Number 7 *July 2005*

North Carolina Medicaid Bulletin

Visit DMA on the Web at: http://www.dhhs.state.nc.us/dma

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

Attention: All Providers

Claim Adjustments for Physician, Laboratory, and Independent Mental Health Procedure Codes

N.C. Medicaid will continue to adjust claims for physician procedure codes, laboratory procedure codes, and independent mental health procedure codes that had a rate change in 2004. This adjustment is necessary due to Medicare providing a second set of Medicare rates for 2004. The adjustment will affect claims with dates of service January 1, 2004 through February 18, 2004.

These adjustments began on the May 5, 2004 checkwrite and continued for several checkwrites. Providers can identify these adjustments by their batch numbers. The additional batch numbers to be used for these adjustments will begin with these numbers 902004241, 902004242, 902004346, 902005128, 902005008, and 902005009.

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 the Division of Medical Assistance's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm:

5A – Durable Medical Equipment (formerly numbered as Clinical Policy #5)
5B – Orthotics and Prosthetics

11A-1 – High Dose Chemotherapy +/- Total Body Irradiation Including Autologous and Allogeneic Stem Cell Support for Acute Lymphocytic Leukemia
11A-2 – High Dose Chemotherapy + Total Body Irradiation Including Autologous and Allogeneic Stem Cell Support in Acute Myelogenous Leukemia
11A-3 – High Dose Chemotherapy +/- Total Body Irradiation and Allogeneic Stem Cell Support in Chronic Myelogenous Leukemia
11A-4 – Donor Leukocyte, Donor Lymphocyte or Buffy Coat Infusion for Hematologic Malignancies that Relapse or at a High Risk for Relapse after Allogeneic Stem Cell Transplantation
11A-5 – High Dose Chemotherapy +/- Total Body Irradiation Including Allogeneic Stem Cell Support for Genetic Diseases and Acquired Anemias
11A-6 – High Dose Chemotherapy with Autologous and Allogeneic Stem Cell Support for Germ Cell Tumors
11A-7 – High Dose Chemotherapy Bone Marrow or Autologous/Allogeneic Peripheral Stem Cell Transplant for Hodgkin's Disease
11A-8 – High Dose Chemotherapy for Multiple Myeloma and Primary Am yloidosis
11A-9 – High Dose Chemotherapy +/- Total Body Irradiation Including Allogeneic Bone Marrow and Peripheral Stem Cell Support for Myelodysplastic Diseases

11A-10 – High Dose Chemotherapy and Autologous Stem Cell Support for Neuroectodermal Tumors (PNET) and Ependymoma

11A-11 – High Dose Chemotherapy, Bone Marrow or Peripheral Stem Cell Transplant for Non-Hodgkins Lymphoma

11A-12 – Non-Myeloablative Allogeneic Stem Cell Transplant (Mini-Transplant, Mini-Allograft Reduced Intensity Conditioning) for Treatment of Malignancies

11A-13 – High Dose Chemotherapy, Bone Marrow or Peripheral Stem Cell Transplant for Ovarian Cancer and Germ Cell Tumors Arising in the Ovaries

11A-14 – Placental and Umbilical Cord Blood as a Source of Stem Cells

11A-15 – High Dose Chemotherapy + Total Body Irradiation with Autologous/Allogeneic Stem Cell Support for Solid Tumors of Childhood

11B-1 – Lung Transplantation

11B-2 – Heart Transplantation

11B-3 – Islet Cell Transplantation

11B-4 – Kidney Transplantation

11B-5 – Liver Transplantation

11B-6 – Heart/Lung Transplantation

11B-7 – Pancreas Transplantation

11B-8 – Small Bowel and Small Bowel/Liver and Multivisceral Transplants

11C – Ventricular Assist Device

11D – Biventricular Pacemaker for the Treatment of Congestive Heart Failure

11E – Implantable Cardioverter Defibrillator

11F – Extracorporeal Membrane Oxygenation/Extracorporeal Life Support

11G – Photophoresis for Solid Organ Rejection Autoimmune Disease and GVHD

11H – Bone Morphogenic Protein-2

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

Compression Garments

Effective with date of service July 1, 2005, compression garments for recipients less than 21 years of age will be available through both the Orthotics and Prosthetics Program and through a physician's office. Please refer to Clinical Coverage Policy # 5B, Orthotics and Prosthetic Devices when ordering compression stockings and compression burn garments for these recipients.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

CPT Codes 90465 and 90466 - New Immunization Administration Codes for Recipients Under Eight Years of Age

Effective with date of service July 1, 2005, the N.C. Medicaid program covers two new CPT codes for immunization administration, 90465 and 90466. These codes are used to bill for injections provided to recipients under 8 years of age when the physician counsels the patient and/or family.

CPT Code	Description
90465	Immunization administration under 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	Immunization administration under 8 years of age (includes percutaneous, intradermal, subcutaneous, or intramuscular injections) **when the physician counsels the patient/family**; each additional injection (single or combination vaccine/toxoid), per day

Medicaid continues to cover CPT codes 90471 and 90472, which are used to bill immunization administration for recipients of all ages when counseling has not been provided.

CPT Code	Description
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **one vaccine** (single or combination vaccine/toxoid)
90472	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid) **each additional vaccine** (single or combination vaccine/toxoid)

The following principles should guide the billing of these codes:

1. The recipient must be under eight years of age.
2. CPT codes 90465 and 90466 are in the same code family, and 90471 and 90472 are in the same code family. A code from one family cannot be used with a code from another family (e.g., CPT 90465 cannot be used with 90472).
3. The new codes, like the current codes, are immunization administration codes. They are not add-on "counseling" codes. Therefore, a new code plus a current code for a single administration cannot be reported (i.e., 90465 plus 90471 cannot be reported for the **SAME** immunization administration).
4. Physicians, nurse practitioners, and physician assistants may perform these services.
5. The physician, nurse practitioner or physician assistant must perform face-to-face **vaccine counseling** associated with the administration; the counseling provided should be documented in the patient's record. The physician, nurse practitioner or physician assistant is not required to administer the vaccine.
6. A "first" administration is defined as the first vaccine administered to a recipient during a single patient encounter.
7. Codes 90466 and 90472 must be listed separately on a claim form in addition to the code for the primary procedure.Refer to the following table for Health Check immunization billing information for these codes.

