July 2007 Medicaid Bulletin

Visit DMA on the Web at: http://www.ncdhhs.gov/dma

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Attention: All Providers

Include Zip+4 on Claims

Providers are now required to include the last four digits of the ZIP code in the billing address and service facility location address fields on all claims. Requirements for each claim form regarding ZIP+4 are listed below.

- **CMS-1500**: The ZIP+4 is required in blocks 32 (service facility location) and 33 (billing address), or electronic equivalent. Unless the place of service is the recipient's home, complete both fields even if the billing address and service facility location address are identical. Do not use the word "SAME." If the place of service on the claim is the recipient's home, leave block 32 blank.
- **UB-04**: The ZIP+4 is required in form locator 1, or electronic equivalent. Complete form locator 1 using the provider's site address. Complete form locator 2 (billing address) only if the billing address is different from the site address entered in form locator 1.
- **ADA**: The ZIP+4 is required in fields 48 (billing address) and 56 (site address), or electronic equivalent. Complete both fields even if the addresses are identical. Do not use the word "SAME."

To locate your ZIP+4, use the following link: USPS - ZIP Code Lookup. Once NPI is implemented, the ZIP+4 will be an important component for claims processing. Therefore, it is imperative for providers to begin including this information on claims.

NPI – Get it! Share It! Use It! Getting one is free – Not having one can be costly!

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

Attention: All Providers

17th Baby Love Conference

Join us for the 2007 Baby Love Conference, August 27-28, 2007, at the Sheraton Imperial Hotel & Convention Center in Durham, N.C. This year's theme is Celebrating Victories, Promoting Partnerships. This is an important event that will provide training, skill building, and networking opportunities for a broad variety of professionals who provide essential services to women, children, and families.

Conference participants will include social workers, nurses, paraprofessionals, and other human service professionals providing services through many program areas. Program areas include maternity care coordination, maternal outreach worker services, child service coordination, health and behavior intervention, early intervention, home visiting programs, childbirth education, health education, and other programs that support North Carolina's families.

Participants may register for the conference by completing the registration form that will be available beginning mid-July at Northwest Area Health Education Center's Web site: http://northwestahec.wfubmc.edu/.

Clinical Policy
DMA, 919-855-4329

Attention: All Providers

2007 Legislative Rate Allocation

Effective with date of service January 1, 2007, the legislature allocated $12 million to be used for rate increases for Medicaid providers. All providers' rates were reviewed for an allocation by a third party and rate increases were subsequently allotted to the following provider types: dialysis centers; intermediate care facilities for the mentally retarded; dentists; physicians and other professionals; nursing facilities; ambulatory surgery centers and birthing centers; ambulances; independent laboratories; optical program; the Community Alternatives Program; adult care homes and personal care services; private duty nursing; home health agencies, home infusion therapy, community personal care services; and durable medical equipment and orthotic and prosthetic devices.

The claims payment system was not updated for these rate increases until after the effective date of the rate changes. Therefore, providers should check for changes to the maximum allowable rates on the applicable fee schedules at http://www.ncdhhs.gov/dma/fee/fee.htm. Providers with individual accommodation rates will receive an official notification letter from the Division of Medical Assistance (DMA). Providers should continue to bill their usual and customary charges. DMA will request that EDS review and recalculate affected claims filed prior to the update. Providers should not file adjustment claims. Any additional reimbursement will be reflected in future payments and indicated on the RA as an adjustment.

Financial Management
DMA, 919-855-4200

Attention: All Providers

Clinical Coverage Policies

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

A-2, Over-the-Counter Medications (6/21/07)
1A-16, Surgery of the Lingual Frenulum
1A-22, Medically Necessary Circumcision
3H-2, Home Tocolytic Infusion Therapy
4A, Dental Services (6/1/07)
4B, Orthodontics (6/1/07)
5B, Orthotics and Prosthetics

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

Coverage of Perflutren Lipid Microspheres, per ml (HCPCS procedure code Q9957), in the Physician's Drug Program

Effective with date of service January 1, 2006, HCPCS procedure code Q9957 is covered by the N.C. Medicaid program. Providers may file claims that have previously been denied, keeping in mind the rules regarding timely filing.

For Medicaid billing, one unit of Q9957 is 1 ml. The maximum reimbursement rate for 1 unit is $61.89.

