, 2009.

Providers who received a denial with the following EOBs for the CPT procedure codes listed below for dates of service on January 1, 2009, and after may resubmit new claims (not adjustments) for processing.

CPT Code	Description	EOB	Description
96360	Intravenous infusion, hydration; initial 31 minutes to 1 hour	3765	Intravenous infusion, hydration must be billed with primary procedure code.
96365	Intravenous infusion, for therapy, prophylaxis or diagnosis; initial, up to 1 hour	3765	Intravenous infusion, hydration must be billed with primary procedure code.
96374	Intravenous push, single or initial substance/drug	3765	Intravenous infusion, hydration must be billed with primary procedure code.
		2066	Immunization administration and therapeutic injections not allowed same day as E/M
96375	Each additional sequential intravenous push of a new substance/drug	2066	Immunization administration and therapeutic injections not allowed same day as E/M

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

Attention: All Providers**Implementation of Utilization Management by Local Management Entities**

N.C. Session Law 2008–107, Section 10.15(x), requires the Department of Health and Human Services to return the service authorizations, utilization reviews, and utilization management functions to the Local Management Entities (LMEs). In the March 2009 General Medicaid Bulletin, providers were notified that four LMEs had been selected to perform this function and that implementation was planned for July 1, 2009.

DMA is continuing to work on transferring the utilization review functions to the LMEs to meet the intent of the legislation. However, due to factors such as the state of the economy, the magnitude of the required system changes, and other budget concerns, we do not anticipate being able to implement until January 2010.

Prior to implementation, there will be provider training and outreach. Providers will know the implementation plans well in advance of the effective date. DMA will use the Medicaid Bulletins and the Implementation Updates from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and DMA to keep providers informed and up to date on activities.

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

Attention: All Providers**Change in Procedure Codes Covered Under the Family Planning Waiver**

Effective with date of service May 1, 2009, based on guidance from CMS, providers are no longer able to bill and receive reimbursement for the following CPT procedure codes for Medicaid recipients under the MAFD coverage category:

- CPT procedure code 00840 (anesthesia for intraperitoneal procedures in the lower abdomen including laparoscopy; not otherwise specified)
- CPT procedure code 99281 (emergency department visit)
- Revenue codes 450 through 459

This means that MAFD recipients are not covered to receive any services under the Family Planning Waiver Program in an emergency department.

CPT procedure code 00840 cannot be used when billing for anesthesia associated with a sterilization procedure for an MAFD recipient. Providers must use either CPT procedure code 00851 (anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transaction) or 00921 (anesthesia for procedure on male genitalia [including open urethral procedures]; vasectomy, unilateral or bilateral).

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

Attention: All Providers**Changes to Prior Authorization Criteria for Growth Hormones**

Effective with date of service May 4, 2009, and after, the N.C. Medicaid Outpatient Pharmacy Program revised the prior authorization criteria for growth hormones to include coverage for children with craniopharyngiomas, multiple pituitary hormone deficiencies (panhypopituitarism), and unexplained short stature. Revisions also include criteria for continuation of therapy in adults and in children.

Prescribers can request prior authorization by contacting ACS at 866-246-8505 (telephone) or 866-246-8507 (fax). Prescribers requesting prior authorization of growth hormones by fax have two new forms available to choose from when making their requests: one for children under 21 years of age, and one for adults 21 years of age and older.

The updated criteria and new prior authorization request forms for these medications are available on the N.C. Medicaid Enhanced Pharmacy Program website at <http://www.ncmedicaidpbm.com/>.

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

Attention: All Providers**Changes to Prior Authorization Criteria for Sedative Hypnotics**

Effective with date of service of May 15, 2009, and after, the N.C. Medicaid Outpatient Pharmacy Program revised the sedative hypnotic prior authorization criteria to allow coverage for only 15 tablets/capsules **per drug class** in a calendar month without a prior authorization. Quantities greater than 15 tablets/capsules per drug class per calendar month will require a prior authorization.

Prescribers can request prior authorization by contacting ACS at 866-246-8507 (fax). Prior authorization requests for these medications will be accepted by fax and U.S. mail only. The signature of the prescriber on the request form is required as an important safeguard against fraud and abuse.

The updated criteria for coverage of these medications are available on the N.C. Medicaid Enhanced Pharmacy Program website at <http://www.ncmedicaidpbm.com/>.

