



July 2009 Medicaid Bulletin

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**Providers are responsible for informing their billing agency of information in this bulletin.
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Attention: All Providers

Public Notice

The Department of Health and Human Services, Division of Medical Assistance hereby provides notice of its intent to amend the Medicaid State Plan for the purpose of revising rate methodology language to reflect an inflationary adjustment factor of zero (0) percent for SFY 2009 – 2010 to all Medicaid private and public providers with the following exceptions: federally qualified health clinics, rural health centers, State institutions, outpatient hospitals, pharmacies and the noninflationary components of the case-mix reimbursement system for nursing facilities. Medicaid rates predicated upon Medicare fee schedules shall follow Medicare reductions but not Medicare increases unless federally required. Inflationary increases for Medicaid providers paying provider fees (private ICF-MRs and nursing facilities) can occur if the State share of the increases can be funded with provider fees.

A public notice will be issued for any future rates adjustments for SFY 2009 – 2010.

This amendment will become effective July 1, 2009.

The annual estimated state fiscal impact of this change is:

- a. SFY 2009-2010 (\$ 63,000,443).
- b. SFY 2010-2011 (\$ 63,000,443).

A copy of the proposed amendment(s) may be viewed at the county department of social services. Questions, comments and requests for copies of the proposed State Plan amendment should be directed to the Division of Medical Assistance at the address listed below.

Craig L. Gray, MD, MBA, JD
Medicaid Director
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501



Attention: All Providers

**National Provider Identifier Guidelines for
Claims Filed With a CCNC/CA Referral**

Effective with date of processing May 1, 2009, the 7-digit **Carolina ACCESS Medicaid Provider Referral Number is no longer accepted on paper or electronic claims.** In order to receive payment and avoid denials, submit **ONLY** the Carolina ACCESS National Provider Identifier (NPI) referral number in block 17b on the CMS-1500 claim form or on the left side of form locator 78 on the UB-04 claim form.

To determine the recipient's primary care provider (PCP) and whether to obtain the group NPI or individual NPI for the Carolina ACCESS referral authorization, refer to the recipient's Medicaid identification (MID) card or the Automated Voice Response (AVR) system. When calling the AVR system for PCP information, select option 6 for eligibility, and then option 2 for enrollment.

Tips on Submitting Claims for Carolina ACCESS Recipients

- A taxonomy code for the referring provider is **NEVER** required.
- **NPI is NOT used for Carolina ACCESS overrides.** Providers must continue to submit the override number in block 17a on the CMS-1500 claim form or on the right side of form locator 78 on the UB-04 claim form along with the appropriate qualifier when applicable: 1D on the CMS-1500 claim form and G2 on the UB-04 claim form.

Note: Qualifiers are required only when billing paper claims. They are not required when using the NCECSWeb Tool. Providers using a software vendor or clearinghouse, should contact them to verify whether qualifiers are required.

- Block 17 (name) is **NOT** a required field on the CMS-1500 claim form.
- After obtaining the Carolina ACCESS NPI from the PCP, verify that the NPI matches the provider name on the recipient's MID card and/or on the AVR system by using the NPI and Address Database on DMA's website at <http://www.ncdhhs.gov/dma/WebNPI/default.htm>.

Note: Coordination of care is a required component of CCNC/CA. PCPs are responsible for ensuring that they have provided their correct Carolina ACCESS NPI to the referring provider.

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****Submitting ZIP+4 on Claims**

The N.C. Medicaid National Provider Identifier (NPI) mapping solution uses both billing (accounting) and service facility ZIP codes to map claims. Providers with one NPI that represents multiple Medicaid provider numbers at different locations must submit the ZIP+4 that is on file for the appropriate provider number, in order for claims to map properly.

Also, within the ZIP code mapping step, the accounting ZIP+4 is considered first. If no match is found, it moves to service facility ZIP+4. Providers may need to add an accounting address to additional provider numbers for mapping purposes.

To verify your provider information, visit the NPI and Address database at <http://www.ncdhhs.gov/dma/WebNPI/default.htm>.

Always include your service facility ZIP+4 when completing your claim. On the NCECSWeb Tool there is a specific field for the service facility ZIP code. On the CMS-1500, the service facility ZIP+4 is entered in block 32. On the UB-04, the service facility ZIP+4 is entered in form locator 1 as the “attending physician” ZIP.

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**Updated EOB Code Crosswalk to HIPAA Standard Codes**

The list of standard national codes used on the Electronic Remittance Advice (ERA) has been cross-walked to EOB codes as an informational aid to adjudicated claims listed on the Remittance and Status Report (RA). An updated version of the list is available on DMA’s website at <http://www.ncdhhs.gov/dma/hipaa/>.