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

Attention: All Providers

CPT Code 77003 Denials

CPT code 77003 *(fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures, including neurolytic agent destruction)* was a new code effective January 1, 2007. Audits were established to prevent procedure 77003 from being billed with certain surgical or radiological procedures as detailed in the 2007 CPT book. Seven of the CPT codes placed on the audits are causing incorrect denials: 27096, 62270, 62272, 62273, 62280, 62281, and 62282. Claims payment system changes have been made to correct the problem. Providers who received claim denials related to EOB 4237 or 4238 for CPT code 77003 may resubmit new claims (not adjustments) for processing.

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

Attention: All Providers

Obesity Resource Information

Obesity resource information is available on the N.C. Division of Medical Assistance (DMA) Web site at www.ncdhhs.gov/dma/ca/qehoinitiatives.html. This information may be helpful to providers in educating recipients about obesity issues (pediatric and adult). Links will also be added to help identify provider education related to obesity. Providers are encouraged to check the Web site on a regular basis for additional resource links regarding obesity. To inquire about adding obesity resources to the DMA Web site, please e-mail Nubya Shabazz at nubya.shabazz@ncmail.net.

Quality, Evaluation, and Health Outcomes Unit
DMA, 919-855-4173

Attention: All Providers

HCPCS Procedure Code Changes for the Physician's Drug Program

The following HCPCS code changes have been made to comply with the Centers for Medicare and Medicaid Services (CMS) HCPCS code changes.

New HCPCS Codes
The following HCPCS codes were added to the list of covered codes for the Physician's Drug Program effective with date of service July 1, 2007.

New HCPCS Code	Description	Unit	Maximum Reimbursement Rate
Q4089	Injection RHO(D) Immune Globulin (Human) (Rhophylac), IM or IV	100 IU	$80.00
Q4090	Injection, Hepatitis B Immune Globulin (HepaGam B), IM	0.5 ml	$64.74
Q4095	Injection, Zoledronic Acid (Reclast). See separate article in this bulletin.	1 mg	$44.16

End-Dated Codes with Replacement Codes
HCPCS procedure code J1567 (Injection, Immune globulin, IV, non-lyophilized (e.g., liquid)), 500 mg, was end-dated with date of service June 30, 2007, and replaced with the following four new procedure codes effective with date of service July 1, 2007. Claims submitted for dates of service on or after July 1, 2007 using the end-dated code will be denied.

End Dated HCPCS Code	Description	Unit	New HCPCS Code	Description	Unit	Maximum Reimbursement Rate
J1567	Injection, Immune globulin, IV, non-lyophilized (e.g., liquid)	500 mg	**Q4087**	Injection, Immune Globulin (Octagam), IV, non-lyophilized (e.g. liquid)	500 mg	$33.48
			Q4088	Injection, Immune Globulin (Gammagard liquid), IV, non-lyophilized (e.g. liquid)	500 mg	$31.20
			Q4091	Injection, Immune Globulin (Flebogamma), IV, non-lyophilized, (e.g. liquid)	500 mg	$32.61
			Q4092	Injection, Immune Globulin (Gamunex), IV, non-lyophilized (e.g., liquid)	500 mg	$31.86

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

Attention: All Providers

Palatoplasty or Modified Palatoplasty for Sleep Apnea

The Division of Medical Assistance (DMA) has determined that palatoplasty, modified palatoplasty, or other procedure of the palate or uvula for the treatment of sleep apnea is not considered first-line therapy for most pediatric patients, according to clinical guidelines developed by the American Academy of Pediatrics. Most children with snoring and/or sleep apnea have resolution of symptoms with tonsillectomy and/or adenoidectomy when these symptoms are due to an obstructive etiology. Therefore, DMA will not reimburse for palatoplasty, modified palatoplasty, or other procedure of the palate or uvula in recipients under the age of 18 when performed for sleep apnea, snoring, or any related conditions.

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

Attention: All Providers

Upcoming National Drug Code (NDC) Seminars NDCs on Professional and Outpatient Dialysis-Administered Drug Claims

The Deficit Reduction Act of 2005 (DRA) includes provisions regarding State collection and submission of data for the purpose of collecting Medicaid drug rebates from manufacturers for all outpatient drug claims. In order to do this, North Carolina Medicaid will require that professional and outpatient dialysis drug claims include both the National Drug Code (NDC) and the NDC units in addition to the HCPCS code and units. This change will be implemented in **December 2007** for providers who bill for drugs on the CMS-1500 claim form and for dialysis providers who bill drugs on the UB-04 claim form. The NDC numbers and NDC units will be required on the 837P and 837I transaction sets. Please look for future bulletin articles regarding this change.

