



July 2008 Medicaid Bulletin

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Attention: All Providers

National Provider Identifier Requirements for Claims

Effective May 23, 2008, all claims (except pharmacies and atypical providers), **including** Medicare crossover claims, must contain a National Provider Identifier (NPI) and taxonomy code or the claim will be denied.

N.C. Medicaid is aware that some claims are crossing over from Medicare **without** the taxonomy code indicated on the claim. DMA is currently researching this issue with Medicare. In the meantime, DMA is working to develop a workaround to prevent providers from having to submit a secondary claim directly to Medicaid. Until the workaround is implemented, providers must file these claims directly to Medicaid and include the taxonomy code. Professional crossovers can be filed electronically via the 837 transaction or the NCECSWeb, or on paper. Inpatient hospital and nursing home crossovers must be filed on paper.

Providers are also reminded that claims need to include the ZIP+4 for the billing address and service facility location, if applicable.

It is highly recommended that providers continue to submit their Medicaid Provider Number (MPN) on all claims until they receive the NPI Ready letter.

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

Contact Information for EDS Finance and Remittance Payments

Effective July 1, 2008, EDS discontinued the use of the following e-mail addresses:

- RemittancePayments@ncxix.hcg.eds.com
- NCXIXFinance@ncxix.hcg.eds.com

Providers with questions related to financial issues may call EDS at the numbers listed below. Explain the purpose of the call and ask to speak to someone in Provider Services.

Note: The e-mail address EFT@ncxix.hcg.eds.com will continue to be available to providers for the submission of Electronic Funds Transfer requests, as will fax number 919-816-3186.

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

Attention: All Providers**Essure and Hysterosalpingogram Implementation**

The N.C. Medicaid Program covers the Essure system of permanent sterilization retroactive to date of service September 1, 2003 and the hysterosalpingogram (HSG) procedure to demonstrate successful tubal occlusion retroactive to date of service December 1, 2003. The Essure procedure is covered when performed in an inpatient or outpatient hospital setting, ambulatory surgical center, or a physician's office. The HSG procedure is covered when performed in an inpatient or outpatient hospital setting or a physician's office following the Essure procedure.

Federal guidelines for sterilization procedures must be followed, which includes providing a sterilization consent form. Refer to Clinical Coverage Policy #1E-3, *Sterilization Procedures*, (<http://www.ncdhhs.gov/dma/mp/mpindex.htm>) for requirements and instructions on completing the form. "Essure" must be stated on the consent form as the operation to be performed.

The Essure procedure is covered for recipients with Medicaid for Pregnant Women (MPW) coverage benefits during their eligibility period. Since the HSG procedure can be performed three full months (90 days) after the placement of the Essure micro inserts, the HSG procedure **is not** covered under MPW. Neither the Essure procedure nor the HSG procedure is covered for recipients with Family Planning Waiver (MAFD) coverage benefits.

Providers must follow the billing guidelines for Essure as outlined in the table below.

Provider	Claim Type	Code	Modifier	Dates of Service
Physician	CMS-1500	58579	with FP modifier	September 1, 2003 through March 31, 2004
		S2255	with FP modifier	April 1, 2004 through December 31, 2004
		58565	with FP modifier	January 1, 2005 and forward
Anesthesiologist or CRNA	CMS-1500	58579	with FP modifier and one of the following anesthesia modifiers: QK, QX, QY, QZ, or AA	September 1, 2003 through September 30, 2003
		00840, 00851, or 00952	with FP modifier and one of the following anesthesia modifiers: QK, QX, QY, QZ, or AA	October 1, 2003 and forward
Ambulatory Surgery Center	CMS-1500	58565	with modifiers FP, SG,73, or 74	July 1, 2005 and forward
Inpatient and Outpatient Hospital	UB-04	RC 278	no modifier	September 1, 2003 and forward

All claims (except inpatient and outpatient hospital claims) must be billed with modifier FP. Other modifier guidelines must be followed. Assistant at surgery (modifier 80 and 82) is not covered for the Essure procedure. The device is not separately reimbursed for any provider type. All claims must be billed with ICD-9-CM diagnosis V25.2 as the primary or secondary diagnosis on the claim.

HSG Billing Guidelines

The HSG procedure is only covered following the Essure procedure to demonstrate location of micro inserts and bilateral tubal occlusion. Coverage for HSG is limited to a maximum of two units. The HSG procedure can be performed three full months (90 days) following the date of the Essure procedure. If a second HSG is necessary, it may be covered up to six months following the date of service of the Essure procedure.