With the implementation of standards for electronic transactions mandated by HIPAA, providers now have the option to receive an ERA in addition to the paper version of the RA.

The EOB codes that providers currently receive on a paper RA are not used on the ERA. Because the EOB codes on the paper RA provide a greater level of detail on claim denials, all providers will continue to receive the paper version of the RA, even if they choose to receive the ERA transaction. The crosswalk is current as of the date of publication. Providers will be notified of changes to the crosswalk through future Medicaid bulletins.

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

Attention: All Providers**E**lectronic Claims Submission

As a cost-saving measure and to increase efficiency, the N.C. Medicaid Program will require all providers to file claims electronically. Providers will be notified of the implementation date for this requirement in a future Medicaid bulletin.

By submitting claims electronically, providers have the advantage of expedited claims processing and improved cash flow. Electronic claims software includes time-saving features such as automatic insertion of required claims information, retrieval of previously submitted claims from backup files, and generation of lists of commonly used billing codes. Claims submitted electronically by 5:00 p.m. on the cut-off date are processed in the following checkwrite.

Electronic Claims Submission Agreement

Providers who did not complete an Electronic Claims Submission (ECS) Agreement at the time of their enrollment must now complete and submit an ECS Agreement. Effective with this requirement, all providers enrolling in the N.C. Medicaid Program will be required to complete and submit the ECS Agreement in their Provider Enrollment Packet. Providers who are already filing claims electronically do not need to resubmit an ECS Agreement.

The ECS Agreement must be submitted and approved prior to submitting claims electronically, regardless of how claims are submitted – through a clearinghouse, with software obtained from an approved vendor, or through the NCECSWeb Tool. Once notification of approval is received, providers must contact the EDS Electronic Commerce Services Unit (1-800-688-6696 or 919-851-8888, option 1) to obtain a logon ID and password for electronic claims submission.

Group providers must submit the name and Medicaid provider number for each individual provider who is affiliated with their group and for whom they will be submitting claims using their group provider number. This is required even if there is only one provider in the group. Each individual must sign the ECS Agreement for the group authorizing the group to use the individual's National Provider Identifier to bill Medicaid for services provided.

Providers may obtain a copy of the ECS Agreement for either a group or an individual by visiting CSC's Provider Enrollment website at <http://www.nctracks.nc.gov/provider/forms/> or DMA's website at <http://www.ncdhhs.gov/dma/provider/forms.htm>.

Trading Partner Agreement

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

Additional information regarding billing claims electronically is available in the *Basic Medicaid Billing Guide*, Section 10 (on DMA's website at <http://www.ncdhhs.gov/dma/basicmed/>), or from the EDS Electronic Commerce Services Unit (telephone 1-800-688-6696 or 919-851-8888, option 1).

Electronic Claim Exceptions

The following list outlines some of the situations in which a claim must be billed on paper.

- Medicare HMO (Part C) primary claims
- Medicare Part A inpatient claims submitted directly to Medicaid

- Services that require an invoice to be submitted with the claim including, but not limited to
 - ◆ Hearing aids and related items
 - ◆ Some visual aids
 - ◆ Unclassified and unlisted procedures
 - ◆ Undelivered dentures
 - ◆ Compounded injectable drugs billed with an unclassified HCPCS procedure code (for example, J3490)
Note: 17-P compounds do not require invoices and should be billed electronically when this provision becomes effective.
- Claims submitted with a Medicaid Resolution Inquiry Form for
 - ◆ Time limit override
 - ◆ Medicare override
 - ◆ Third-party override
- Pharmacy claims for
 - ◆ Charges over \$9,999
 - ◆ Compound drugs, when the compound comprises both legend and non-legend drugs
 - ◆ Compound drugs, when the compound contains an over-the-counter drug
 - ◆ Non-covered over-the-counter drugs prior approved through EPSDT
 - ◆ Retroactive charges that exceed the time limit for filing
 - ◆ DMA-approved quantity overrides
 - ◆ Medicare deductibles
 - ◆ Synagis that does not meet the established guidelines for coverage
 - ◆ Depo-Provera that does not meet the established guidelines for coverage
- Visual field exams requiring medical justification
- Any claim that requires manual review of records after the initial filing in order to make a coverage determination
- Non-covered services provided under EPSDT
- Any claim billed with one of the following ICD-9-CM diagnosis codes:
 - ◆ 584.8
 - ◆ 589
 - ◆ 593.9
 - ◆ 640 through 640.9
- Any professional claim billed with one of the following CPT procedure codes:
 - ◆ 59136
 - ◆ 59151
 - ◆ 59120
 - ◆ 59100
 - ◆ 99082
- Any dental claim billed with one of the following ADA procedure codes:
 - ◆ D0340
 - ◆ D0470
 - ◆ D7830
- Any institutional claim billed with one of the following ICD-9-CM procedure codes:
 - ◆ 66.6 through 66.9
 - ◆ 62.41 through 62.42
 - ◆ 63.81 through 63.85
 - ◆ 63.89