Seminars on National Drug Code (NDC) Medicaid billing guidelines are scheduled for September 2007. Registration information, a list of dates, and site locations for the seminars will be published in the August 2007 General Medicaid bulletin.

With this change, providers should consider these and other items related to their office/practice setting:

- Capturing the NDC and NDC units on each drug administered
- Preserving the NDC and NDC units for billing purposes
- Office/outpatient setting business practices
- Software
- Vendors

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

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

Prior Authorization of Outpatient Specialized Therapies: Post-Payment Validation Begins August 2007

As announced in the June bulletin, The Carolinas Center for Medical Excellence (CCME) will initiate post-payment validation of therapy authorizations in August 2007. A sample of cases will be drawn each month from authorizations with an end date six months prior to the sample month. Providers will be notified via fax or e-mail to submit cases for validation. (The notification process will be similar to the method currently used to notify providers of authorization outcomes.) The documentation requested will include the therapy order, evaluation, and progress notes for the identified authorization period. Four validations may be performed on each authorization:

- Valid order, as defined by guidelines in DMA clinical coverage policy 10A, for the entire authorization period
- Evaluation supports the submitted diagnosis or speech severity
- Reported progress towards goals consistent with daily treatment notes
- Paid service dates supported by treatment notes

Providers who exceed established validation thresholds will be subjected to a more intensive validation process.

Information about post-payment validation is also available on CCME's prior authorization Web site, https://www2.mrnc.org/priorauth/pages/Home.aspx.

CCME, 1-800-682-6250

Attention: Community Alternative Program Providers – Disabled Adults (CAP-DA), Children (CAP-Ch), and Choice (CAP-Choice)

Rate Change

Effective with date of service January 1, 2007, providers were allocated a rate increase by the Legislature. This inflationary rate increase for the 2006-2007 fiscal year was based on Senate Bill 1741.

Please note the following rate changes for CAP-DA service codes:

Service Code	Old Rate	New Rate
H0045	$113.91/unit	$179.02/unit
S5102	$36.51/unit	$41.51/unit
S5125	$3.60/unit	$3.65/unit
S5150	$3.60/unit	$3.65/unit
S5161	$29.67/unit	$30.32/unit
S5170	$3.14/unit	$3.21/unit
T1016	$13.82/unit	$15.25/unit
T4535	$0.34/unit	$0.36/unit

Please note the following rate changes for CAP-CH service codes:

Service Code	Old Rate	New Rate
H0045	$113.91/unit	$179.02/unit
S5125	$3.60/unit	$3.65/unit
S5150	$3.60/unit	$3.65/unit
T1000	$9.11/unit	$9.31/unit
T1005	$9.11/unit	$9.31/unit
T1016	$13.82/unit	$15.25/unit
T4535	$0.34/unit	$0.36/unit

Please note the following rate changes for CAP-CO service codes:

Service Code	Old Rate	New Rate
H0045	$113.91/unit	$179.02/unit
S5102	$36.51/unit	$41.51/unit
S5125	$3.60/unit	$3.65/unit
S5135	$3.60/unit	$3.65/unit
S5150	$3.60/unit	$3.65/unit
S5161	$29.67/unit	$30.32/unit
S5170	$3.14/unit	$3.21/unit
T2040	$12.50/unit	$25.00/unit
T2041	$13.82/unit	$15.25/unit
T4535	$0.34/unit	$0.36/unit

This rate is effective as of January 1, 2007. Providers are not required to resubmit their claims. An automatic recoupment and repayment will be done by EDS.

Rate Setting
DMA, 919-855-4200

Attention: Independent Laboratories and Physicians

CLIA Certification–Related Claim Denials

The Division of Medical Assistance has made recent system changes to the lists of CPT-4 codes that are subject to and exempt from Clinical Laboratory Improvement Amendment (CLIA) editing based on CLIA guidelines. In order to ensure that claims are coded appropriately when submitting and resubmitting claims, providers should refer to the Centers for Medicare and Medicaid (CMS) Web site at http://www.cms.hhs.gov/CLIA/10_Categorization_of_Tests.asp for current lists of

- Waived tests
- Tests categorized as provider-performed microscopy procedures (PPMP)
- Tests (CPT-4 codes) subject to CLIA edits that includes non-waived and non-PPMP tests
- Tests (CPT-4 codes) excluded from CLIA edits

The lists may be printed and retained for future reference. This information is periodically updated and new tests are added as they are approved.

Billing Reminders

If the CPT code indicates that the code must be billed with a QW modifier, the modifier must be appended to the CPT code to process for reimbursement. Failure to append the QW, will result in claims being denied for EOB 0936, "Certification not valid for DOS/Level and a delay in payment." Claims submitted with a QW modifier and CPT codes that are not considered "waived" will also deny for EOB 0936, "Certification not valid for DOS/Level.

