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North Carolina Medicaid Bulletin

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

Attention: All Providers

2006 Revised Fees

Effective July 1, 2006, rates for the 2006 CPT codes were revised based on information from the Centers for Medicare and Medicaid Services (CMS). Due to the rate freeze that is currently in effect, only those rates that CMS decreased were revised. All other codes remained at their current rate.

Providers may receive a current fee schedule by completing and submitting a copy of the Fee Schedule Request form http://www.ncdhhs.gov/dma/Forms/pubr.pdf.

As of July 1, 2006, revised fee schedules will be available on the DMA website at http://www.ncdhhs.gov/dma/fee/fee.htm. Mental Health fee schedules can be found at http://www.ncdhhs.gov/dma/fee/mhfee.htm.

Providers must bill their usual and customary charges.

Financial Management
DMA, 919-855-4200

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.ncdhhs.gov/dma/mp/mpindex.htm:

A4 – Services for Individuals with Mental Retardation/Developmental Disabilities and Mental Health/Substance Abuse Co-occurring Disorders

1M-1 – Child Care Coordination

1A-20 – Sleep Studies and Polysomnography Services

5A – Durable Medical Equipment

5B – Orthotics and Prosthetics

8A – Enhanced Mental Health and Substance Abuse Services

9 – Outpatient Pharmacy Services

10B – Independent Practitioner

10C - Local Education Agencies

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

Electronic Funds Transfer Form – Revised Form

EDS offers EFT as an alternative to paper checks. This service enables Medicaid payments to be automatically deposited in the provider's bank account. EFT guarantees payment in a timely manner and prevents checks from being lost or stolen. This form has been revised and is included in this bulletin.

To initiate the automatic deposit process, providers are required to complete and return the EFT form. To confirm the provider's account number and bank transit number, a voided check or a letter from the bank verifying the banking information, must be attached to the form. A separate EFT form and voided check or bank letter must be submitted for each provider number. Providers must also submit a new EFT form and voided check or bank letter if they change banks or bank accounts. It is not necessary to fill in and send the revised form to maintain direct deposit by EFT if the provider has an EFT form with current information already on file. With the numerous bank mergers, please make sure that the bank routing number is correct. Many times bank's will allow their customer's to use old check stock that may contain old routing numbers. Although these checks will process and pay, there have been EFT deposits that have rejected.

Completed forms may be faxed to the number or mailed to the address listed on the form. If a provider has the ability to scan documents and send via email, the EFT form and voided check/bank letter may be emailed to EFT@ncxix.hcg.eds.com.

Note: Providers will continue to receive paper checks for two checkwrite periods before automatic deposit begins or resumes to a new bank account. Providers may verify that the EFT process for automatic deposit has been completed by checking the top left corner of the last page of their Remittance and Status Report, which will indicate **EFT number** rather than **check number**.

The Electronic Funds Transfer Form is available on DMA's website at http://www.ncdhhs.gov/dma/forms/eft.pdf.

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

Attention: All Providers

Contact Information for EDS Finance

EDS is working to make it easier for the provider community to contact Finance with questions and for follow-up communications. We recently added the following email addresses:
EFT@ncxix.hcg.eds.com – Contact this address if you need the form to request Electronic Funds Transfer (EFT), have the ability to scan in and return the forms, or have a question regarding EFT.
RemittancePayments@ncxix.hcg.eds.com – Contact this address if you have not received your Remittance Advice (RA), cannot read your RA, or have questions regarding your RA.
NCXIXFinance@ncxix.hcg.eds.com – Contact this address if you have a question for Finance on items OTHER THAN Remittance Advices or EFT.

Note: Please make sure that you do not send Personal Health Information to any of the above email addresses. This will prevent possible disclosure of confidential data, thereby avoiding violation of HIPAA regulations. Violations can result in substantial penalties.

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

Attention: All Providers

HMO SouthCare Termination

Effective August 1, 2006, the SouthCare health maintenance organization, which operates solely in Mecklenburg County, will no longer serve the Medicaid population. Community Care of North Carolina (CCNC), which includes Carolina ACCESS, will be the only Medicaid managed care option for recipients in Mecklenburg County. Please refer all recipients who have questions to the health benefit advisor, Public Consulting Group. Their phone number is 704-373-2273. SouthCare providers are encouraged to submit claims to the Plan timely.