Private Sector Providers

	With Physician Counseling	Without Physician Counseling
Health Check Screening with Immunization(s)	For the first vaccine, bill 90465EP.	For the first vaccine, bill 90471EP.
	For two vaccines or more, also bill 90466EP.	For two vaccines or more, also bill 90472EP.
	Immunization diagnosis code(s) **not** required.	Immunization diagnosis code(s) **not** required.
	Immunization procedure code(s) **are** required.	Immunization procedure code(s) **are** required.
Immunization(s) Only	For the first vaccine, bill 90465EP.	For the first vaccine, bill 90471EP.
	For two vaccines or more, also bill 90466EP.	For two vaccines or more, also bill 90472EP.
	One immunization diagnosis code **is** required.	One immunization diagnosis code **is** required.
	Immunization procedure code(s) **are** required.	Immunization procedure code(s) **are** required.
Office Visit with Immunization(s)	For the first vaccine, bill 90465EP.	For the first vaccine, bill 90471EP.
	For two vaccines or more, also bill 90466EP.	For two vaccines or more, also bill 90472EP.
	Immunization diagnosis code(s) **not** required.	Immunization diagnosis code(s) **not** required.
	Immunization procedure code(s) **are** required.	Immunization procedure code(s) **are** required.
Core Visit With Immunization(s)	N/A	N/A

FQHC/RHC – Bill using the provider number with the "C" suffix

	With Physician Counseling	Without Physician Counseling
Health Check Screening with Immunization(s)	For the first vaccine, bill 90465EP.	For the first vaccine, bill 90471EP.
	For two vaccines or more, also bill 90466EP.	For two vaccines or more, also bill 90472EP.
	Immunization diagnosis code(s) **not** required.	Immunization diagnosis code(s) **not** required.
	Immunization procedure code(s) **are** required.	Immunization procedure code(s) **are** required.
Immunization(s) Only	For the first vaccine, bill 90465EP.	For the first vaccine, bill 90471EP.
	For two vaccines or more, also bill 90466EP.	For two vaccines or more, also bill 90472EP.
	One immunization diagnosis code **is** required.	One immunization diagnosis code **is** required.
	Immunization procedure code(s) is **not** required.	Immunization procedure code(s) is **not** required.
Office Visit with Immunization(s)	N/A	N/A
Core Visit With Immunizations	Cannot bill 90465.	Cannot bill 90471.
	Cannot bill 90466.	Cannot bill 90472.
	Immunization diagnosis code is **not** required.	Immunization diagnosis code is **not** required.
	Immunization procedure code(s) **are** required.	Immunization procedure code(s) **are** required.

Local Health Departments

	With Physician Counseling	Without Physician Counseling
Health Check Screening with Immunization(s)	Cannot bill 90465.	Cannot bill 90471.
	Cannot bill 90466.	Cannot bill 90472.
	Immunization diagnosis code(s) **not** required.	Immunization diagnosis code(s) **not** required.
	Immunization procedure code(s) **are** required.	Immunization procedure code(s) **are** required.
Immunization(s) Only	For one or more vaccines, bill 90465EP.	For one vaccine or more, bill 90471EP.
	Cannot bill 90466.	Cannot bill 90472.
	One immunization diagnosis code **is** required.	One immunization diagnosis code **is** required.
	Immunization procedure code(s) **are** required.	Immunization procedure code(s) **are** required.
Office Visit with Immunization(s)	For one or more vaccines, bill 90465EP.	For one or more vaccines or more, bill 90471EP.
	Cannot bill 90466.	Cannot bill 90472.
	Immunization diagnosis code(s) **not** required.	Immunization diagnosis code(s) **not** required.
	Immunization procedure code(s) **are** required.	Immunization procedure code(s) **are** required.
Core Visit With Immunization(s)	N/A	N/A

Immunization procedure code(s) must be listed in block 24D of the CMS-1500 claim form for all immunizations administered.

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

Attention: All Providers

HCPCS Code A4570 – Splint

Effective with date of service July 1, 2005, A4570 will no longer be reimbursed as a physician service. According to Session Law 2004-124, this item will now be reimbursed through the Orthotics and Prosthetics Program and may only be provided by certified orthotic or prosthetic providers as outlined in Clinical Coverage Policy # 5B, Orthotics and Prosthetic Devices.

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

Attention: All Providers

Referrals to Adult Care Homes

When referring a recipient to a care facility, it is important to consider the type of care that is needed by the recipient. An Adult Care Home is a category of facility that provides room and board, 24-hour supervision, and services for people needing assistance with activities of daily living (ADLs) and some healthcare needs resulting from normal aging, a chronic illness, a cognitive disorder or a disability. These activities include assistance with bathing, dressing, laundry, housekeeping, ambulation, eating, and toileting and/or medication administration.

To begin the Adult Care Home referral process, Medicaid requires a physician to complete and sign an FL2. The physician is accountable for the content and the completeness of the FL2. It is extremely important that the FL2 be a complete picture of the current medical condition of the proposed resident. It must include the psychiatric history and any precautions that may need to be considered by the Adult Care Home in determining the appropriateness of admission. The FL2 must provide sufficient medical and behavioral information for an Adult Care Home to determine if it can meet the needs of the particular resident.

Physicians, hospital discharge planners, case managers and other referral agents are reminded that it is not appropriate to rewrite or revise an FL2 and change the level of care from Nursing Facility to Adult Care Home once a referral is made to a Nursing Facility and the PASSAR process is initiated.

For further information contact:
Julie Budzinski, Adult Care Home Consultant
Division of Medical Assistance
919-855-4368

Facility and Community Care
DMA, 919-855-4360

Attention: All Providers

NCLeads Update

Information related to the implementation of the new Medicaid Management Information System, *NCLeads*, scheduled for implementation in mid-2006 can be found online at http://ncleads.dhhs.state.nc.us. Please refer to this website for information, updates, and contact information related to the *NCLeads* system.