- ◆ 65.51 through 65.52
- ◆ 65.61 through 65.62
- ◆ 66.71 through 66.79
- ◆ 66.91
- ◆ 66.94 through 66.99
- Claims submitted with a Provider Enrollment Packet from an out-of-state provider for reimbursement of services rendered to N.C. Medicaid recipients in response to an emergency
- Nursing home crossovers submitted directly to Medicaid

Only claims that comply with the exceptions listed above may be submitted on paper. All other claims are required to be submitted electronically. This list will be maintained on the DMA website at <http://www.ncdhhs.gov/dma/provider/ECSEExceptions.htm>. Providers will be notified of updates to the list through the Medicaid Bulletin.

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

Attention: All Providers

***E*lectronic Funds Transfers**

As a cost-saving measure and to increase efficiency, the N.C. Medicaid Program will require all providers to receive payments electronically. Providers will be notified of the implementation date for this requirement in a future Medicaid Bulletin.

By receiving payments electronically, providers eliminate the possibility of their paper checks' being lost, stolen, misrouted, damaged or returned to sender. Electronic funds transfers (EFT) also eliminate delays incurred in receipt of Medicaid payment for the mailing and delivery of the check, which can take 5 to 7 business days. EFT payments are deposited through a secure transaction into the provider-designated checking or savings bank account. EFT provides payment in a timely and safe manner and supports an increased cash flow to the provider's business operation.

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

Completed forms can be returned by fax to the EDS financial unit at 919-816-3186 or by e-mail to NCXIXEFT@eds.com. Providers will continue to receive paper checks until automatic deposits begin or resume to a new bank account. When the EFT process for automatic deposits has been completed, the top left corner of the last page of the Remittance and Status Report will show "EFT number" rather than "check number."

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

Attention: All Providers**Notice of Possible Medicaid Identification Card Changes**

As a cost-saving measure and to increase efficiency, the N.C. Medicaid Program may begin issuance of no more than one Medicaid identification (MID) card per year to each recipient. The proposed annual cards would be printed on white stock; DMA would no longer have blue, pink, green, and buff colored MID cards. The cards would include, at a minimum, the recipient's name, MID number, and managed care primary care provider information (if applicable).

If implemented, this change would mean that the MID card will no longer serve as proof of recipient eligibility. Providers must verify the cardholder's current eligibility at each visit. Once providers have verified eligibility during a particular month, the provider may assume that the cardholder remains eligible for the remainder of that month.

An exception to the one card per year rule would be made for those managed care recipients who change their primary care physician or change their name. A recipient would also be able to ask the county department of social services to submit a request for a replacement card, if needed.

Should the proposed legislation be implemented, providers will be notified of the change in future Medicaid Bulletins and through Remittance and Status Report banner messages, e-mail blasts, and the DMA Budget Initiative web page.

Medicaid Eligibility Unit
DMA, 919-855-4000

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/>:

- A2, *Over-the-Counter Medications* (eff. 7/17/09)
- 1-I, *Dietary Evaluation and Counseling*
- 1L-1, *Anesthesia*
- 8A, *Enhanced Mental Health and Substance Abuse Services*
- 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**False Claims Act Education Compliance for Federal Fiscal Year 2008**

Effective January 1, 2007, Section 6023 of the Deficit Reduction Act (DRA) of 2005 requires providers receiving annual Medicaid payments of \$5 million or more to educate employees, contractors, and agents about federal and state fraud and false claims laws and the whistleblower protections available under those laws.

Each year DMA will notify those providers who received a minimum of \$5 million in Medicaid payments during the last federal fiscal year (October 1 through September 30) that they must submit a Letter of Attestation to Medicaid in compliance with the DRA. (A complete list of providers who meet this requirement will be available on DMA's website at <http://www.ncdhhs.gov/dma/fcadata/default.htm>.) This minimum amount may have been paid to one N.C. Medicaid provider number or to multiple Medicaid provider numbers associated with the same tax identification number. A separate notification will be mailed for each Medicaid provider number.

Providers must complete and submit a copy of the Letter of Attestation Form within 30 days of the date of notification. Upon completion, submit the Letter to EDS by fax or by mail.