Managed Care
DMA, 919-647-8179

Attention: All Providers

Sleep Study and Polysomnography

Effective with date of service June 15, 2006, the N.C. Medicaid program will no longer cover CPT procedure code 95806 (sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, unattended by a technologist). All sleep study and polysomnography services must be attended/supervised in a sleep laboratory.

Effective with date of service June 15, 2006, the CPT procedure codes 95805, 95807, 95808, 95810, and 95811 are covered by N.C. Medicaid only for the following diagnoses:

ICD-9-CM Diagnosis Code	Description
278.01	Morbid obesity
278.8	Other hyperalimentation
307.47	Other dysfunctions of sleep states or arousal from sleep
307.48	Repetitive intrusions of sleep
345.80	Other forms of epilepsy without mention of intractable epilepsy
345.81	Other forms of epilepsy with intractable epilepsy
347.00	Narcolepsy without cataplexy
347.01	Narcolepsy with cataplexy
347.10	Narcolepsy in conditions classified elsewhere without cataplexy
347.11	Narcolepsy in conditions classified elsewhere with cataplexy
780.09	Alterations of consciousness, other
780.51	Insomnia with sleep apnea
780.53	Hypersomnia with sleep apnea
780.54	Other hypersomnia
780.55	Disruptions of 24-hour sleep–wake cycle
780.56	Dysfunctions associated with sleep stages or arousal from sleep
780.57	Other and unspecified sleep apnea
780.58	Sleep related movement disorder
780.59	Other sleep disturbances
799.0	Asphyxia

Providers must bill the ICD-9-CM diagnosis code that most accurately describes the reason for the encounter. Diagnostic codes must be billed at their highest level of specificity.

Refer to Clinical Coverage Policy #1A-20, *Sleep Studies and Polysomnography Services,* on DMA's Web site at http://www.ncdhhs.gov/dma/mp/mpindex.htm for additional information on coverage criteria and service requirements.

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

Attention: All Providers

Tax Identification Information

Providers receiving Medicaid payments of more than $600 annually receive a 1099 MISC tax form from EDS. The 1099 MISC tax form is generated as required by IRS guidelines. It is mailed to each qualifying provider no later than January 31st of the following year. The 1099 MISC tax form will reflect the tax information on file with Medicaid as of the last Medicaid checkwrite cycle cutoff date.

The N.C. Medicaid program must have the correct tax information on file for all providers. This ensures that 1099 MISC forms are issued correctly each year and that correct tax information is provided to the IRS. Incorrect information on file with Medicaid can result in the IRS requiring Medicaid to withhold 28% of a provider's Medicaid payments. **The individual responsible for maintenance of tax information must receive the information contained in this article.**

How to Verify Tax Information
The last page of the Medicaid Remittance and Status Report (RA) indicates the tax name and number on file with Medicaid for the provider number listed. Reviewing the Medicaid RA throughout the year helps ensure the correct tax information is on file for each provider number. If you do not have access to a Medicaid RA, call EDS Provider Services at 919-851-8888 or 1-800-688-6696 to verify the tax information on file for each provider.

How to Correct Tax Information
Providers with incorrect information on file must complete a W-9 form, available from the IRS at http://www.irs.gov/pub/irs-pdf/fw9.pdf. Provider Services at the Division of Medical Assistance (DMA) must receive correct information **by the first week of December** in order to have the correct information filed for that calendar year. The procedure for submitting corrected tax information to the Medicaid program is outlined below.

All providers, including Managed Care providers, must submit completed and signed W-9 forms, along with a completed and signed Medicaid Provider Change Form, to the address listed below:

Division of Medical Assistance
Provider Services
2501 Mail Service Center
Raleigh, NC 27699-2501

Additional instructions can be found on the IRS' website at www.irs.gov under the link "Forms and Pubs." for forms and publications.