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

Attention: All Providers**Genotyping and Phenotyping for HIV Drug Resistance Testing**

Effective with date of service July 1, 2008, the unit limit for CPT procedure code 87904 (infectious agent phenotype analysis by nucleic acid [DNA or RNA] with drug resistance tissue culture analysis, HIV 1; each additional drug tested) was increased from eight units to nine units, as outlined in Clinical Coverage Policy #1S-1, *Genotyping and Phenotyping for HIV Drug Resistance Testing* (<http://www.ncdhhs.gov/dma/mp/>). Providers may submit new claims for the additional unit for dates of service July 1, 2008, and after as long as the claims are filed within 12 months of the original date of service.

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

Attention: All Providers**Updates Related to National Drug Code Project**

As of date of processing June 26, 2009, for dates of service on and after December 28, 2007, all providers billing for drugs are impacted by the following edit updates for claims processing with National Drug Codes (NDCs). These additional edits are necessary to capture accurate NDC information from providers.

Denial of DESI Products

The FDA's Drug Efficacy Study Implementation (DESI) Program evaluates the safety and effectiveness of drugs. The DESI Program reviews drugs that were previously determined to be safe but lacked an evaluation of their effectiveness. If a drug has been determined DESI code 5 (less than effective) or DESI code 6 (less than effective and withdrawn from market), the drug will no longer be eligible for Medicaid coverage per CMS mandate. Claims submitted with NDCs identified as DESI code 5 or 6 will be denied with EOBs 9930 through 9940 (NDC is DESI [Less-than-effective]).

Denial of Non-covered Over-the-Counter Medications

To determine over-the-counter drug coverage under N.C. Medicaid, refer to General Clinical Policy #A-2, *Over-the-Counter Medications* (<http://www.ncdhhs.gov/dma/mp/>).

If an over-the-counter drug is not covered by N.C. Medicaid, the claim will be denied with EOBs 9941 through 9951 (NDC is non-covered either by DMA or CMS mandate).

Institutional billers may submit claims for non-covered over-the-counter drugs using Revenue Code 637 and may list the charges as non-covered. RC637 does not require HCPCS procedure code or NDC information. RC637 charges can be listed as patient liability using Value Code 31.

If an over-the-counter drug is covered, it can be billed using Revenue Code 25X with a HCPCS procedure code and NDC information.

Multi-NDC Claims Suspended for Manual Review

Claims submitted with more than one NDC per detail will be suspended for manual review of the NDC units. The NDC units will be reviewed and the claim will be denied if the NDC units do not correspond to the value of the submitted HCPCS procedure code units or the submitted NDC units are reported as an incorrect unit of measure.

Claims submitted with inaccurate NDC units may be denied with EOB 2424 (Detail reviewed by Pharmacy Department. NDC units incorrect. NDC units must correspond to submitted HCPCS procedure units. Verify and resubmit correct NDC units).

Denial of Miscellaneous Drug Related HCPCS Codes

Miscellaneous HCPCS procedure codes (for example, J3490, J3590, J9999, and C9399) are used when no other national codes exist to better describe the product or service being billed. Providers must not bill NDCs using miscellaneous HCPCS procedure codes if a specific HCPCS procedure code more correctly describes a product or drug. Professional and institutional claim details for a miscellaneous HCPCS procedure code will be denied with EOB 9509 (Service denied. Based on the NDC information provided a more specific HCPCS code must be billed instead of the miscellaneous code used. Correct and resubmit) if it is determined that a more appropriate HCPCS procedure code exists.

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

Attention: All Providers**UD Modifier and 340B Drugs**

The 340B Drug Pricing Program resulted from the enactment of the Veterans Health Care Act of 1992, which is Section 340B of the Public Health Service Act. Providers are able to acquire drugs through that program at significantly discounted rates. Because of the discounted acquisition cost, these drugs are not eligible for the Medicaid Drug Rebate Program. State Medicaid programs are obligated to ensure that rebates are not claimed on 340B drugs. The DRA 2005 does not exclude 340B drugs; therefore, all providers must meet these requirements.

In order for providers to identify 340B drugs dispensed in an outpatient or clinic setting, the National Medicaid Electronic Data Interchange HIPAA workgroup has recommended use of the UD modifier. This will allow Medicaid to identify claim details for 340B drugs and exclude them from the rebate collection process. The UD modifier should be billed on the CMS-1500/837P and the UB04/837I claims forms, associated with applicable HCPCS procedure code and National Drug Code (NDCs) to properly identify the 340B drugs. The UD modifier is to be used only in this circumstance. All non-340B drugs are billed using the applicable HCPCS procedure code and NDC pair without the UD modifier.

Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III*, on DMA's website (<http://www.ncdhhs.gov/dma/bulletin/>) for additional information.

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

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/>:

- 1S-1, *Genotyping and Phenotyping for HIV Drug Resistance Testing*
- 5A, *Durable Medical Equipment*

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**CSC to Initiate 12-Month Provider Verification and Credentialing Activities**

CSC is ready to begin the 12-month process to verify information and credential enrolled Medicaid providers who have not been credentialed in the last 18 months. Beginning in June 2009, 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 pre-printed report of information currently on file with N.C. Medicaid plus a checklist of credentialing-related documents that must be returned to CSC. (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.)

The pre-printed NC MMIS Verification Form includes demographic data and NPI information currently on file with N.C. Medicaid and also contains space for providers to enter license/certification numbers, type of ownership, and contact information. Providers must complete the form, attach copies of documents required for credentialing, and return the verification packet to CSC within 30 days of the date of receipt. Failure to respond to the notification may result in termination of Medicaid participation.

The verification process will take up to three weeks from the time CSC receives the correct and complete verification packet from the provider; the return of incomplete or incorrect information will prolong the verification process. CSC will review the information and conduct credentialing activities that include criminal background checks, queries of practitioner databases, and verification of licensure, certification, and endorsement.

DMA and CSC will continue to inform providers of various events and changes through the General Medicaid Bulletin, the DMA website, and the EVC Call Center website.

EVC Call Center Contact Information

EVC 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
EVC Call Center Mailing Address	N.C. Medicaid Provider Enrollment CSC PO Box 300020 Raleigh NC 27622-8020
EVC Call Center Site Address	N.C. Medicaid Provider Enrollment CSC 2610 Wycliff Road, Suite 102 Raleigh NC 27607-3073
EVC Call Center Website	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

Medicaid Credit Balance Reporting

All providers participating in the Medicaid Program are required to submit to the DMA Third Party Recovery Section, a quarterly **Credit Balance Report** indicating balances due to Medicaid. Providers must report any **outstanding** credits owed to Medicaid that have not been reported previously on a Medicaid Credit Balance Report. However, hospital and nursing facility providers are required to submit a report every calendar quarter even if there are no credit balances. The report must be submitted no later than 30 days following the end of the calendar quarter (March 31, June 30, September 30, and December 31).

The Medicaid Credit Balance Report is used to monitor and recover “credit balances” owed to the Medicaid Program. A credit balance results from an improper or excess payment made to a provider. For example, refunds must be made to Medicaid if a provider is paid twice for the same service (e.g., by Medicaid and a medical insurance policy, by Medicare and Medicaid, by Medicaid and a liability insurance policy), if the patient liability was not reported in the billing process or if computer or billing errors occur.

For the purpose of completing the report, a Medicaid Credit Balance is the amount determined to be refundable to the Medicaid Program. When a provider receives an improper or excess payment for a claim, it is reflected in the provider’s accounting records (patient accounts receivable) as a “credit.” However, credit balances include money due to Medicaid regardless of its classification in a provider’s accounting records. If a provider maintains a credit balance account for a stipulated period (e.g., 90 days) and then transfers the account or writes it off to a holding account, this does not relieve the provider of liability to the Medicaid Program. The provider is responsible for identifying and repaying all monies owed the Medicaid Program.

The Medicaid Credit Balance Report requires specific information on each credit balance on a claim-by-claim basis. The reporting form provides space for 15 claims but may be reproduced as many times as necessary to accommodate all the credit balances being reported. Specific instructions for completing the report are on the reverse side of the reporting form.

Submitting the Medicaid Credit Balance Report does not result in the credit balances automatically being reimbursed to the Medicaid Program. A check is the preferred form of satisfying the credit balances; the check must be made payable to EDS and sent to EDS with the required documentation for a refund. If an adjustment is to be made to satisfy the credit balance, an adjustment form must be completed and submitted to EDS with all the supporting documentation for processing.