If a test is not included on the list, providers should contact CLIA at the Licensure and Certification Section of the North Carolina Division of Facility Services at 919-733-1610 to discuss their certificate type and the tests that can be performed based on the certificate type.

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

Attention: Local Management Entities and Private Providers of Mental Health Services

Mental Health Cost Report Training Sessions

During 2007 there will be two types of cost report training sessions offered simultaneously. One session will be for Local Management Entities (LMEs) which are required to file the 2006-2007 Mental Health Cost Report if any enhanced mental/behavioral health services were provided. The other type of session will be for private providers who provide any enhanced mental/behavioral health service for any fiscal year ending on or after December 31, 2007.

We have established training sites throughout the state. There will be two days to choose from in the Central Region, two days in the West, two days in the East and four days in Raleigh. All full day LME sessions will begin at 8:30 a.m. and end at 4:30 p.m. For the private providers, half day morning sessions will begin at 8:30 a.m. and end at 12:00 p.m., and the half day afternoon sessions will begin at 1:00 p.m. and end at 4:30 p.m.

More information regarding training including the complete list of training sessions can be found online at http://www.ncdhhs.gov./dma/prov.htm

DHHS Controller's Office
DMA, 919-855-3680

Attention: Local Management Entities, CAP/MR-DD Case Managers, and CAP/MR-DD Service Providers

Rate Change

Effective with date of service January 1, 2007, providers were allocated a rate increase by the Legislature. This inflationary rate increase for the 2006-2007 fiscal year was based on Senate Bill 1741. Please note the following rate changes for CAP/MR-DD service codes:

Service Code	Old Rate	New Rate
H2025	$7.61/unit	$7.80/unit
H2025HQ	$1.97/unit	$2.01/unit
S5102	$36.51/unit	$41.51/unit
S5150	$3.60/unit	$3.65/unit
S5150HQ	$2.78/unit	$2.83/unit
S5161	$29.67/unit	$32.00/unit
T1005TD	$9.11/unit	$9.31/unit
T1005TE	$9.11/unit	$9.31/unit

This rate is effective as of January 1, 2007. Providers are not required to resubmit their claims. An automatic recoupment and repayment will be done by EDS.

Rate Setting
DMA, 919-855-4200

Attention: Medical Doctors and Doctors of Osteopathic Medicine

Orthotic and Prosthetic Devices in the Office

Effective with date of service July 1, 2007, medical doctors (MDs) and doctors of osteopathic medicine (DOs) may bill for the orthotic and prosthetic devices listed in the table below. Providers must follow all requirements stated in Clinical Coverage Policy 5B, Orthotics and Prosthetics, which can be located at http://www.ncdhhs.gov/dma/dme/5B.pdf. Please note that a Certificate of Medical Necessity and Prior Approval form (CMN/PA) must be completed for all devices provided. (See Attachment A of the policy for complete instructions.) Coverage criteria for these items are provided in Section 5.3 of the policy. The CMN/PA must be maintained in the medical record as specified in Section 7.1.

The EDS prior approval unit can be reached through the automated attendant telephone line, 1-800-688-6696 or 919-851-8888.

HCPCS CODE	ORTHOTIC & PROSTHETIC DEVICES DESCRIPTION	MAXIMUM RATE
	Diabetic foot codes	
A5512*	For diabetics only, multiple density insert, direct formed, molded to foot after external heat source of 230 degrees Farenheit or higher, total contact with patient's foot, including arch, base layer minimum of 1/4 inch material of shore a 35 durometer or	24.89
A5513*	For diabetics only, multiple density insert, custom molded from model of patient's foot, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer or higher, includes arch filler and other shaping	37.14
	Elastic supports	
A6530	Gradient compressions stocking, below knee, 18-30 mm Hg, each	40.43
A6531	Gradient compressions stocking, below knee, 30-40 mm Hg, each	43.27
A6532	Gradient compressions stocking, below knee, 40-50 mm Hg, each	60.96
A6533	Gradient compressions stocking, thigh length, 18-30 mm Hg, each	64.51
A6534	Gradient compressions stocking, thigh length, 30-40 mm Hg, each	76.52
A6535	Gradient compressions stocking, thigh length, 40-50 mm Hg, each	78.82
A6536	Gradient compressions stocking, full length/chap style, 18-30 mm Hg, each	97.65
A6537	Gradient compressions stocking, full length/chap style, 30-40 mm Hg, each	109.09