If DMA is not contacted and the incorrect tax identification number is used, that provider will be **liable for taxes** on income not necessarily received by the provider's business. DMA will assume no responsibility for penalties assessed by the IRS or for misrouted payments prior to written receipt of notification of ownership changes.

The Medicaid Provider Change Form and Carolina ACCESS Provider Information Change Forms are available on DMA's website at http://www.ncdhhs.gov/dma/forms.html#prov.

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

Attention: All Providers

HIV Diagnosis Code 042 Used with 87534 and 87536

Effective with date of processing March 24, 2006, ICD-9-CM diagnosis code 042, *Human Immunodeficiency Virus (HIV)*, is not required when billing CPT codes 87534, *Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, direct probe technique*, and 87536, *Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, quantification.* However, providers must enter an appropriate ICD-9-CM diagnosis on the claim when billing codes 87534 and 87536.

Providers who received claim denials related to ICD-9-CM diagnosis code 042 may resubmit a new claim for processing.

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

Attention: Adult Care Home Providers

Prior Approval Process for Medicaid Payment for Recipients Residing in an Adult Care Home (ACH) Special Care Unit for Persons with Alzheimer's and Related Disorders (SCU-A)

Session Law 2005- 276 provided for additional Medicaid funding for the care of residents residing in Special Care Units for Persons with Alzheimer's and Related Disorders (SCU-A) located in Adult Care Homes. Effective with the date of service October 1, 2006, the N.C. Medicaid Program will implement a special care rate for ACH providers Operating Special Care Units for Persons with Alzheimer's and Related Disorders.

Medicaid will reimburse providers according to the following procedure:

1. ACH providers who admit Medicaid recipients who receive State and County Special Assistance and have an Ambulation Code of "C" on their eligibility file are eligible to apply for prior approval to receive a special Medicaid enhanced service rate through the Division of Medical Assistance when that recipient is admitted to a SCU-A.
2. Providers must obtain prior approval from DMA before admitting a new resident to a SCU-A. No retroactive prior-approval will be provided.
3. Providers must obtain prior approval from DMA within 7 days of admitting a Resident who currently resides in another unit of the ACH into the home's SCU-A. in order to receive the SCU-A rate from the date of admission. Otherwise, if approved, prior approval will be effective retroactive to the date received by DMA.
4. Providers must send the following information to obtain prior approval from DMA:
    a. Completed DMA SCU-A Prior Approval Request Form[1].
    b. Current FL-2, signed by a physician, with a primary diagnosis of Alzheimer's and Related Disorders[2]
    c. Copy of the Pre-Admission Screening by the facility to evaluate the appropriateness of an individual's placement in the SCU-A as required by current rule.
    d. Copy of current 3050R if resident is not new to the home.
    e. Copy of the Provider's current ACH License with SCU-A designation[3].
    f. Copy of Provider's current ACH SCU-A Disclosure statement.

[1] See Attachment A

[2] ICD-9-CM Acceptance Indicator – A list of diagnosis codes relating to Alzheimer's and Related Disorders--- Alzheimer's Disease 331, Multi-Infarct Dementia 290.4, Parkinson's disease 332, Huntington's disease 333.4, Creutzfeldt - Jakob disease 294.10, Pick's Disease 331.11, Lewy Body Dementia 331.82. One of these diagnosis codes must be listed as the primary diagnosis on the claim for payment of SCU-A codes.

[3] Complete facility information is only due once per year –as per schedule or upon facility status change or as needed.

5. Providers send the requested information via US Mail to:
   DMA ACH Unit
   NC DHHS
   Division of Medical Assistance
   Facility and Community Care Section
   1985 Umstead Drive
   2501 Mail Service Center
   Raleigh, NC 27699-2501

Other important information for ACH Providers to know related to the Prior Approval for SCU-A Payment:

1. Providers will not receive payment for Enhanced ACH/PCS services for a recipient receiving payment for SCU-A.
2. Recipients must receive Basic PCS at the same time as SCU-A services.
3. DMA will mail a decision notice to the ACH provider within 15 working days of receipt of prior approval request.
4. DMA will contact fiscal agent and authorize Medicaid reimbursement for days approved.
5. In order to avoid payment processing delays, beginning August 1, 2006, providers may begin to submit the required prior approval information to DMA for residents who currently reside in a SCU-A and are expected to remain until October1, 2006. Upon approval, the new rate will begin effective with date of service October 1, 2006.