Submit Medicaid Credit Balance Report Form to	Submit refund checks to	Submit Medicaid Claim Adjustment Request Form to
Third Party Recovery Section Division of Medical Assistance 2508 Mail Service Center Raleigh NC 27699-2508	EDS Refunds P.O. Box 300011 Raleigh NC 27622-3011	EDS Adjustment Unit P.O. Box 300009 Raleigh NC 27622-3009

Submit **only** the completed Medicaid Credit Balance Report to DMA. **Do not** send refund checks or adjustment forms to DMA. **Do not** send the Credit Balance Report to EDS. Failure to submit a Medicaid Credit Balance Report will result in the withholding of Medicaid payment until the report is received.

A copy of the Medicaid Credit Balance Report form follows this article. Both the Medicaid Claim Adjustment Request form and the Medicaid Credit Balance Report form are also available on DMA’s website at <http://www.ncdhhs.gov/dma/provider/forms.htm>.

Debbie Odette
Third Party Recovery Section
DMA, 919-647-8100

Instructions for Completing Medicaid Credit Balance Report

Complete the "Medicaid Credit Balance Report" as follows:

- Full name of facility as it appears on the Medicaid Records
- The facility's Medicaid provider number. If the facility has more than one provider number, use a separate sheet for each number.
- DO NOT MIX
- Circle the date quarter end
- Enter year
- The name and telephone number of the person completing the report. This is needed in the event DMA has any questions regarding some item in the report

Complete the date fields for each Medicaid balance by providing the following information:

Column 1 – The last name and first name of the Medicaid recipient (e.g., Doe, Jane)

Column 2 – The individual Medicaid identification (MID) number

Column 3 – The month, day, and year of beginning service (e.g., 12/05/03)

Column 4 – The month, day, and year of ending service (e.g., 12/10/03)

Column 5 – The R/A date of Medicaid payment (not your posting date)

Column 6 – The Medicaid ICN (claim) number

Column 7 – The amount of the credit balance (not the amount your facility billed or the amount Medicaid paid)

Column 8 – The reason for the credit balance by entering: "81" if it is a result of a Medicare payment; "83" if it is the result of a health insurance payment; "84" if it is the result of a casualty insurance/attorney payment or "00" if it is for another reason. Please explain "00" credit balances on the back of the form.

After this report is completed, total column 7 and mail to **Third Party Recovery, DMA, 2508 Mail Service Center, Raleigh, NC 27699-2508.**

MEDICAID CREDIT BALANCE REPORT

PROVIDER NAME: _____ CONTACT PERSON: _____
 PROVIDER NUMBER: _____ TELEPHONE NUMBER: _____
 QUARTER ENDING: (Circle one) 3/31 6/30 9/30 12/31 YEAR: _____

(1) RECIPIENT'S NAME	(2) MEDICAID NUMBER	(3) FROM DATE OF SERVICE	(4) TO DATE OF SERVICE	(5) DATE MEDICAID PAID	(6) MEDICAID ICN	(7) AMOUNT OF CREDIT BALANCE	(8) REASON FOR CREDIT BALANCE
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Circle one: Refund Adjustment Third Party Recovery
 DMA
 2508 Mail Service Center
 Raleigh, NC 27699-2508

Revised 10/07

Attention: Federally Qualified Health Centers and Rural Health Clinics**Implanon Contraceptive (HCPCS Procedure Code J7307)**

Effective with date of service May 1, 2009, DMA reimburses Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for Implanon when it is billed with HCPCS procedure code J7307 (Etonogestrel [contraceptive] implant system, including implant and supplies). Providers must use the FP modifier (family planning) and the family planning ICD-9-CM diagnosis code V25.5 when billing for this service.

DMA has determined that Implanon furnished by an FQHC or RHC is not a core service and is reimbursed based on the fee schedule allowable for the FQHC or RHC. CPT procedure codes 11981, 11982 or 11983 for insertion, removal or removal with reinsertion of the non-biodegradable drug delivery implant are included in the core service, and are, therefore, not separately reimbursed and should not be billed to Medicaid.

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

Attention: Nurse Practitioners and Physicians**Regadenoson (Lexiscan) – Billing Guidelines**

Lexiscan is a pharmacologic stress agent indicated for radionuclide myocardial perfusion imaging (MPI) in patients unable to undergo adequate exercise stress. Lexiscan is contraindicated in second- or third-degree atrioventricular (AV) block or sinus node dysfunction unless these patients have a functioning artificial pacemaker. Lexiscan should be administered as a 0.4-mg rapid intravenous injection followed immediately by saline flush and radiopharmaceutical. Providers must indicate the number of units used in block 24G on the CMS-1500 claim form and must bill their usual and customary charges with one of the HCPCS procedure codes listed below. The fee schedule for the Physician's Drug Program is available on DMA's website at <http://www.ncdhhs.gov/dma/fee/>.