HCPCS CODE	ORTHOTIC & PROSTHETIC DEVICES DESCRIPTION	MAXIMUM RATE
A6538	Gradient compressions stocking, full length/chap style, 40-50 mm Hg, each	117.84
A6539	Gradient compressions stocking, waist length, 18-30 mm Hg, each	134.67
A6540	Gradient compressions stocking, waist length, 30-40 mm Hg, each	139.50
A6541	Gradient compressions stocking, waist length, 40-50 mm Hg, each	150.30
A6543	Gradient compressions stocking, lymphedema, each	122.46
A6544	Gradient compressions stocking, garter belt, each	30.00
	Cervical	
L0120	Cervical, flexible, nonadjustable (foam collar)	23.28
L0140	Cervical, semi-rigid, adjustable (plastic collar)	58.05
L0210	Thoracic, rib belt	41.48
L0625	Lumbar orthosis, flexible, provides lumbar support, posterior extends from l-1 to below l-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include pendulous abdomen design, shoulder str	45.85
L0626	Lumbar orthosis,sagittal control, with rigid posterior panel(s), posterior extends from l-1 to below l-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder	64.86
L0976	LSO, full corset	164.97
L0980	Peroneal straps, pair	13.51
L0982	Stocking supporter grips, set of four (4)	14.72
L0984	Protective body sock, each	46.98
	Lower limb - hip	
L1800	KO, elastic with stays, perfabricated, includes fitting and adjustment	68.63
L1810	KO, elastic with joints, prefabricated, includes fitting and adjustment	100.73
L1815	KO, elastic or other elastic type material with condylar pad(s), prefabricated, includes fitting and adjustment	92.32
L1820	KO, elastic with condylar pads and joints, with or without patellar control, prefabricated, includes fitting and adjustment	100.33
L1825	KO, elastic knee cap, prefabricated, includes fitting and adjustment	44.72
L1830	KO, immobilizer, canvas longitudinal, prefabricated, includes fitting and adjustment	83.93
L1831	KO, locking knee joint(s), positional orthosis, prefabricated, includes fitting and adjustment	244.88
L1836	KO, rigid, without joint(s), includes soft interface material, prefabricated, includes fitting and adjustment	111.01

HCPCS CODE	ORTHOTIC & PROSTHETIC DEVICES DESCRIPTION	MAXIMUM RATE
L1901	AO, elastic, prefabricated, includes fitting and adjustment (e.g., neoprene, lycra)	14.72
L1902	AFO, ankle gauntlet, prefabricated, includes fitting and adjustment	63.56
L1906	AFO, multiligamentous ankle support, prefabricated, includes fitting and adjustments	106.33
L2112	AFO, fracture orthosis, tibial fracture orthosis, soft, prefabricated, includes fitting and adjustment	392.58
	Orthopedic shoes	
L3002+	Foot insert, removable, molded to patient model, Plastazote or equal, each	134.38
L3003+	Foot insert, molded to patient model, silicone gel, each	144.88
L3010+	Foot insert, removable, molded to patient model, longitudinal arch support, each	144.97
L3020+	Foot insert, removable, molded to patient model, longitudinal/metatarsal support, each	165.09
L3030+	Foot insert, removable, formed to patient foot, each	63.49
L3040+	Foot, arch support, removable, premolded, longitudianl, each	39.15
L3050+	Foot, arch support, removable, premolded, metatarsal, each	39.15
L3060+	Foot, arch support, removable, premolded, longitudinal/metatarsal, each	61.37
L3070+	Foot, arch support, non-removable, attached to shoe, longitudinal, each	26.46
L3080+	Foot, arch support, non-removable, attached to shoe, metatarsal, each	26.45
L3090+	Foot, arch support, non-removable, attached to shoe, longitudinal/metatarsal, each	33.87
L3100+	Hallus-valgus night dynamic splint	35.96
L3140+	Foot, abduction rotation bar, including shoe(s)	74.07
L3150+	Foot, abduction rotation bar, without shoe(s)	67.72
L3160+	Foot, adjustable shoe-styled positioning device	83.29
L3170	Foot, plastic, silicone or equal, heel stabilizer, each	42.34
L3208	Surgical boot, each, infant	37.43
L3209	Surgical boot, each, child	38.20
L3211	Surgical boot, each, junior	33.73
L3216+	Orthopedic footwear, ladies shoe, depth inlay, each	148.34
L3217+	Orthopedic footwear, ladies shoe, hightop, depth inlay, each	115.52
L3221+	Orthopedic footwear, mens shoe, depth inlay, each	189.71
L3222+	Orthopedic footwear, mens shoe, hightop, depth inlay, each	139.84
L3260+	Surgical boot/shoe, each	48.42
L3265+	Plastazote sandal, each	60.55