Thomas Liverman, Provider Relations
Office of MMIS Services,
919-647-8315

Attention: Adult Care Home Providers

Medicaid ACH-PCS Cost Settlements FYE-2005

The amendment to the North Carolina State Medicaid Plan, Attachment 4.19-B, Section 23 (f), Page 6 amendment to eliminate the Medicaid ACH-PCS Cost Settlement requirement of private and public providers that was to become effective with the Fiscal Year Ending in 2005, has been withdrawn from approval consideration by the Centers for Medicare and Medicaid Services (CMS). Recent negotiations and subsequent conversations with CMS strongly indicated that withdrawing the amendment request from consideration is the best course of action for DMA to pursue at this time.

The Medicaid ACH/PCS Cost Settlement for FY 2004-2005 is due in the DMA Rate Setting Section on or before January 31, 2006.

Finance Management
DMA, 919-855-4200

Attention: Ambulance Providers

Revision to Rates for Ambulance Services

Effective with date of service June 1, 2005, the rates for the following HCPCS codes have changed:

Procedure Code	Description	Non-Facility Fee Maximum Reimbursement Rate	Facility Fee Maximum Reimbursement Rate
A0425	Ground Mileage, per statute mile	$3.00	$3.00
A0426	Ambulance Service, advanced life support, non-emergency transport, level 1 (ALS 1)	$70.09	$70.09
A0427	Ambulance Service, advanced life support, emergency transport, level 1 (ALS 1 – emergency)	$123.52	$123.52
A0428	Ambulance Service, basic life support, non-emergency transport (BLS)	$70.09	$70.09
A0429	Ambulance Service, basic life support, emergency transport (BLS - emergency)	$70.09	$70.09
A0433	Advanced life support, level 2 (ALS 2)	$128.16	$128.16
T2003	Non-Emergency transportation; encounter/trip	$77.52	$77.52

The rate increases were not approved until the Rate Review Board meeting on Monday, May 23, 2005, making it impossible to get this article in the June 2005 Medicaid Bulletin.

Providers must bill their usual and customary charges.

Financial Management
DMA, 919-855-4200

Attention: Physicians, Anesthesiologists, Certified Registered Nurse Anesthetists and Hospitals

01967 and 01996 Modifier Billing Changes

The Division of Medical Assistance implemented the use of anesthesia modifiers effective with date of processing May 15, 2004. Providers were instructed in the April 2004 Medicaid Bulletin to append one of the modifiers QX, QZ, QY, QK or AA each time anesthesia is billed. System changes have been made to support the following requirements for CPT codes 01996 and 01967:

- Only Anesthesiologists and Certified Registered Nurse Anesthetists are required to append anesthesia modifiers when billing CPT Code 01967 *Neuraxial labor analgesia/anesthesia for planned vaginal delivery.*
- CPT Code 01996 *Daily hospital management of epidural or subarachnoid continuous drug administration* is a management service and does not require anesthesia modifiers. This service will be reimbursed only once per day.

Previously submitted claims by all providers with 01996 that denied with EOB 2988 "Anesthesia services must be appended with modifiers AA, QK, QX, QY or QZ" may be refiled without the anesthesia modifiers appended. Similarly, denied claims from providers other than Anesthesiologists and Certified Registered Nurse Anesthetists, with 01967 for EOB 2988, may be refiled without the anesthesia modifiers appended. Claims must be refiled within 18 months of the denial.

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

Attention: CAP-MR/DD Providers

Day Habilitation Rate Increase

Effective October 1, 2004, the rate for the Day Habilitation procedure code T2021 appended with modifier HQ changed from $3.00 to $3.68.

Providers must bill Day Habilitation at the customary charge for the units provided to the recipient for each date of service. Those providers who billed at the $3.00 rate instead of the customary charge for services provided after October 1, 2004 have the option to refund and resubmit claims to EDS. Following is the process for refunding and resubmitting claims for provider refunds. The complete guide on provider refunds is located in the Basic Medicaid Billing Guide on DMA's website at http://www.dhhs.state.nc.us/dma/medbillcaguide.htm.

Refunds are submitted in accordance with the following instructions:
1. Highlight on the RA the appropriate recipient, claim information, and dollar amount of the refund to apply to that recipient.
2. Attach a copy of the RA to the check.

If a copy of the RA is not available, document the information listed below by whatever means are available and include it with the check. This information is **required** in order to apply the funds against the correct provider claim and recipient history.

- provider number
- recipient name and MID number
- ICN
- date(s) of service
- dollar amount paid
- dollar amount of refund
- reason for refund (brief explanation)

An attempt will be made to contact the provider if any of this required information is missing. If the missing information has not been provided to EDS within 30 days, the check will be returned to the provider.

1. Make the refund check payable to EDS.
2. Mail the refund with the requested information to:
   EDS
   ATTN: Finance
   P.O. Box 300011
   Raleigh, NC 27622-3011

   Once refunds are entered into the system, the following data will appear on the next RA distributed to the provider:
   - The Financial Items section will contain a listing of refunds issued and processed for the provider. EOB 0113 is indicated for any refund transaction.
   - The Credit Amount field in the Claims Payment Summary will indicate the total amount of refund(s) processed, thereby giving credit for the returned funds. As a result of returning those funds, the "Net 1099 Amount" field is decreased by the refund amount to ensure the IRS is informed of the correct amount of monies received and kept by the provider. Refund transactions do not affect the Claims Paid, Claims Amount, Withheld Amount or Net Pay amount fields in this section.

If a refund is sent due to a claim billing error and you wish to resubmit the claim, please ensure that you have received credit on your RA as noted above. This will eliminate any possibility of the resubmitted claim being denied due to a duplicate claim.

Rate Setting
DMA, 919-855-4200

Attention: CAP-MR/DD Providers

New Effective Date on Proposed CAP-MR/DD Rates

The effective date of the CAP-MR/DD rates and service changes has changed from July 1, 2005 to September 1, 2005. The new effective date has been updated on the DMA web site: **http://www.dhhs.state.nc.us/dma/fee/mhfee.htm.**

Rate Setting
DMA, 919-855-4200

Attention: Case Manager Agencies

Targeted Case Management for Individuals with Mental Retardation/Developmental Disabilities – Effective Date Change

The effective date of implementing coverage of procedure code T1017 with the HI modifier for targeted case management for individuals with mental retardation/developmental disabilities (MR/DD) has changed from July 1, 2005 to September 1, 2005. The maximum allowable fee is $22.66 per 15 minutes. Providers should continue to bill their usual and customary fee.