Instructions for completing the Adult Care Home SCU-A form:

1. This form is only to be used by Adult Care Homes with Special Care Unit Designations which is available on DMA's website at http://www.ncdhhs.gov/dma/forms.html#prov.
2. Print clearly.
3. All copies of items submitted must be legible.
4. The complete facility information is only due once per year- as per schedule or upon facility status change or as otherwise needed.

5. THIS IS A HIPAA REQUIREMENT: The completed form and information must be sent in a sealed envelope with "confidential" written in red and then placed in another envelope and addressed as in #6 below. DMA will not accept faxed records.

6. Completed form must be sent via US Mail to the following address:
   NC DHHS – DMA
   ACH Unit
   Facility and Community Care
   1985 Umstead Drive
   2501 Mail Service Center Raleigh, NC 27699-2501

7. For questions contact:
   Nancy Roberts @ 919-855-4116 or Nancy.Roberts@ncmail.net or
   Julie Budzinski @ 919-855-4368 or Julie.Budzinski@ncmail.net

Clinical Policy and Programs
DMA, 919-855-4116 and /or 919-855-4368

Attention: Child Service Coordination Providers

Infant-Toddler Program Referrals

Effective July 1, 2006, the new eligibility definition for the North Carolina infant-toddler program at http://www.ncei.org/ei/index.html should be used when determining the appropriateness of a referral to the program. Clinical Coverage Policy #1m-1, *Child Care Coordination*, has been updated to direct providers to the North Carolina early intervention services webpage for eligibility requirements.

Clinical Policy and Programs
DMA, 919-855-4260

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

Electronic Submission Process for Prior Authorization Requests for Outpatient Specialized Therapy Services

Over the past year, the Division of Medical Assistance (DMA) and the Carolinas Center for Medical Excellence (CCME) have worked together to develop a Web-based electronic submission process for prior authorization requests for outpatient specialized therapy services. The process was developed in collaboration with the Therapy Advisory Group. Because outpatient specialized therapy services can be provided by different provider types, subgroups within the Therapy Advisory Group were established according to provider type to identify and recommend the types of fields and formats that are needed to accommodate prior authorization requests submitted by each type of provider.

The new Web site is based on the recommendations of the subgroups as well as on current documentation requirements. Besides being the starting point for submission of prior authorization requests, the site will allow providers to complete information missing from a request, track the review status of individual submissions, print outcome letters, enter discharge information, and generate various reports.

While providers still have the option to submit requests via fax or mail, the Web site offers many features that are not available through these traditional routes:

- Assessment areas include corresponding evaluation templates, so the user can simply enter appropriate scores or measurements instead of pages of text.
- Reauthorizations require only the addition of new information; all previous goals and goal status will be displayed.
- Users will receive e-mail notification either that requests have been completed or that required information is missing.
- Any information entered may be printed.
- All documentation submitted for review will be accessible in a history function.

As part of the implementation plan for the Web site, the current, one-page prior authorization request form was revised to comply with the fields and format of the electronic prior authorization request. The form was also changed to include all of the documentation required for review. No additional or agency-specific forms are needed.

To ensure that the revised form meets the needs of the provider community, the Therapy Advisory Group and various state associations (N.C. Physical Therapy Association, Association for Home and Hospice Care of N.C., etc.) reviewed the form in April 2006. Comments from this review were sent to DMA and CCME and incorporated into the revised form.

Providers who choose to submit prior authorization requests electronically also have the option of using a file transfer protocol. CCME will provide a file format to providers.

Members of the Therapy Advisory Group will test the Web-based electronic submission process for prior authorization requests during July 2006. Once the testing phase is complete, training will be scheduled for all providers. Details on training and implementation dates will be published in future general Medicaid bulletins. Updates will also be included in the fax cover sheets sent with communications from CCME and on the CCME Web site at http://www.mrnc.org/mrnc_web/mrnc/medicaid.aspx.