Mail to
EDS
Attn: PVS-False Claims Act
P.O. Box 300012
Raleigh NC 27622

OR

Fax to
919-851-4014
Attn: PVS-False Claims Act

Compliance with Section 6023 of the DRA is a condition of receiving Medicaid payments. Medicaid payments will be denied for providers who do not submit a signed Letter of Attestation within 30 days of the date of notification. Providers may resubmit claims once the signed Letter is submitted to and received by EDS.

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

Attention: All Providers**DMA Budget Initiative Web Page**

DMA will implement a number of changes in response to proposed legislated budget reductions. Providers will be notified of operational changes and coverage and policy changes via the Medicaid Bulletin. These changes will also be listed on DMA's website at <http://www.ncdhhs.gov/dma/provider/budgetinitiatives.htm>.

Provider Services
DMA, 919-855-4050

Attention: All Providers**C**larification for Completing the W-9

The Medicaid provider enrollment process includes the completion of the Internal Revenue Service's (IRS) W-9 form. The N.C. Medicaid Program must collect this information in order to correctly report income paid to the provider. The W-9 form is retained by the N.C. Medicaid Program and is not sent to the IRS. The instructions that the IRS provides with the W-9 form explain that payments you receive may be subject to backup withholding if you do not report your correct tax identification number (TIN). The instructions further explain that the TIN provided must match the name given on Line 1. Failure to provide your correct TIN may result in a penalty. (The W-9 form and instructions for completing the form are available at <http://www.irs.gov>.)

Some individual providers who are also associated with a group practice submitted their W-9 with the group's TIN listed instead of their social security number (SSN). Now that the N.C. Medicaid Program is aware of this issue, the IRS instructions and guidelines for completion of the W-9 form will be followed. Providers who have supplied incorrect TINs in the past may correct their W-9s at any time by sending a completed Medicaid Provider Change Form with a corrected W-9 attached to the form to the address listed below.

N.C. Medicaid Provider Enrollment
CSC
PO Box 300020
Raleigh NC 27622-8020

Earnings reported on the 1099 form are based on the provider number associated with the National Provider Identifier entered on the claim form. If incorrect earnings are reported it may be because claims are incorrectly filed without the group number, which results in income being reported to the individual (attending) provider number entered on the claim. Incorrect earnings are **NOT** reported based on the W-9. It is important that all providers carefully review the Financial Section of their Remittance and Status Report (RA) to verify that the claim is submitted properly and income is reported to the correct TIN.

Monica T. Jones, Provider Services
DMA, 919-855-4050

Attention: All Providers**B**illing CPT Procedure Code 72295 with Modifiers 76 or 77

Effective with date of service November 1, 2008, the unit limitation for CPT procedure code 72295 (discography, lumbar, radiological supervision and interpretation) was changed to five units per day. Modifiers 76 (repeat procedure by the same physician) or 77 (repeat procedure by another physician) should no longer be used when billing 72295. Providers who received a denial with EOB 5201 (diagnostic procedure allowed once per day unless billed with appropriate modifiers) or EOB 5202 (repeat diagnostic procedure allowed twice per day) for procedure code 72295 for dates of service on or after November 1, 2008, may resubmit the denied charges as a new claim (not as an adjustment request) for processing.

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

Attention: All Providers**P**rovider Information Regarding Changes in N.C. Health Choice Dental Benefits

Effective with date of service July 1, 2009, the following changes have been made to the dental benefits for N.C. Health Choice.

There will be coverage for selected new extraction codes, as follows:

Code	Description
D7111	Extraction, coronal remnants - deciduous tooth - Allowed for teeth A through T and AS through TS.
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal) - Allowed for A through T, AS through TS, 2 through 15, 18 through 31, 52 through 65, and 68 through 81.
D7250	Surgical removal of residual tooth roots (cutting procedure) - Allowed for A through T, AS through TS, 2 through 15, 18 through 31, 52 through 65, and 68 through 81

There is no coverage for third molar extractions: teeth numbers 1, 16, 17, and 32.

There will be coverage for space maintainers, as follows:

Code	Description
D1510	Space maintainer - fixed - unilateral - Allowed for UR, UL, LL, and LR
D1515	Space maintainer - fixed - bilateral - Allowed for UP and LO

There will be coverage for selected endodontic codes, as follows:

Code	Description
D3310	Endodontic therapy, anterior tooth (excluding final restoration) - allowed for teeth #'s 6 through 11 and 22 through 27 only
D3330	Endodontic therapy, molar (excluding final restoration) -- allowed for teeth #'s 3, 14, 19, and 30 only

No prior review is required for the extraction, space maintainer, and endodontic codes listed above.