Rate Setting
DMA, 919-855-4200

Attention: Health Departments and Children's Development Service Agencies Providers

Revision to Rates for Specific Services

Effective with dates of service **June 15, 2005**, rates for the following HCPCS / CPT codes have changed for the **Health Departments:**

Procedure Code	Description	Non-Facility Fee Maximum Reimbursement Rate	Facility Fee Maximum Reimbursement Rate
90471EP	Immunization Administration	$27.42	$27.42
99201	Office/Outpatient Visit New Pt Minor-Phys Time Approx. 10 Minutes	$62.10	$62.10
99202	Office/Outpatient Visit New Pt,Moderate-Phys Time Approx 20 Minutes	$93.15	$93.15
99203	Ov New Pt, Moderate-Phys Time Approx 30 Minutes	$132.48	$132.48
99204	Ov New Pt, Complex-Phys Time Approx 45 Minutes	$194.58	$194.58
99205	Ov New Pt, Severe-Phys Time Approx 60 Minutes	$244.26	$244.26
99211	Ov Estab Pt, Minimal W/Wo Phys, Time Approx 5 Min	$34.16	$34.16
99212	Ov Established Pt, Minor-Phys Time Approx 10 Min.	$56.93	$56.93
99213	Ov Estab. Pt, Moderate. Phys Time Approx 15 Min.	$78.66	$78.66
99214	Ov Estab. Pt, Severe. Phys Time Approx 25 Min.	$122.13	$122.13
99215	Ov Estab. Pt, Severe. Phys Time Approx 40 Min.	182.16	$182.16
S9442	Birthing Class (One Unit = 2 Hours)	$19.09	$19.09
T1016	Case Management (One Unit = 15 Minutes)	$21.74	$21.74

Effective with dates of service **June 15, 2005**, rates for the following HCPCS / CPT codes have changed for the **Children's Developmental Services Agencies:**

Procedure Code	Description	Non-Facility Fee Maximum Reimbursement Rate	Facility Fee Maximum Reimbursement Rate
99201	Office/Outpatient Visit New Pt Minor-Phys Time Approx. 10 Minutes	$62.10	$62.10
99202	Office/Outpatient Visit New Pt,Moderate-Phys Time Approx 20 Minutes	$93.15	$93.15
99203	Ov New Pt, Moderate-Phys Time Approx 30 Minutes	$132.48	$132.48
99204	Ov New Pt, Complex-Phys Time Approx 45 Minutes	$194.58	$194.58
99205	Ov New Pt, Severe-Phys Time Approx 60 Minutes	$244.26	$244.26
99211	Ov Estab Pt, Minimal W/Wo Phys, Time Approx 5 Min	$34.16	$34.16
99212	Ov Established Pt, Minor-Phys Time Approx 10 Min.	$56.93	$56.93
99213	Ov Estab. Pt, Moderate. Phys Time Approx 15 Min.	$78.66	$78.66
99214	Ov Estab. Pt, Severe. Phys Time Approx 25 Min.	$122.13	$122.13
99215	Ov Estab. Pt, Severe. Phys Time Approx 40 Min.	$182.16	$182.16

Note: Providers must continue to bill their usual and customary charges. No adjusting recoupments or repays will be made.

Financial Management
DMA, 919-855-4200

Attention: Local Management Entities, Children's Developmental Service Agencies, Head Start/Local Education Agencies, Home Health Providers, Outpatient Hospital Clinics, Independent Practitioners, Local Health Departments, and Physician Services

Updates to Outpatient Specialized Therapies Prior Approval Process

This article provides additional information relating to outpatient specialized therapies. **This article does not reflect a change in the current policy.** The current policy went into effect on October 1, 2002 for recipients age 21 and over, and for Children's Developmental Service Agencies (CDSAs) and CDSA-referred children under the age of 5. Effective November 1, 2002, the policy was revised to include all other recipients under the age of 21.

Outpatient specialized therapies encompasses all outpatient treatment services for occupational therapy, physical therapy, speech therapy, respiratory therapy, and audiological services regardless of where the services are provided except for those services that are provided by the school. N.C. Medicaid contracts with Medical Review of North Carolina (MRNC) (http://www.MRNC.org) to review these services and authorize care.

In addition to obtaining prior approval, providers must follow the established guidelines for their respective programs. Clinical Coverage Policy #10A, Outpatient Specialized Therapies, is not all inclusive of program requirements. Refer to the individual clinical coverage policies on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm for detailed information regarding recipient eligibility, coverage, limitations, and exclusions.

Note: Local Education Agencies (LEAs), Medicaid HMOs, and Medicare/Medicaid (dually-eligible) recipients are exempt from the prior approval process.

When the Service is Covered

All services must be medically necessary. Medically necessary services are covered for recipients of all ages. Recipients over the age of 21 are covered for services only when provided by home health, outpatient hospital clinics, physician offices, and local management entities. Specific criteria can be found in Clinical Coverage Policy #10A on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm.

Policy Guidelines

Treatment Services

The initial process for providing treatment, regardless of place of service, consists of the following steps and requirements:

1. For initial requests, a current evaluation is required.
2. The request for continuation of services must be accompanied by the documentation of the plan, goals and outcomes for the previous service interval.
3. All services must be provided according to a written plan.
4. The written plan for services must include defined goals for each therapeutic discipline.
5. Each plan must include a specific content, frequency and intensity of services for each therapeutic discipline.
6. A verbal or written order must be obtained for services prior to starting the services. Backdating is not allowed.

Service providers must review and renew or revise plans and goals no less than every six months, to include obtaining another dated physician signature for the renewed or revised orders. There will be no payment for services rendered more than six months **after** the most recent physician order signature date **or before** the following renewal/revision signature date. The signature date must be the date the physician signs the order. Backdating is not allowed.