CCME, 1-800-228-3365, ext 2043

Attention: Durable Medical Equipment Providers

Fee Schedule Changes for Durable Medical Equipment Interim Rates

Effective with date of service August 1, 2006, rates changed for the durable medical equipment (DME) HCPCS code below, previously added with an interim rate. Medicare pricing has now become available for this code.

E0705	Transfer board or device, any type, each

For current pricing on this and all DME codes, refer to DMA's Web page, Fee Schedules portion, at http://www.ncdhhs.gov/dma/fee/fee.htm.

For all billings, providers are reminded to bill their usual and customary rates. Do not automatically bill the established maximum reimbursement rate. Payment will be the lesser of the billed usual and customary rate or the maximum reimbursement rate.

Rate Setting
DMA, 919-855-4200

Attention: Durable Medical Equipment Providers

New DME codes

Effective July 1, 2006, the following items have been added to the capped rental section of the Durable Medical Equipment (DME) fee schedule

E1029	**WHEELCHAIR ACCESSORY, VENTILATOR TRAY, FIXED**
E1030	**WHEELCHAIR ACCESSORY, VENTILATOR TRAY, GIMBALED**

These items may be covered if the patient is dependent on mechanical ventilator support. The codes do not require prior approval. The lifetime expectancy is three (3) years.

For current pricing on this and all DME codes, refer to DMA's web page at http://www.ncdhhs.gov/dma/fee/fee.htm.

For all billings, providers are reminded to bill their usual and customary rates. Do not automatically bill the established maximum reimbursement rate. Payment will be the lesser of the billed usual and customary rate or the maximum reimbursement rate.

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

Attention: Nursing Facilities, Medical and Psychiatric Hospital Providers, Adult Care Home Providers, and Intermediate Care Facilities for the Mentally Retarded

Medicaid Reimbursement and Date of Admission and Discharge Dates

Medicaid reimbursement to nursing facilities and intermediate care facilities is based on the facility's midnight census. Because payment can be made to only one facility for each day of care, the date of admission is counted as the first day the patient occupies a bed at the midnight census.

The date of discharge is counted as the last day the patient occupies a bed at the midnight census. The discharge date is not considered a day of patient care and is not billable to Medicaid. This also applies to the date of death when it occurs prior to the midnight census. The date of death is not considered a day of patient care and is not billable to Medicaid. The only exception to this procedure is if the date of admission and the date of discharge (or the date of death) occur on the same day.

This policy will be effective August 1, 2006.

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

Attention: Orthotic and Prosthetic Providers

Fee Schedule Changes for Interim Rates

Effective July 1, 2006, rates have been changed for the Orthotic and Prosthetic Equipment (O&P) HCPCS codes below, previously added with an interim rate. Medicare pricing has now become available for these codes.

L2034	Knee-ankle-foot orthosis, full plastic, single upright, with or without free motion knee, mediallateral rotation control, with or without free motion ankle, custom fabricated
L2387	Addition to lower extremity, polycentric knee joint, for custom fabricated knee-ankle-foot orthosis, each joint
L3671	Shoulder orthosis, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustments
L3672	Shoulder orthosis, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3673	Shoulder orthosis, abduction positioning (airplane design), thoracic component and support bar, includes nontorsion joint/turnbuckle, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3702	Elbow orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3763	Elbow-wrist-hand orthosis, rigid, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3764	Elbow-wrist-hand orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3765	Elbow-wrist-hand-finger orthosis, rigid, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3766	Elbow-wrist-hand-finger orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3905	Wrist-hand orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment

L3913	Hand-finger orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3919	Hand orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3921	Hand-finger orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3933	Finger orthosis, without joints, may include soft interface, custom fabricated, includes fitting and adjustment
L3935	Finger orthosis, nontorsion joint, may include soft interface, custom fabricated, includes fitting and adjustment
L3961	Shoulder-elbow-wrist-hand orthosis, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3967	Shoulder-elbow-wrist-hand orthosis, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3971	Shoulder-elbow-wrist-hand orthosis, shoulder cap design, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3973	Shoulder-elbow-wrist-hand orthosis, abduction positioning (airplane design), thoracic component and support bar, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3975	Shoulder-elbow-wrist-hand-finger orthosis, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3976	Shoulder-elbow-wrist-hand-finger orthosis, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3977	Shoulder-elbow-wrist-hand-finger orthosis, shoulder cap design, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3978	Shoulder-elbow-wrist-hand-finger orthosis, abduction positioning (airplane design), thoracic component, and support bar, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment

L5703	Ankle, symes, molded to patient model, socket without solid ankle cushion heel (SACH) foot, replacement only
L5971	All lower extremity prosthesis, solid ankle cushion heel (SACH) foot, replacement only
L6883	Replacement socket, below elbow/wrist disarticulation, molded to patient model, for use with or without external power
L6884	Replacement socket, above elbow disarticulation, molded to patient model, for use with or without external power
L6885	Replacement socket, shoulder disarticulation/interscapular thoracic, molded to patient model, for use with or without external power
L7400	Addition to upper extremity prosthesis, below elbow/wrist disarticulation, ultralight material (titanium, carbon fiber or equal)
L7401	Addition to upper extremity prosthesis, above elbow disarticulation, ultralight material (titanium, carbon fiber or equal)
L7402	Addition to upper extremity prosthesis, shoulder disarticulation/interscapular thoacic, ultralight material (titanium, carbon fiber or equal)
L7403	Addition to upper extermity prosthesis, below elbow/wrist disarticulation, acrylic material
L7404	Addition to upper extremity prosthesis, above elbow disarticulation, acrylic material
L7405	Addition to upper extremity prosthesis, shoulder disarticulation/interscapular thoracic, acrylic material

For current pricing on this and all O & P codes, refer to DMA's Web page, Fee Schedules portion, at http://www.ncdhhs.gov/dma/fee/fee.htm.

For all billings, providers are reminded to bill their usual and customary rates. Do not automatically bill the established maximum reimbursement rate. Payment will be the lesser of the billed usual and customary rate or the maximum reimbursement rate.

Rate Setting
DMA, 919-855-4200

Attention: Personal Care Services and Personal Care Services–Plus Providers

Personal Care Services Provider Training Sessions

The Carolinas Center for Medical Excellence (CCME) has recently been awarded a contract by the Division of Medical Assistance (DMA) to begin performing personal care service (PCS) compliance reviews. Please visit CCME's Web site at www.mrnc.org for more information about the PCS compliance review contract. (From the home page, go to NC, then Private Services, Contracts, and Projects: Medicaid Reviews, then Personal Care Services.)

As part of this contract, CCME will be conducting quarterly provider training sessions for registered nurses, agency administrators, and agency owners throughout the state. The initial series of training sessions will target the following issues related to the PCS Policy:

- Physician orders
- Physician Authorization for Certification and Treatment (PACT) form
- Quality Assurance/Utilization Review

Preregistration is required and space is limited to 200 participants at each session.

To register online, go to http://www.mrnc.org/mrnc_web/mrnc/medicaid.aspx?ID=Registration and follow the instructions for registration. A computer-generated confirmation number will confirm your registration.

To register via fax, complete the following form and fax it to the attention of Jennifer Manning at 919-380-9457. A member of the PCS team will call you with a confirmation number.

Registration is open now for all sites. Closing dates are **July 7** for Greenville, Fayetteville, and Raleigh and **July 14** for Asheville and Winston-Salem. If you need to cancel at any time, please contact Jennifer Manning at 919-380-9860, x2018.

Training locations are across the state; please choose the most convenient date and time from the list below. Check-in for each session begins at 8:00 a.m. and the training sessions are scheduled from 9:00 a.m. to 5:00 p.m. Lunch will not be provided during the training.