A4641, June 24, 2008, through December 31, 2008

For dates of service June 24, 2008, through December 31, 2008, the N.C. Medicaid Program covers regadenoson, 0.4 mg per 5 ml, in 5-ml single-use vials and single-use pre-filled syringes, when billed with HCPCS procedure code A4641 (radiopharmaceutical, diagnostic, not otherwise classified). One Medicaid unit of coverage is one single-use vial or one single-use syringe, 5 ml. Providers must include an invoice with the recipient's name, Medicaid identification number, the agent, the dose and the cost (less shipping and handling). HCPCS procedure code A4641 should not be billed for regadenoson for dates of service on January 1, 2009, or after.

J2785, January 1, 2009, and After

For dates of service January 1, 2009, and after, the N.C. Medicaid Program covers regadenoson, 0.1 mg when billed with HCPCS procedure code J2785 (injection, regadenoson, 0.1mg, [Lexiscan]). One Medicaid unit of coverage is 0.1 mg. The maximum units billed are four units (0.4 mg) per treatment. An invoice is not required for J2785. Providers must bill 11-digit National Drug Codes (NDC) and appropriate NDC units. Refer to the March 2009 Special Bulletin, *National Drug Code Implementation Phase III* on the DMA website at <http://www.ncdhhs.gov/dma/bulletin/>.

Drug	HCPCS Code	Description	Billing Unit	Maximum Units	Invoice Required	Bill Dates of Service
Regadenoson, 0.4 mg/5 ml, in 5-ml single-use vials and single-use pre-filled syringes	A4641	Radiopharmaceutical, diagnostic, not otherwise classified	One unit is one single-use vial or one single-use syringe, 5 ml	One single-use vial or one single-use syringe, 5 ml	Yes	June 24, 2008, through December 31, 2008
Regadenoson, 0.1 mg	J2785	Injection, regadenoson, 0.1 mg, (Lexiscan)	One unit is 0.1 mg	4 units (0.4 mg) per treatment	No	January 1, 2009, and forward

Lexiscan must be billed in conjunction with one of the following CPT codes:

CPT Code	Description
78460	Myocardial perfusion imaging; (planar) single study, at rest or stress (exercise and/or pharmacologic), with or without quantification
78461	Myocardial perfusion imaging; multiple studies (planar), at rest or stress (exercise and/or pharmacologic), and redistribution and or rest injection, with or without quantification
78464	Myocardial perfusion imaging; tomographic (SPECT), single study (including attenuation correction when performed), at rest or stress (exercise and/or pharmacologic), with or without quantification
78465	Myocardial perfusion imaging; tomographic (SPECT), multiple studies (including attenuation correction when performed), at rest or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, with or without quantification
93015	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report
93016	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; physician supervision only, without interpretation and report
93017	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation and report
93018	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only

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

Attention: Nurse Practitioners and Physicians**Sodium Fluoride F-18 (HCPCS Procedure Code A9580) – Billing Guidelines**

Effective with date of service January 1, 2009, the N.C. Medicaid program covers sodium fluoride F-18 (diagnostic, per study dose, up to 30 mCi) when billed with HCPCS procedure code A9580. Sodium fluoride F-18 is a positron-emitting radiopharmaceutical and is indicated for diagnostic purposes in conjunction with positron emission tomography (PET) as a bone imaging agent for detection of primary and metastatic malignancy in the bone. The recommended dose is 16.5 to 74.0 MBq (0.5 to 2.0 mCi). The maximum recommended dose should not exceed 148.0 MBq (4.0 mCi).

One Medicaid unit of coverage per study dose is up to 30 mCi. Providers must include an invoice with the recipient's name, Medicaid identification number, the agent, the dose, and the cost (less shipping and handling). Providers must indicate the number of units used in block 24G on the CMS-1500 claim form and must bill their usual and customary charges. Sodium fluoride F-18 does not require billing with National Drug Codes. The fee schedule for the Physician's Drug Program is available on DMA's website at <http://www.ncdhhs.gov/dma/fee/>.