HCPCS CODE	ORTHOTIC & PROSTHETIC DEVICES DESCRIPTION	MAXIMUM RATE
L3332+	Lift, elevation, inside shoe, tapered, up to one-half inch	61.37
L3334+	Lift, elevation, heel, per inch	31.74
L3350+	Heel wedge	19.03
L3480+	Heel, pad and depression for spur	51.81
L3485+	Heel, pad, removable for spur	23.10
	Upper limb orthoses	
L3650	SO, figure of eight design abduction restrainer, prefabricated, includes fitting and adjustment	45.32
L3651	SO, single shoulder, elastic, prefabricated, includes fitting and adjustment (e.g., neoprene, lycra)	49.85
L3652	SO, double shoulder, elastic, prefabricated, includes fitting and adjustment (e.g., neoprene, lycra)	150.18
L3660	SO, figure of eight design abduction restrainer, canvas and webbing, prefabricated, includes fitting and adjustment	77.83
L3807	WHFO, without joint(s), perfabricated, includes fitting and adjustments, any type	189.34
L3908	WHO, wrist extension control cock-up, non-molded, prefabricated, includes fitting and adjustment	45.36
L3909	WO, elastic, prefabricated, includes fitting and adjustment (e.g., neoprene, lycra)	10.71
L3910	WHFO, Swanson design, prefabricated, includes fitting and adjustment	335.17
L3911	WHFO, orthosis, elastic, prefabricated, includes fitting and adjustment (e.g., neoprene, Lycra)	18.78
L3917	HO, metacarpal fracture orthosis, prefabricated, includes fitting and adjustment	79.99
L3918	HFO, knuckle bender, prefabricated, includes fitting and adjustment	64.99
L3920	HFO, knuckle bender, with outrigger, prefabricated, includes fitting and adjustment	77.49
L3922	HFO, knuckle bender, two segment to flex joints, prefabricated, includes fitting and adjustment	88.89
L3923	HFO, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustments	29.46
L3924	Whfo, Oppenheimer, prefabricated, includes fitting and adjustment	95.07
L3926	WHFO, Thomas suspension, prefabricated, includes fitting and adjustment	78.12
L3928	HFO, finger extension, with clock spring, prefabricated, includes fitting and adjustment	46.16
L3930	WHFO, finger extension, with wrist support, prefabricated, includes fitting and adjustment	47.66
L3932	FO, safety pin, spring wire, prefabricated, includes fitting and adjustment	41.34

HCPCS CODE	ORTHOTIC & PROSTHETIC DEVICES DESCRIPTION	MAXIMUM RATE
L3934	FO, safety pin, modified, prefabricated, includes fitting and adjustment	36.46
L3936	WHFO, Palmer, prefabricated, includes fitting and adjustment	67.45
L3938	WHFO, dorsal wrist, prefabricated, includes fitting and adjustment	70.95
L3940	WHFO, dorsal wrist, with outrigger attachment, prefabricated, includes fitting and adjustment	81.35
L3942	HFO, reverse knuckle bender, prefabricated, includes fitting and adjustment	56.26
L3944	HFO, reverse knuckle bender, with outrigger, prefabricated, includes fitting and adjustment	92.66
L3946	HFO, composite elastic, prefabricated, includes fitting and adjustment	76.08
L3948	FO, finger knuckle bender, prefabricated, includes fitting and adjustment	50.94
L3980	Upper extremity fracture orthosis, humeral, prefabricated, includes fitting and adjustment	234.09
L3982	Upper extremity fracture orthosis, radius/ulnar, prefabricated, includes fitting and adjustment	289.22
L3984	Upper extremity fracture orthosis, wrist, prefabricated, inlcudes fitting and adjustment	308.72
	Ancillary orthoses	
L4350	Ankle control orthosis, stirrup style, rigid, includes any type interface (e.g., pneumatic, gel), prefabricated, includes fitting and adjustment	81.37
L4360	Walking boot, pneumatic, with or without joints, with our without interface material, prefabricated, includes fitting and adjustment	227.64
L4370	Pneumatic full leg splint, prefabricated, includes fitting and adjustment	146.08
L4380	Pneumatic knee splint, prefabricated, includes fitting and adjustment	89.57
L4386	Walking boot, non-pneumatic, with or without joints, with or without interface material, prefabricated, includes fitting and adjustment	131.93