July 12, 2006 Greenville, North Carolina Hilton Greenville 207 SW Greenville Boulevard 252-355-5000 http://www.hilton.com/en/hi/hotels/maps_directions.jhtml?ctyhocn=PGVNCHF
July 14, 2006 Fayetteville, North Carolina Holiday Inn Bordeaux 1707 Owen Drive 910-323-0111 http://www.ichotelsgroup.com/h/d/hi/1/en/hd/fayow

July 17, 2006 Raleigh, North Carolina North Raleigh Hilton 3415 Wake Forest Road 919-872-2323 http://www.hilton.com/en/hi/hotels/index.jhtml?ctyhocn=RDUNHHF
July 19, 2006 Asheville, North Carolina Crown Plaza (formerly Holiday Inn Sunspree) One Holiday Inn Drive 828-254-3211 http://www.ashevillecp.com/
July 20, 2006 Winston-Salem, North Carolina Hawthorne Inn and Conference Center 420 High Street 336-777-3000 http://www.hawthorneinn.com/

Facility and Community Care
DMA, 919-855-4360

Attention: TCM/MR-DD Case Managers, CAP/MR Case Managers, CAP/MR Service Providers

Prior Authorization for Services by ValueOptions

Effective with date of service September 1, 2006, all new CAP/MR/DD recipients must have their initial plans of care reviewed by ValueOptions. These will be submitted by the targeted case manager for MR/DD to ValueOptions for approval. Copies of the plan of care should be submitted to the local management entity (LME) in the recipient's catchment area as a registering mechanism to alert the LME to new CAP consumers.

Also beginning September 1, 2006, all continued need reviews (CNRs) will be reviewed by ValueOptions during the birthday month of recipient.

Within the plan of care, there are discrete services that will require review and authorization between the initial plan of care and the CNRs. Please refer to the July Special Bulletins for a list of these services.

Training specific to CAP/MR/DD providers and targeted case management providers regarding this process will be held the week of July 17th in Asheville, Hickory, Greenville, and Raleigh. For registration forms, site locations, and directions, please go to the ValueOptions Web site at www.Valueoptions.com, click on "For Providers," then on "Network-Specific Information," and then on "North Carolina Medicaid."

Behavioral Health Services
DMA, 919-855-4290

Attention: UB-92 Billers

Use of National Coding on the UB-92 Claim Form

Health Insurance Portability and Accountability Act (HIPAA) standards mandate the use of valid national coding for all services billed for payment. In addition to valid service codes, providers are required to use nationally recognized codes for patient status, condition code, occurrence code and occurrence span code, and value code.

Effective with claims received for processing after August 1, 2006, the following locally created codes will no longer be accepted for billing Medicaid services. Claims submitted using these codes will be denied with EOB 1808 and will require resubmission for payment. Refer to the *Basic Medicaid Billing Guide*, Section 5 (available online at (http://www.ncdhhs.gov/dma/bulletin/Section5.pdf) for the valid national codes.

Form Locator	Field	Ranges
FL 22	Patient Status	10-19 21-29 31-39
FL 24-30	Condition Code	X0-ZZ *88
FL 32-35	Occurrence Code	50-69 J0-LZ
FL 36	Occurrence Span Code	X0-ZZ 80-99
FL 39-41	Value Code	80-99 X0-ZZ

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

NCLeads Update

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

Provider Relations
Office of MMIS Services
919-647-8315

Proposed Clinical Coverage Policies

In accordance with Session Law 2005-276, proposed new or amended Medicaid clinical coverage policies are available for review and comment on DMA's website at http://www.ncdhhs.gov/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.

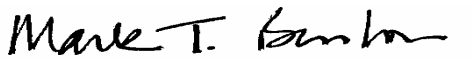
Gina Rutherford
Division of Medical Assistance
Clinical Policy Section
2501 Mail Service Center
Raleigh, NC 27699-2501

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.

2006 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
July	06/30/06	07/06/06
	07/07/06	07/11/06
	07/14/06	07/18/06
	07/21/06	07/27/06
August	08/04/06	08/08/06
	08/11/06	08/15/06
	08/18/06	08/22/06
	08/25/06	08/30/06
September	09/01/06	09/06/06
	09/08/06	09/12/06
	09/15/06	09/19/06
	09/22/06	09/28/06

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, Senior Deputy Director
and Chief Operating Officer
Division of Medical Assistance
Department of Health and Human Services

Cheryll Collier
Executive Director
EDS