Sodium fluoride F-18, A9580, must be billed in conjunction with one of the following CPT codes:

CPT Code	Description
78811	Positron emission tomography (PET) imaging; limited area (eg, chest, head/neck)
78812	Positron emission tomography (PET) imaging; skull base to mid-thigh
78813	Positron emission tomography (PET) imaging; whole body
78814	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (eg, chest, head/neck)
78815	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh
78816	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; whole body

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

Attention: Pharmacists**Synagis Pharmacy Claims for 2008/2009 Season**

The last accepted date of service for Synagis pharmacy claims for the 2008/2009 policy coverage period was March 31, 2009. Synagis claims processing began on October 13, 2008, for this season. All Synagis requests must be completed on criterion-specific forms, which can be found at DMA's website at <http://www.ncdhhs.gov/dma/pharmacy/synagis.htm>.

No more than five monthly doses of Synagis can be obtained by using these forms. Copies of the submitted North Carolina Medicaid Synagis for RSV Prophylaxis forms should be mailed by pharmacy distributors to DMA at the following address:

N.C. Division of Medical Assistance
Pharmacy Program
1985 Umstead Drive
2501 Mail Service Center
Raleigh, N.C. 27699-2501

Pharmacy distributors with a large volume of Synagis claims should submit scanned copies of the North Carolina Medicaid Synagis for RSV Prophylaxis forms on a diskette. Please call Charlene Sampson at 919-855-4306 to coordinate this process if you need further assistance or have questions. All diskettes must be sent to DMA by June 15, 2009.

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

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

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

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

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

Attention: Pharmacists**P**rescription Origin Code

Effective August 1, 2009, the use of NCPDP field 419-DJ (prescription origin code) will become mandatory for the N.C. Medicaid Outpatient Pharmacy Program. This field indicates the origin of the prescription. The following standard values will be accepted in this field:

- 1=Written
- 2=Telephone
- 3=Electronic
- 4=Facsimile

Zero and null values will not be accepted in this field. The information entered into the prescription origin code field will be required to assist with auditing processes.

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

Attention: Pharmacists**A**ddition of Dispense As Written Code "8"

Effective May 22, 2009, the Dispense As Written (DAW) code "8" was added to the list of DAW codes allowed by the N.C. Medicaid Outpatient Pharmacy Program. Pharmacists can use this DAW code in field 408-D8 on prescription drug claims when a brand name drug must be dispensed because a generic version of the drug is not available due to marketplace shortages. The use of DAW codes is monitored by Program Integrity.

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

Attention: Pharmacists and Prescribers**T**acrolimus Added to the Narrow Therapeutic Index List

On January 27, 2009, the Secretary of the N.C. Department of Health and Human Services approved the addition of tacrolimus to the list of narrow therapeutic index drugs upon advice from the N.C. Board of Pharmacy, the N.C. Medical Board, and the State Health Director. The updated list of narrow therapeutic index drugs was published in the N.C. Register, Volume 23, Issue 17, March 2, 2009.

Effective May 1, 2009, pharmacists can use the Dispense As Written (DAW) code "7" in field 408-D8 when it is necessary to dispense tacrolimus as a brand name drug. The DAW 7 code means that substitution is not allowed and dispensing the brand drug is mandated by law. When it is necessary to dispense the brand name drug, the prescriber must indicate that the brand name drug is necessary by writing "medically necessary" on the prescription.

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

Attention: Enhanced Behavioral Health Services (Community Intervention Services) Providers and Local Management Entities**Diagnosis Code Update**

In Implementation Update #48 (issued in September 2008), providers were advised of the MMIS Upgrade for Adult Enhanced Services – specifically the transition to DSM-IV-TR Diagnostic Coding. Subsequent to this original announcement, many providers have had difficulty in managing this transition. In an effort to further clarify, the following information is offered:

- DSM-IV-TR was nationally accepted and implemented in 2007. The revised text consolidated many previously used codes and streamlined the specificity required in diagnosing. There are numerous crosswalks available online to assist in the transition to the updated coding system. Further resources may also be found from organizations such as the APA, licensing boards, and coding associations.
- MMIS is using the DSM-IV-TR for both authorization and payment processes for adult services only. Child and shared procedure codes (both adult and child) may still bill under ICD and DSM categories.
- The format in which a diagnosis code can be submitted in the NCECSWeb Tool screen is restricted in comparison to a manual claim submission. The NCECSWeb Tool allows up to five characters to be entered in a diagnosis field. Examples of appropriate billing entry into NCECS follow:
 - ◆ Diagnosis code 295.90 should be entered into the NCECSWeb Tool as 29590.
 - ◆ Diagnosis code 292.9 should be entered into the NCECSWeb Tool as 2929.
 - ◆ Diagnosis code 311 should be entered into the NCECSWeb Tool as 311.
- Community Support providers have been concerned that denied claims will affect the computation of QP time. As noted in Implementation Update #56, the computation of QP time is based upon claims billed per month.