Up to six unmanaged visits per recipient, per discipline, per provider category are allowed without prior approval. Evaluations, re-evaluations, and/or multi-disciplinary evaluations are **not** counted in the six unmanaged visits. Prior approval will be used before the six visits. CDSAs are not eligible for the six unmanaged visits. There will be no payment for services rendered in excess of six visits and before the date of the approval for continuation of services.

If a recipient is under five years of age and has had a CDSA evaluation or a CDSA-approved evaluation and has an Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP), the time for required prior approval for continued services will change to six months after the initial physician's order. The date of the physician's order is known as the first treatment date. **Once a recipient reaches their fifth birthday, the 6-month exemption ends and prior approval is required even if the six months is not over.** The same first treatment date must be entered on each claim submitted during this 6-month period. If a date of service on the claim is prior to the first treatment date, the claim is subject to prior approval. Providers who bill on the CMS-1500 must enter the first treatment date in block 15. Providers who bill on the UB-92 must use the occurrence form locators 32, 33, 34, or 35. Enter a "28" in the occurrence code field and then enter the first treatment date in the corresponding "date" field. Once a first treatment date is entered on a claim, per discipline, and the six months have been exhausted, there can not be another first treatment date or six unmanaged visits. If there is no first treatment date on the claim, prior approval will be required. If a recipient starts on a six unmanaged visit track within a particular discipline then they are not able to change to a 6-month track within that same discipline.

Faxed orders and faxed signatures are permissible and serve the same purposes for documentation as an original signature on an original form or orders sheet.

Prior Approval Process

After six unmanaged visits or six months, prior approval is required for continued treatment. **Please note that prior approval is for medical approval only and does not guarantee payment or ensure recipient eligibility on the date of service.**

When providers accept an individual as a private patient, and the individual subsequently becomes Medicaid eligible, the providers, should they agree to bill Medicaid, may request prior approval from the contractor.

For dates of service on October 1, 2002 and after, providers may request retroactive prior approval. Approval will not be granted for dates of service prior to the recipient's effective date of eligibility.

Providers must submit all required paperwork to the contractor requesting the retroactive date as the start date. **Providers must write "Retroactive Medicaid" on the prior approval form.**

Retroactive Medicaid requests are reviewed by the contractor following the same process that is used for all other outpatient specialized therapy prior approval requests.

A prior approval request form signed by the provider must be faxed to the contractor for treatment to be continued. If appropriate, the contractor will authorize services for a specific number of units through a specific length of time. Units should be requested based on the revenue code/CPT code billed. If the CPT code is billed by event then 1 unit should be requested. If the CPT code is billed in 15-minute increments with 15

minutes equaling 1 unit, then the number of units to be provided should be requested. Revenue codes are billed by event; therefore, one unit should be requested per event. Once these limits have been reached, prior approval must again be requested for continued treatment.

In processing claims for payment, Medicaid will utilize the following hierarchy for counting visits/units:
1. Prior approval units will be expended, if available.
2. If units billed exceed prior approval units remaining, six unmanaged visit count will begin.
3. If units billed exceed prior approval units remaining and there are no unmanaged visits left, the claim will have the units cutback and the remaining units will be decremented.

For example:

If…	**Then…**
The CDSA provider does not have a first treatment date on the claim,	The service will require prior approval.
The CDSA provider has a first treatment date on the claim,	They can provide services for six months without prior approval and the same first treatment date must be present on all claims submitted during these six months.
The provider has prior approval and a first treatment date is on the claim,	Prior approval units will be expended.***
The number of units billed exceeds the PA units remaining,	The six unmanaged visit count will begin, with the exception of CDSA providers.
The number of units billed exceed the PA units remaining and there are no unmanaged visits left,	The claim will have the units cutback and the remaining PA units will be decremented, with the exception of CDSA providers.

*****Exception:** If the first treatment date is before the prior approval start date, the first treatment date will be used to count the six months. The same first treatment date must be present on all claims submitted during these six months. No prior approval will be expended until the six months have ended.

Note: Providers are responsible for ensuring the recipient has not expended their unmanaged visits, therefore, it is suggested that the provider obtain prior approval for each recipient prior to the visit(s).

Billing Guidelines
Providers billing services for recipients who had a CDSA evaluation or a referral from a CDSA must enter the first treatment date (date of physician's order) on the claim. This first treatment date must be on every claim form submitted during the 6-month period. If the provider does not put the first treatment date on the form, the claim is subject to prior approval. Remember that only one first treatment date is permitted per discipline. Providers who bill on the CMS-1500 claim form must enter the date of the physician's order for services in block 15. Providers who bill on the UB-92 must use the occurrence form locators 32, 33, 34, or 35. Enter a "28" in the occurrence code and then enter the first treatment date in the corresponding "date" field.

CMS-1500 Claim Form Billing Reminders
- Separate CMS-1500 claim forms must be filed for assessment/evaluation and treatment services, and for each type of service provided. Because individual and group speech therapy are considered the same type of service, they can be listed on the same claim form.
- Claims for physical therapy, occupational therapy, respiratory therapy, and speech therapy – including claim adjustments and resubmitted claims – submitted for billing, must include one of the discipline-specific ICD-9-CM diagnosis codes listed below as a secondary diagnosis on the claim. This allows Medicaid to correctly accrue the units billed for each specialized therapy authorized during the prior

approval process. This does not change the requirement to bill the primary diagnosis that justifies the need for the specialized therapy.

- **The primary treatment ICD–9-CM diagnosis code must be entered first on the claim form. The discipline-specific V code should follow the primary treatment code.**
  V57.0 – Respiratory Therapy
  V57.1 – Physical Therapy
  V57.21 – Occupational Therapy
  V57.3 – Speech Therapy
- Providers who bill on the CMS-1500 claim form must enter the first treatment date in block 15. The same first treatment date must be entered on each claim submitted during this 6-month period. If a date of service on the claim is prior to the first treatment date, the claim is subject to prior approval.
- Evaluations, re-evaluations, and/or multi-disciplinary evaluations are not subject to prior approval requirements.
- Obtaining prior approval does **not** preclude compliance with the Medicaid program's stipulation that all claims must be received by EDS within 365 days of the first date of service in order to be accepted for processing and payment.