Providers must follow the billing guidelines for HSG as outlined in the table below.

Provider	Claim Type	Essure Procedure Within 6 Months	Code	Diagnosis Code (V25.2)	FP Modifier	Valid Sterilization Consent Form	Dates of Service
Physician	CMS-1500	Yes	58340, 74740	Yes	Yes	Yes	December 1, 2003 and forward
Inpatient or Outpatient Hospital	UB-04	Yes	RC 320	Yes	No	Yes	December 1, 2003 and forward

Time Limit Overrides

Claims for the Essure procedure for dates of service September 1, 2003, through January 31, 2008, and for the HSG procedure for dates of service December 1, 2003, through January 31, 2008, **must be submitted for processing by January 31, 2009**. Claims with these dates of service **will not** require time limit override. Claims submitted **after** January 31, 2009 with the dates of service specified above **will be denied**. For dates of service **after** January 31, 2008, continue using N.C. Medicaid guidelines for submitting claims.

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

Attention: All Providers

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

All individuals admitted to a nursing facility must be screened before admission and annually thereafter, according to federal regulations. This is called the Pre-admission Screening and Annual Resident Review (PASARR). Regional training sessions for the PASARR segment of the new N.C. Uniform Screening Program (USP) and the N.C. Medicaid Uniform Screening Tool (MUST) application are scheduled for August 2008. These training sessions will focus on the PASARR screening segment of the MUST that will be implemented in September 2008.

Six training sessions have been scheduled throughout the state. Pre-registration by using the online registration form at <http://www.ncmust.com> is required. A valid e-mail address is required to send a confirmation notice to each registered participant. **Registrations submitted by fax will not be processed and will not guarantee availability at the training session.** Registration for each training session will remain open until all spaces are filled. If you are unable to attend your scheduled class, please notify EDS of the cancellation in order to allow the vacant space to be filled.

The training sessions begin at 8:30 a.m. and end at 4:30 p.m. Providers should arrive at least 30 minutes early to complete the registration process. Lunch will not be served; however, there will be a lunch break. Because meeting room temperatures vary, dressing in layers is strongly advised.

Training materials are available from the MUST website at <http://www.ncmust.com>. **Please print the Provider Training Manual and bring it with you to the training.** Although an online training will also be available, attendance at a regional training session is strongly recommended.

Note: Training sessions are subject to change. If a training session is postponed and you are registered for that session, you will be notified by e-mail. Please visit <http://www.ncmust.com> frequently for training updates.

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

Attention: All Providers

Suspension of Enrollment for Community Support Services

On November 8, 2007, Dempsey E. Benton, Secretary of the Department of Health and Human Services, suspended enrollment of providers and expansion of sites for the provision of child and adult community support services. The suspension is expected to remain in effect until several key steps that impact the quality of the services are completed. At this time, all steps have not been implemented and the suspension of Medicaid enrollment for new Community Support Services will remain in effect until further notice.

**Provider Services
DMA, 919-855-4050**

Attention: All Providers

National Drug Codes Required on Outpatient Institutional Claims

The Deficit Reduction Act of 2005 (DRA) includes provisions regarding state collection and submission of data for the purpose of collecting Medicaid drug rebates from manufacturers for all professional and institutional claims. The DRA 2005 does not exclude 340B providers; therefore, 340B providers must also meet these requirements.

Effective with date of processing July 1, 2008, for claims with dates of service on or after December 28, 2007, the N.C. Medicaid Program requires providers to list the 11-digit National Drug Code (NDC) in addition to the HCPCS codes and units on all outpatient institutional claims billed with Revenue Codes 25X, 634, 635, and 636 for all drugs administered by physicians.

Providers affected by this change **must** implement a process to record and maintain the NDC(s) of the drug(s) administered to the recipient as well as the quantity of the drug(s) given. An 11-digit NDC must be billed with the individual HCPCS code that corresponds to the appropriate Revenue Code.

Refer to the revised version (5/20/08) of the October 2007 Special Bulletin, *National Drug Code Implementation* (<http://www.ncdhhs.gov/dma/bulletinspecial.htm>), and the November 2007 National Drug Code seminar presentation (<http://www.ncdhhs.gov/dma/services/physiciandrug.html>) for additional information.

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

Attention: All Providers

National Drug Codes Required on Professional Crossover Claims

The Deficit Reduction Act of 2005 (DRA) includes provisions regarding state collection and submission of data for the purpose of collecting Medicaid drug rebates from manufacturers for all professional and institutional claim forms.