Please refer to the July 2007 Special Bulletin, *NCECSWeb Instruction Guide*, on DMA's website at <http://www.ncdhhs.gov/dma/bulltin/> for information on using the NCECSWeb Tool.

The Implementation Updates may be accessed from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services' website at <http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/>.

Behavioral Health Section
DMA, 919-855-4290

Attention: Enhanced Behavioral Health Services (Community Intervention Services) Providers**Enhanced Behavioral Health Services Seminars**

Enhanced behavioral health and substance abuse (Community Interventions) services provider seminars are scheduled to be held at locations throughout the State during August 2009. Information on the enhanced behavioral health and substance abuse billing procedures as well as claim submission instructions will be presented at these seminars.

The dates and the locations of the seminar sites will be announced in the July 2009 General Medicaid Bulletin, which will be posted to <http://www.ncdhhs.gov/dma/bulletin/>. Pre-registration will be required. Due to limited seating, registration will be limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

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

Attention: Outpatient Behavioral Health Service Providers and Provisionally Licensed Providers Billing “Incident-to” a Physician or through the Local Management Entity

Prior Authorization and Billing Guidelines

This is a reminder of current outpatient prior authorization and billing guidelines for outpatient behavioral health services. To assist providers in requesting prior authorization, ValueOptions has revised the current Outpatient Review Form (ORF2). Please see the ValueOptions website (http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm) for the revised form.

Effective July 1, 2009, providers must use the revised ORF2 for prior authorization requests. Providers should pay special attention to these two fields on the revised form:

- Attending Provider Name/Medicaid #
- Billing Provider Name/Medicaid #

Both fields must be completed. Prior authorizations will be created for the Billing Provider/Medicaid Number. Providers must enter the Billing Medicaid Provider Number associated with the Billing NPI with which they will submit their claims (do not submit NPI on the ORF2).

Prior authorization requests for group providers will cover all providers under that Billing Medicaid Provider Number. Do not submit a new request for a provider that fills in should the primary provider be absent.

After September 1, 2009, ValueOptions will return any request as “Unable to Process” if it is submitted on the old ORF2 form or if the two fields noted above are not completed.

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

Attention: Maternal Outreach Worker Program Providers

Service Continuation

Current economic conditions have forced some providers to scale back their Maternal Outreach Worker (MOW) programs. Until further notice, for existing providers, DMA will not enforce the requirements listed in Section 6.1, Agency Qualifications, of Clinical Coverage Policy #1M-7, *Baby Love Maternal Outreach Worker Program* (<http://www.ncdhhs.gov/dma/mp/>).

An agency that has previously been approved as a provider will be permitted to resume or continue rendering MOW program services once it determines service is feasible, regardless of whether the agency’s program had lapsed, positions had remained vacant, or both.

If you have any questions or need additional information, contact the DMA’s Baby Love Program Manager at 919-855-4321.

**Baby Love Program Manager
DMA, 919-855-4321**

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) for CAP/DA lead agencies.

The second quarterly training session this year will be held on June 23, 2009, at the Hilton in Greenville. 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, Diagnosis, 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 if their name is on the required attendance list. Online registration for the seminar will be available beginning June 1, 2009, 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.

Driving Directions**Hilton Greenville**

207 SW Greenville Boulevard
Greenville NC 27834-6907
252-355-5000

Take US 64 East to US 264 East to Greenville. Turn right at the 2nd traffic light as you come into the city onto Allen Road/US Alternate 264. Travel approximately 2 miles. Allen Road becomes Greenville Boulevard/Alternate 264. Follow Greenville Boulevard for 2.5 miles. The Hilton Greenville is located on the right.

CCME, 1-800-682-2650

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
June	6/4/09	6/9/09
	6/11/09	6/16/09
	6/18/09	6/25/09
July	7/2/09	7/7/09
	7/9/09	7/14/09
	7/16/09	7/23/09
	7/30/09	8/4/09

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.

Craigan L. Gray, MD, MBA, JD
 Director
 Division of Medical Assistance
 Department of Health and Human Services

Melissa Robinson
 Executive Director
 EDS, an HP Company