UB-92 Claim Form Billing Reminders

- Claims for hospital and home health services are filed on a UB-92 claim form.
- Providers who bill on the UB-92 claim form must use the occurrence form locators 32, 33, 34, or 35. Enter a "28" in the occurrence code and then enter the first treatment date in the corresponding "date" field. If a date of service on the claim is prior to the first treatment date, the claim is subject to prior approval.
- Providers who bill on the UB-92 claim form are not required to enter discipline-specific V code following the primary treatment code.
- Outpatient Hospital: When requesting prior authorization for outpatient specialized therapy services, the units requested should be based on the revenue code. **Revenue codes are billed by event; therefore, one unit should be requested and billed per day. Failure to follow this policy will result in claim denials.**
- Evaluations, re-evaluations, and/or multi-disciplinary evaluations are not subject to prior approval requirements.
- Obtaining prior approval does **not** preclude compliance with the Medicaid program's stipulation that all claims must be received by EDS within 365 days of the first date of service in order to be accepted for processing and payment.

Systematic Reprocessing

Specialized therapy claims that have been paid or denied incorrectly will be systematically identified and adjusted. In an effort to eliminate the adjusting of claims already identified for systematic processing, all specialized therapy adjustments and replacement claims submitted by providers will be denied until the system adjustments have been completed. If you have submitted an adjustment request or replacement claim for a specialized therapy service that has been identified for systematic adjustment it will be denied with EOB 2046 that states: "Adj request denied. Adj/replacement claims for specialized therapy services will be adjusted systematically."

Time frames for system generated adjustments will be published in future bulletins. When you receive your RA, please review the adjusted specialized therapy claims to determine if your initial adjustment request has been addressed. If so, no further action is required. Providers will be notified when the systematic adjustment processing is complete. Once the systematic adjustments have been completed, the denials of manual adjustments will no longer be in effect.

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

Attention: Durable Medical Equipment and Orthotic and Prosthetic Providers

New Certificate of Medical Necessity and Prior Approval Forms

Based on the new requirements for Board-certification for orthotic and prosthetic providers, effective with the date of service July 1, 2005, the Certificate of Medical Necessity and Prior Approval (CMN/PA) form has been revised. The changes to this document will allow providers to send all pertinent information to EDS for processing of orthotic and prosthetic device prior approval requests.
Changes to the CMN/PA form include:

1. Title will now include Orthotic and Prosthetic Devices.

2. Block 7 "Attending Number" was added to this line.

3. Block 9 the word "Prescribing" was added to "Physician Name" and line also includes a new field for telephone number.

4. Line 14 includes new fields for Height and Weight.

5. Line 20 includes new fields for O2, Flow Rate, Frequency, Test Date and Results.

6. Line 23 includes a new field for Max. distance walked.

7. Line 27 allows for both the billing provider signature and the Board-Certified Practitioner signature.

8. Line 28 now reads Physician, Physician Assistant or Nurse Practitioner.

Changes to the instructions include the directions for completing the new fields added to this document.

EDS, 1-800-688-6692 or 919-851-8888

Attention: Family Planning Services Providers

Medicaid Family Planning Waiver Training Seminars

On October 1, 2005, the N.C. Medicaid program will implement the new Family Planning Waiver program. The program is designed to reduce unintended pregnancies and to improve the well being of children and families in North Carolina by providing family planning services to eligible men and women.
Training on the new Medicaid Family Planning Waiver (MAF-D) is scheduled for September 2005. The training will focus on services that are covered by the waiver program and how to bill for the services. The training schedule and registration information will be published in the August 2005 general Medicaid bulletin.

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

Attention: Health Departments

Rates for New Immunization Codes

Effective with dates of service **July 1, 2005** the following rates for the new Immunization procedure code are available for billing by Health Departments:

Procedure Code	Description	Non-Facility Fee Maximum Reimbursement Rate	Facility Fee Maximum Reimbursement Rate
90465EP	IMMUNIZATION ADMINISTRATION with Physician Counseling	27.42	27.42
90466EP	IMMUNIZATION ADMINISTRATION with Physician Counseling	00.00	00.00
90465	IMMUNIZATION ADMINISTRATION with Physician Counseling	13.71	13.71
90466	IMMUNIZATION ADMINISTRATION with Physician Counseling	13.71	13.71

Financial Management
DMA, 919-855-4200

Attention: Physicians and Hospitals

Extracorporeal Membrane Oxygenation

Effective with date of service July 1, 2005, extracorporeal circulation membrane oxygenation **(**ECMO) procedures require prior approval as outlined in Clinical Coverage Policy #11F.

For ECMO procedures provided to neonates who are not candidates or potential candidates for a transplant procedure, prior approval must be obtained from the Division of Medical Assistance's fiscal agent, EDS.

In urgent situations, providers must submit a request within five days of performing the service. (The first day of treatment is counted as Day 1.) If the request is received within five days, authorization will begin on the first date of treatment if coverage criteria are met. If the request is received six or more days after the initiation of treatment, authorization will begin on the date the service is approved by the fiscal agent. Requests for urgent situations should be marked urgent and may be submitted by fax to 919-816-3139.

Example

ECMO Initiated	Date Approval Request Received by Fiscal Agent	Approval Effective Date
July 6, 2005	July 10, 2005	July 6, 2005
July 6, 2005	July 11, 2005 or later	Date approved by fiscal agent

DMA's fiscal agent reviews the request to determine if the situation meets Medicaid coverage criteria as listed in Clinical Coverage Policy #11F and also to determine if the services were provided under urgent conditions.

Requests for non-urgent care will not be processed under this procedure and must be received and approved prior to rendering the service. These requests may also be submitted by fax to 919-816-3139.

Refer to DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm for a copy of Clinical Coverage Policy #11F.

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

Attention: Physicians and Hospitals

Submission of Prior Approval Requests for Transplants

The Division of Medical Assistance (DMA) requires a complete clinical packet to be submitted with a request for prior approval of transplant procedures.