Please note: *Requires prior approval (PA) for all recipients

+Requires PA for all recipients 21 years of age or older

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

Attention: All Mental Health Providers

Rate Update on 2007 CPT codes for Mental Health Specialties

Effective July 1, 2007, rates for the 2007 CPT codes were revised for all mental health specialties based on information from the Centers for Medicare and Medicaid Services (CMS). These specialties include the following:

- Licensed Psychologist
- Licensed Clinical Social Workers
- Licensed Professional Counselor
- Licensed Marriage and Family Therapist
- Certified Clinical Nurse Specialist
- Certified Nurse Practitioner
- LMEs
- Licensed Psychologist Associate
- Certified Clinical Supervisor
- Certified Clinical Addictions Specialist

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, 2007, revised mental health fee schedules will be available on the DMA website at http://www.ncdhhs.gov/dma/fee/mhfee.htm. Providers must bill their usual and customary charges.

Financial Management
DMA, 919-855-4200

Attention: PCS and PCS-Plus Providers

PCS and PCS-Plus Recoupments

This is a republished from October 2004 General Medicaid Bulletin

Effective with checkwrite May 8, 2007, EDS started recouping any PCS overpayments since the implementation of PCS-Plus in November 2003. Recoupments occurred for covered dates of service from November 1, 2003 to July 31, 2004 and be automatically deducted from the provider's checkwrite. Providers who have received PCS payments that exceeded 60 hours (240 units) a month or 3.5 hours a day (14 units) for PCS clients without PCS-Plus prior approval will have these payments recouped. Any providers who have received payments that exceeded 80 hours (or 320 units) a month for Medicaid recipients with PCS-Plus prior approval will have also these payments recouped. As a reminder, PCS is limited to 60 hours and 3.5 hours a day for each eligible Medicaid recipient. Medicaid recipients with DMA prior approval for PCS-Plus are eligible for up to 80 hours a month of PCS without daily limits.

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

Attention: Physicians and Nurse Practitioners

Linezolid, 200mg (Zyvox, J2020) Billing Guidelines

Effective with date of service July 1, 2007, N.C. Medicaid covers Zyvox for use in the Physician's Drug Program when billed with HCPCS procedure code J2020. Zyvox is indicated for treatment in patients with

- Vancomycin-resistant *Enterococcus faecium* (VRE) infections
- Nosocomial pneumonia caused by *Staphylococcus aureus*, including MRSA, or *Streptococcus pneumoniae* (including multidrug-resistant strains [MDRSP])
- Complicated and uncomplicated skin and skin structure infections (including diabetic foot infections without concomitant osteomyelitis) or
- Community-acquired pneumonia caused by susceptible gram-positive organisms

Zyvox will usually not be administered on an outpatient basis unless administrations were begun on an inpatient basis.

One Medicaid unit of coverage is 200 mg. The maximum reimbursement rate per unit is $25.72.

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

Attention: Physicians and Nurse Practitioners

Zoledronic Acid, 1mg (Reclast, Q4095) Billing Guidelines

Effective with date of service July 1, 2007, the N.C. Medicaid program covers zoledronic acid (Reclast) for use in the Physician's Drug Program when billed with HCPCS code Q4095. Reclast is indicated for treatment in patients with Paget's disease of the bone.

The recommended dose of Reclast is a 5mg/100ml intravenous infusion administered as a single treatment. The infusion is to be given at a constant infusion rate and the infusion time must not be less than 15 minutes.

For Medicaid Billing:

- The ICD-9-CM diagnosis code required for billing Reclast is:
  - 731.0 - Osteitis deformans without mention of bone tumor (*Paget's disease of bone*)
- Providers must indicate the number of units given in block 24G on the CMS-1500 claim form.
- Providers must bill their usual and customary charge.

The Medicaid unit of coverage is 1 mg. The maximum reimbursement rate per unit is $44.16.

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

Attention: Private Duty Nursing Providers

Rate Change

Effective with date of service January 1, 2007, providers were allocated a rate increase by the Legislature. This inflationary rate increase for the 2006-2007 fiscal year was based on Senate Bill 1741.

Please note the following rate change for PDN service code:

Service Code	Old Rate	New Rate
T1000	$9.11/unit	$9.31/unit

This rate is effective as of January 1, 2007. Providers are not required to resubmit their claims. An automatic recoupment and repayment will be done by EDS.