Effective with date of processing July 1, 2008, the N.C. Medicaid Program requests providers to list the 11-digit National Drug Codes (NDC) in addition to the HCPCS codes and units on professional claims that crossover from Medicare for all drugs administered by providers in offices, clinics, or outpatient facilities. **Effective with date of processing November 21, 2008, professional crossover claims without NDC information for applicable HCPCS codes will be denied.** Claims will continue to be reimbursed in the same manner.

Refer to the revised version (5/20/08) of the October 2007 Special Bulletin, *National Drug Code Implementation* (<http://www.ncdhhs.gov/dma/bulletinspecial.htm>), for instructions and the November 2007 National Drug Code seminar presentation (<http://www.ncdhhs.gov/dma/services/physiciandrug.html>) for additional information.

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

Attention: All Providers

Reporting Provider Changes

All providers are responsible for ensuring that information on file with the N.C. Medicaid Program for their practice or facility remains up to date. This includes changes of ownership (within 30 days), name, address, telephone numbers, e-mail addresses, tax identification numbers, licensure status, and the addition or deletion of group members.

Providers shall complete and return the **Medicaid Provider Change Form** to report changes in provider status. The form is available on DMA's website at <http://www.ncdhhs.gov/dma/forms.html> (under Provider Forms, then Administrative).

Failure to report changes in provider status may result in suspension of the Medicaid provider number and a delay in provider's receipt of claims reimbursement. In addition, providers may be liable for taxes on income not received by their business.

If Remittance and Status Advices (RAs) and checks cannot be delivered due to an incorrect billing address in the provider's file, all claims for the provider number are suspended and the subsequent RAs and checks are no longer printed. Automatic deposits are also discontinued. Once a suspension has been placed on the provider number, the provider has 90 days to submit an address change. After 90 days, if the address has not been corrected, suspended claims will be denied and the provider number will be terminated.

Provider Services
DMA, 919-855-4050

Attention: All Providers

Clinical Coverage Policies

The following new or amended clinical coverage policies are now available on DMA's website at <http://www.ncdhhs.gov/dma/mp/mpindex.htm>:

- 1A-12, Breast Surgeries
- 1E-3, Sterilization Procedures
- 9, Outpatient Pharmacy Program

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

Reminder about Sterilization Procedures

To reduce denials of claims submitted for reimbursement of sterilization procedures, providers are reminded of the following:

- Ensure that the signatures and dates for the recipient, witness, and interpreter are present. These signatures may not be altered and the dates must be correct and consistent. Do not make a change on the form by erasing, whitening out, or marking through an error in a signature or date of signature. Discard the form and complete a new one.
- If the signature of the recipient, witness, interpreter, or surgeon includes initials for the first or full name, or if the name is illegible, please print the full name below that signature.
- The sterilization may not be performed less than 30 days after consent was obtained except in cases of premature delivery or emergency surgery.
 - For a premature delivery, mark the premature delivery block in the physician's statement on the consent form and write the expected date of delivery on the consent form. The expected date of delivery must be at least 30 days after consent was obtained in order for the consent to be valid.
 - For an emergency surgery, mark the emergency surgery block and attach a copy of the recipient's medical records including operative notes.
- In no case may the sterilization be performed less than 72 hours after the consent was obtained.
- Outpatient claims for sterilization procedures that were denied with EOB 082 (service is not consistent with/or not covered for this diagnosis) or EOB 1609 (claim includes family planning diagnosis and no family planning procedure) should be resubmitted using the ICD-9-CM procedure codes. The use of ICD-9-CM procedure codes for outpatient claims will eliminate these types of denials.

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

Attention: Enhanced Mental Health Services Providers**R**ate Changes for Intensive In-home and Multi-systemic Therapy Services

Medicaid providers enrolled to offer **Intensive In-home (IIH)** and **Multi-systemic Therapy (MST)** services, please note the following rate changes:

Service Code	Old Rate	New Rate
H2022 - IIH	\$190.00/day	\$258.20/day
H2033 - MST	\$23.54/15 minutes	\$37.32/15 minutes

These rates became effective and began paying with dates of service as of June 1, 2008.

Additional enhanced benefit services are currently being reviewed. Please continue to look for bulletin articles and refer to DMA's website at <http://www.ncdhhs.gov/dma/fee/mhfee.htm> for additional rate updates, which will be posted as changes are made.