For **solid organ transplants**, the clinical packet must contain:

- A cover letter summarizing the clinical history of the patient is required from the physician requesting the transplant.
- All lab results inclusive of HIV, RPR, hepatitis panel, PT, INR, and infectious disease serology inclusive of CMV and EBV.
- All diagnostic and procedure results.
- Complete psychological and social evaluation with documentation of post-transplant care needs.
- If there is a psychiatric history on the patient, a psychiatric evaluation is required.
- If there is a history of or active substance abuse, the clinical packet must include documentation of a substance abuse program completion and six months of negative sequential random drug and alcohol screens.
- Other information specific to the transplant procedure to be performed as indicated in the clinical coverage policies on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm.

For **stem cell transplants**, the clinical packet must contain:

- A cover letter summarizing the clinical history of the patient is required from the physician requesting the transplant.
- A description of previous chemotherapy regimes and dates.
- All lab results inclusive of HIV, RPR, hepatitis panel, PT, INR, and infectious disease serology inclusive of CMV and EBV.
- All diagnostic and procedure results inclusive of bone marrow aspiration.
- Complete psychological and social evaluation with documentation of post-transplant care needs.
- If there is a psychiatric history on the patient, a psychiatric evaluation is required.
- If there is a history of or active substance abuse, the clinical packet must include documentation of a substance abuse program completion and six months of negative sequential random drug and alcohol screens.

- Other information specific to the transplant procedure to be performed as indicated in the clinical coverage policies on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm.

Additional clinical information may be requested during the review of the prior approval request.
All prior approval requests for transplants must be coordinated with DMA's Hospital/Transplant Consultant.
Prior approval requests for transplants may be submitted by fax to:

Debbie Garrett, RNC
Hospital/Transplant Consultant
Division of Medical Assistance
FAX: 919-715-0051

Clinical Policy and Programs
DMA, 919-855-4357

Attention: Pharmacy Providers

Drug Coverage under Hospice

Effective February 25, 2005, the point-of-sale system began notifying pharmacists when a recipient is eligible for hospice drug coverage. If the recipient is hospice eligible, drug claims are denied with the message "recipient claim covered by hospice". If the drug claim is not directly related to the recipient's terminal illness, the pharmacist may override the hospice edit by placing a '1' in the PA field and the ICD-9-CM code for the terminal illness in the diagnosis field. It is acceptable to use the three-digit ICD-9-CM code. Please do not enter the ICD-9-CM code in the field for the indication the drug is being used for. Overrides are not allowed on the following drug classes: narcotic analgesics, hematinics, antiemetics and most chemotherapeutics.

Pharmacy providers may contact the Division of Medical Assistance (919-855-4300) with questions regarding Medicaid coverage of pharmacy claims in the four drug classes for which overrides are not allowed. The provider will be given billing instructions if it is determined that Medicaid coverage is appropriate.

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

Attention: Pharmacy Providers

Medicaid Recipients and Transition to Medicare Part D Prescription Drug Plans

Effective January 1, 2006, new Medicare prescription drug plans will be available to Medicaid recipients with Medicare. North Carolina Medicaid hopes that this will be a seamless transition for Medicaid recipients and providers. Recipients who receive their drug coverage through North Carolina Medicaid will continue to have available to them through December 31, 2005 a 90-day supply of non-controlled, generic, maintenance medications provided there has been a previous 30-day prescription in the last 6 months.

We encourage both recipients and providers to utilize this coverage for those recipients transitioning to Medicare Part D on January 1, 2006.

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

Attention: Pharmacy Providers

Pharmacy Stub Audits

The Division of Medical Assistance's Program Integrity Section does not conduct onsite pharmacy audits for Medicaid identification card stubs. A stub is only required for proof of pharmacy of record status when a recipient who is not exempt from the six- prescription limit has used two or more pharmacies in a month and has exceeded the six prescription limit. In these cases, the pharmacy with the stub on file is considered the pharmacy of record and the stub may be used for guarantee of payment for six prescriptions. However, the pharmacy point-of-sale system notifies pharmacists real-time when a recipient has met the six-prescription limit for a particular month; therefore, cases when stubs are required to guarantee payment are rare.

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

Attention: Prescribers and Pharmacists

Prescription Advantage List Update

The Prescription Advantage List (PAL) has been updated. The updated version is now available on DMA's website at http://www.dhhs.state.nc.us/dma/pal/pal.pdf. The PAL list includes some of the most costly classes of medications. An evaluation of the actual net cost of each medication to the N.C. Medicaid program including rebates is conducted and the medications in each class are ranked in order from least to most expensive based on the listed unit dosage as determined by the N.C. Physicians Advisory Group.

The current percentage net cost variation between the least and the most expensive medication is listed below:

1* > 50% below average net cost
1 15-50% below average net cost
2 +/- 15% average net cost
3 > 15% average net cost

At this time, the most important classes to attain cost savings from are the proton pump inhibitors, non-sedating antihistamines, selective serotonin reuptake inhibitors and sedative hypnotics.

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

Attention: Pharmacy Providers!

Removal of Impotency Drugs from Medicaid Coverage

The N.C. Division of Medical Assistance has made the decision to suspend coverage of drugs used to treat impotency pending a review by the N.C. Physician's Advisory Group (PAG). Effective with date of service June 6, 2005, all drugs in therapeutic class F2A were end-dated to non-coverage status. Claims submitted with dates of service June 6, 2005 and after for these drugs will be denied.

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

Attention: Pharmacy Providers

Six Prescription Limit and Recipient Lock-In To One Pharmacy Each Month

North Carolina Medicaid recipients are restricted to a single pharmacy each month except for emergency situations. An emergency situation can include cases where the original pharmacy is out of a medication and it is necessary for a Medicaid recipient to obtain the needed medication at another pharmacy in the month of record. Another example would be if the pharmacy of record is closed for business and the recipient needs the medication. In such cases, it is important that pharmacy providers work together to meet the medication needs of the recipient. It is also important to note that there is no prescription limit for children under the age of 21; therefore, it is not necessary to lock these recipients into a particular pharmacy. However, to ensure continuity of care, recipients are encouraged to obtain their medications from one pharmacy each month when possible.