Rate Setting
DMA, 919-855-4200

Attention: Residential Child Care Treatment Facilities

Enrollment Effective Dates

Effective September 1, 2006, new Residential Childcare Treatment Facility providers licensed as 10A NCAC 27G.1300 (Level II), 10A NCAC 27G.1700 (Level III) and 10A NCAC 27G.1800 (Level IV) seeking enrollment with the Division of Medical Assistance (DMA) were required to submit a completed Residential Childcare Treatment Facility provider enrollment packet, a copy of their current facility license, and a notification of endorsement action (NEA) letter. Those already enrolled in Medicaid on September 1, 2006, were required to submit a completed Residential Childcare Treatment Facility provider enrollment packet, a copy of their renewed facility license, and an NEA letter prior to the end date of their provider number in order to maintain their eligibility.

Effective March 19, 2007, Residential Childcare Treatment Facility new enrollment and re-enrollment requests were effective the date the corrected and complete provider enrollment/re-enrollment packet with required attachments is date-stamped as received by DMA. DMA does not authorize the provider to place eligible Medicaid recipients in the facility or to render services prior to the facility's assignment of a Medicaid provider number. DMA requires that each Residential Childcare Treatment Facility be enrolled separately and assigned a site-specific Medicaid provider number.

In May 2007, a joint memorandum from the Division of Facility Services (DFS), Division of Mental Health (MH/DD/SAS), and DMA was mailed to all Residential 10A NCAC 27G.1300 (Level II), 10A NCAC 27G.1700 (Level III) and 10A NCAC 27G.1800 (Level IV) facilities explaining these divisions' joint endeavor to coordinate the 2008 license renewal, endorsement, and Medicaid re-enrollment process and timeline for residential providers. This memorandum details the providers' and Divisions' responsibilities and lists a timeline with important dates regarding when to submit DFS renewal applications, Local Management Entity (LME) applications, and Medicaid enrollment and re-enrollment applications. Please review the memorandum at www.http://www.ncdhhs.gov/dma/rccmemo.pdf.

Provider Services
DMA, 919 855-4050

Attention: Durable Medical Equipment Providers

Change in Requests for Prior Approval for Pediatric Mobility Devices

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

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

Attention: Durable Medical Equipment and Orthotic and Prosthetic Device Providers

Change in Prior Approval Process for Non-Listed DME, Orthotic and Prosthetic Devices, and Medical Supplies for Recipients Under 21 Years of Age

Effective with date of request August 1, 2007, providers must submit prior approval requests for items that are not listed on the durable medical equipment or orthotic and prosthetic fee schedules when these items are medically necessary for Medicaid recipients under 21 years of age. Providers should submit the requests to the Assistant Director for Clinical Policy and Programs, Division of Medical Assistance (DMA). Please use the Non-Covered State Medicaid Plan Services Request Form for Recipients less than 21 Years of Age, which can be found on DMA's Web site at www.ncdhhs.gov/dma/Forms/NonCoveredServicesRequest.

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

Attention: CAP/MR-DD Providers

CAP/MR-DD Cost Report Training

Providers of Community Alternatives Program for persons with Mental Retardation/Developmental Disabilities (CAP-MR/DD) are required to submit a cost report due to DMA by September 30, 2007. Providers will complete the cost report for their most recently closed fiscal year for which they have financial statements. Training on the cost report was held in May. We have added **three new training classes** for providers who were unable to attend. The date, time, and location of the classes are below.

Date	Time	Location
Monday, August 13, 2007	9am – 12pm	The Guilford Center Bellemeade Building 201 N. Eugene Street Greensboro, NC 27401
Friday, August 24, 2007	9am-12pm	Western Piedmont Community College 1001 Burkemont Avenue Morganton, NC 28655
Thursday, August 30, 2007	9am – 12pm	NC DOT Training Center 313 Chapanoke Road Room 203 Garner, NC 27603

The deadline to register for training is **Friday, July 27, 2007**. Training dates and times are tentative based on provider response. The CAP-MR/DD cost report, instructions and training registration form can be found online at http://www.ncdhhs.gov/dma/capmrcost/capmrcost.htm

Rate Setting
DMA, 919-855-4200

Proposed Clinical Coverage Policies

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

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

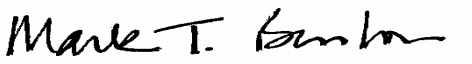
The initial comment period for each proposed policy is 45 days. An additional 15-day comment period will follow if a proposed policy is revised as a result of the initial comment period.

2007 Checkwrite Schedule

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

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

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



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

Cheryll Collier
Executive Director
EDS