Rate Setting
DMA, 919-855-4200

Attention: Hospitals**B**illing of Self-administered Drugs Using Revenue Code 637

Billing of Revenue Code 637 (Pharmacy self-administratable drugs per the *UB-04 Manual*) for self-administered drugs will be allowed effective with date of processing July 1, 2008, for any hospital claims submitted with dates of service on or after December 28, 2007. All self-administered drugs should be listed as non-covered charges using Revenue Code 637 based on guidelines in the *Medicare Benefit Policy Manual*, Chapter 15, Section 50. Because self-administered drugs are not covered by Medicaid, providers are not required to include HCPCS codes or National Drug Code (NDC) information for Revenue Code 637. Charges billed with Revenue Code 637 will not be considered when calculating hospital cost payments, cost settlements, or DSH payments. Charges billed with Revenue Code 637 can be listed as patient liability.

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

Attention: Institutional (UB-04) Claim Billers

Billing Instructions for Form Locators 14 and 15

Effective with date of processing July 1, 2008, providers submitting inpatient or outpatient institutional claims will be required to complete FL14, Priority of Visit, and FL15, Point of Origin for Admission or Visit, according to the instructions documented in the *UB-04 Data Specifications Manual*.

If code 4, Newborn, is used, providers must also enter one of the codes listed in the *UB-04 Manual* from the Code Structure for Newborn in FL15. This requirement applies to all claim formats (paper, 837I, and NCECSWeb claims).

Inpatient and outpatient claims will be denied with EOB 1808 or EOB 319 if these fields are not completed according to the instructions in the *UB-04 Manual*. Refer to the *UB-04 Manual* for guidelines on coding FL14 and FL15 and resubmit the claim for processing.

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

Attention: Pharmacists and Prescribers

New Prior Authorization Program for Brand-name Narcotics

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

If a pharmacy provider receives a point-of-sale message that PA is required, the prescriber may contact ACS at 866-246-8505 (telephone) or 866-246-8507 (fax) to request PA for these medications. The PA criteria and request form for brand-name narcotics will be available on the N.C. Medicaid Enhanced Pharmacy Program website at <http://www.ncmedicaidpbm.com>.

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

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

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

Early and Periodic Screening, Diagnostic and Treatment and Applicability to Medicaid Services and Providers

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria stated in this publication **may be exceeded or may not apply to recipients under 21 years of age** if the provider's documentation shows that

- the requested service is medically necessary to correct or ameliorate a defect, physical or mental illness, or health problem; and
- all other Early and Periodic Screening, Diagnostic and Treatment (EPSDT) criteria are met.

This applies to both proposed and current limitations. Providers should review any information in this publication that contains limitations in the context of EPSDT and apply that information to their service requests for recipients under 21 years of age. A brief summary of EPSDT follows.

EPSDT is a federal Medicaid requirement (42 U.S.C. § 1396d(r) of the Social Security Act) that requires the coverage of services, products, or procedures for Medicaid recipients under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (including any evaluation by a physician or other licensed clinician).

This means that EPSDT covers most of the medical or remedial care a child needs to

- improve or maintain his or her health in the best condition possible OR
- compensate for a health problem OR
- prevent it from worsening OR
- prevent the development of additional health problems

Medically necessary services will be provided in the most economic mode possible, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure that is unsafe, ineffective, experimental, or investigational; that is not medical in nature; or that is not generally recognized as an accepted method of medical practice or treatment.

If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **not** eliminate the requirement for prior approval.

For important additional information about EPSDT, please visit the following websites:

- *Basic Medicaid Billing Guide* (especially sections 2 and 6): <http://www.ncdhhs.gov/dma/medbillcaguide.htm>.
- *Health Check Billing Guide*: <http://www.ncdhhs.gov/dma/healthcheck.htm>.
- EPSDT provider information: <http://www.ncdhhs.gov/dma/EPSDTprovider.htm>.

Proposed Clinical Coverage Policies

In accordance with NCGS §108A-54.2, proposed new or amended Medicaid clinical coverage policies are available for review and comment on DMA’s website at <http://www.ncdhhs.gov/dma/mp/proposedmp.htm>. To submit a comment related to a policy, refer to the instructions on the website. Providers without Internet access can submit written comments to the address listed below.


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

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

2008 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
July	07/03/08	07/08/08
	07/10/08	07/15/08
	07/17/08	07/22/08
	07/24/08	07/30/08
August	08/07/08	08/12/08
	08/14/08	08/19/08
	08/21/08	08/28/08

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



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 Acting Director
 Division of Medical Assistance
 Department of Health and Human Services



Melissa Robinson
 Executive Director
 EDS