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

Attention: Orthotic and Prosthetic Providers

Orthotic and Prosthetic Billing Seminars

Orthotic and Prosthetic Billing Seminars are scheduled for July 2005. As a reminder, the July 2005 Special Bulletin V, Orthotic and Prosthetic Devices, is available on DMA's website at http://www.dhhs.state.nc.us/dma/bulletin.htm#special. Please print this document and bring it to the seminar with you if you are registered to attend. To register for the Orthotic and Prosthetic Billing Seminars, please go to DMA's website at http://www.dhhs.state.nc.us/dma/semreg/O&PSeminar.htm.

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

Attention: Physicians

Add-on Code 61795

As indicated in the CPT code description, add-on code 61795, **Stereotactic computer assisted volumetric (navigational) procedure, intracranial, extracranial, or spinal (list separately in addition to code for primary procedure)**, must be billed with a primary procedure code.

Effective June 24, 2004, the list of primary procedure codes with which CPT code 61795 may be billed has been updated. Refer to the table below for a complete list of acceptable primary procedure codes. Codes that have been added are indicated in bold print.

22100 – 22328	22548 – 22851	**31254 – 31267**	**31276**
31287 – 31288	**31290 – 31294**	61304 – 61793	63001 – 63091

Claims submitted for dates of service on or after June 24, 2004 with add-on code 61795 that were denied because the primary code was not acceptable at the time the claim was processed, may now be refiled.

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

Attention: All Physicians

Hyperbaric Oxygenation Therapy: Approval for Urgent Treatment

As stated in Clinical Coverage Policy # 1A-8, prior approval is required for Hyperbaric Oxygenation (HBO) therapy. In order to facilitate delivery of HBO therapy in urgent situations, the following process is being implemented beginning July 1, 2005.

In urgent situations providers must submit a request within five days of performing the service. (The first day of treatment is counted as Day 1.) If the request is received within five days, authorization will begin on the first date of treatment if coverage criteria are met. If the request is received six or more days after the initiation of treatment, authorization will begin on the date the service is approved by the fiscal agent. (Requests for urgent situations should be marked "urgent" and may be submitted by fax to 919-816-3139.)

Example

HBO Therapy Initiated	**Date Approval Request Received by Fiscal Agent**	**Approval Effective Date**
July 6, 2005	July 10, 2005	July 6, 2005
July 6, 2005	July 11, 2005 or later	Date approved by fiscal agent

DMA's fiscal agent reviews the request to determine if the situation meets Medicaid coverage criteria as listed in Clinical Coverage Policy # 1A-8 and also to determine if the services were provided under urgent conditions.

Requests for non-urgent care will not be processed under this procedure and must be received and approved prior to rendering the service. These requests may also be submitted by fax to 919-816-3139.

Refer to DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm for a copy of Clinical Coverage Policy # 1A-8.

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

Attention: Podiatrists

HCPCS Code A4550

Podiatrists can now refile claims for HCPCS supply code A4550 for dates of service February 11, 2004 through April 8, 2005 that were incorrectly denied with EOB 79: "this service is not payable to your provider type in accordance with Medicaid guidelines." Providers are reminded to file the claim exactly as it was originally submitted and that they have 18 months from the date of denial to resubmit their claims.

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

Attention: CAP-MR/DD Providers

2005 CAP-MR/DD Cost Report

Based on the anticipated knowledge of significantly new service definitions for CAP-MR/DD services, it has been determined that cost data providers would be able to provide on the 2004-2005 cost report would not be usable in establishing the new service rates. Therefore the CAP-MR/DD cost report **is not** required for the period of July 1, 2004, through June 30, 2005. The new services are currently scheduled to become effective on September 1, 2005.

Rate Setting
DMA, 919-855-4200

Attention: All Providers

Basic Medicaid Billing Seminar Schedule

Basic Medicaid Billing seminars are scheduled for August 2005. Seminars are intended for providers who are new to the NC Medicaid program. Topics to be discussed will include, but are not limited to, provider enrollment requirements, billing instructions, eligibility issues, and Managed Care. Persons inexperienced in billing N.C. Medicaid are encouraged to attend.

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

Providers may register for the Basic Medicaid Billing seminars by completing and submitting the registration form below or by registering online at http://www.dhhs.state.nc.us/dma/prov.htm. Please indicate the session you plan to attend on the registration form. Seminars begin at 10:00a.m. and will end at 1:00p.m. Providers are encouraged to arrive by 9:45a.m. to complete registration.

Providers must print the PDF version of the August 2005 Basic Medicaid Billing Guide from DMA's website at http://www.dhhs.state.nc.us/dma/medbillcaguide.htm and bring it to the seminar.

Thursday, August 4, 2005
Coast Line Convention Center
501 Nutt Street
Wilmington, NC

Friday, August 5, 2005
Jane S. McKimmon Center
1101 Gorman Street
Raleigh, NC

Tuesday, August 9, 2005
Holiday Inn Conference Center
530 Jake Alexander Blvd S.
Salisbury, NC

Wednesday, August 10, 2005
Blue Ridge Community College
Bo Thomas Auditorium
College Drive
Flat Rock, NC

Basic Medicaid Billing
Seminar Registration
(No Fee)

Provider Name _____ Provider Number _____
Address _____
City, Zip Code _____ County _____
Contact Person _____ E-mail Address _____
Telephone Number (____) _____ Fax Number (____) _____
1 or **2** (circle one) person(s) will attend the seminar at _____ on _____
(location) (date)

Return to: Provider Services
EDS
P.O. Box 300009
Raleigh, NC 27622
1-800-688-6696 or 919-851-8888

Proposed Clinical Coverage Policies

In accordance with Session Law 2003-284, proposed new or amended Medicaid clinical coverage policies are available for review and comment on DMA's website at http://www.dhhs.state.nc.us/dma/prov.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.

Gina Rutherford
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.

2005 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
July	07/01/05	07/07/05
	07/08/05	07/12/05
	07/15/05	07/19/05
	07/22/05	07/28/05
August	07/29/05	08/02/05
	08/05/05	08/09/05
	08/12/05	08/16/05
	08/19/05	08/25/05
September	09/02/05	09/07/05
	09/09/05	09/13/05
	09/16/05	09/20/05
	09/23/05	09/23/05

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.

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

Cheryll Collier
Executive Director
EDS