Orthognathic surgery will be covered to correct functionally impairing malocclusions when orthodontia was approved and initiated while the child was covered by Medicaid and the need for orthognathic surgery was documented in the orthodontic treatment plan.

The following orthognathic surgery codes that may be covered if considered medically necessary:

Code	Description
D7940	Osteoplasty - for orthognathic deformities
D7941	Osteotomy - mandibular rami

Code	Description
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft
D7944	Osteotomy - segmented or subapical
D7945	Osteotomy - body of mandible
D7946	LeFort I (maxilla - total)
D7947	LeFort I (maxilla - segmented)
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft
D7949	LeFort II or LeFort III - with bone graft
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report
D7955	Repair of maxillofacial soft and/or hard tissue defect

Prior review is required for **all** orthognathic surgery.

N.C. Health Choice

Customer Service 1-800-422-4658

Prior Review 1-800-672-7897

Fax (prior review) 1-919-765-4890

Attention: All Providers

Billing CPT Procedure Codes 93541, 93542, and 93543 with Modifier 51

Effective with date of service January 1, 2008, CMS added modifier 51 (multiple procedures) as an appropriate modifier when billing the following CPT procedure codes:

- 93541 (injection procedure during cardiac catheterizations; for pulmonary angiography)
- 93542 (injection procedure during cardiac catheterizations; for selective right ventricular or right atrial angiography)
- 93543 (injection procedure during cardiac catheterizations; for selective left ventricular or left atrial angiography)

System changes have been completed. Providers who received a denial with EOB 24 (Procedure code, procedure/modifier combination or revenue code is missing, invalid or invalid for this bill type. Correct and rebill denied detail as a new claim.) when billing CPT procedure code 93541, 93542 or 93543 with modifier 51 for dates of service on or after January 1, 2008, may resubmit the denied charges as a new claim (not an adjustment request) for processing as long as filing has been kept timely.

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

Attention: All Providers***The Controlled Substances Reporting System: The State's Newest Tool to Make Prescribing Opioids and Other Controlled Substances Safer and Easier*****Background**

In 2005, the North Carolina Legislature passed enabling legislation (Article 5E, North Carolina Controlled Substances Reporting System Act § 90-113.70-76) to establish a prescription monitoring program. The stated purpose of the Act is to “improve the State’s ability to identify controlled substance abusers or misusers and refer them for treatment, and to identify and stop diversion of prescription drugs in an efficient and cost-effective manner that will not impede the appropriate medical utilization of licit controlled substances.” This legislation was in response to the newly recognized epidemic of unintentional fatal poisonings sweeping the nation and the state, resulting primarily from the increasing misuse and abuse of prescription opioids. The new, centralized database created by the Act was named the Controlled Substances Reporting System (CSRS), as it includes information only on outpatient prescriptions for controlled substances, not on other types of medications that are prescribed and dispensed in North Carolina. In July 2007, the N.C. Department of Health and Human Services (DHHS) put the CSRS into production.

One function of the system is to give providers a tool that helps them more safely and easily decide whether to prescribe opioids and other drugs with abuse or addictive potential to specific patients. All pharmacies dispensing outpatient prescriptions are mandated (see **Legal Mandate**, below) to report these prescriptions to a centralized database managed by DHHS. DHHS in turn may disclose information to the following entities:

- Practitioners and dispensers (who may apply for web access; see **Enrolling in the CSRS**, below)
- Recipients requesting their own data
- Agents of the State Bureau of Investigation’s Diversion and Environmental Crimes unit, pursuant to a bona fide investigation
- State licensing boards with jurisdiction over health care professionals, pursuant to an ongoing investigation
- Primary monitoring authorities in other states, pursuant to an ongoing investigation
- Division of Medical Assistance for the purposes of administering the State Medicaid Plan
- De-identified data for statistical and research purposes only
(Legislation is pending to add medical examiners to the list.)

In addition, DHHS shall report unusual patterns of prescribing to the Attorney General. An independent multidisciplinary advisory committee has been formed to provide ongoing guidance to DHHS on the CSRS. The committee establishes reviews and revises objective criteria as to what constitutes an unusual pattern.

Legal Mandate

The North Carolina Controlled Substances Reporting System Act **requires** that all outpatient dispensers of controlled substances in North Carolina report data to the CSRS. These data are a subset of the standard data routinely collected by most third-party vendors who provide payment reimbursement services to pharmacies, and the specific information that must be reported on each prescription is established by law.

Currently, data must be reported to the CSRS on the 15th and 30th of every month. Pending legislation may increase the reporting frequency, thus improving the currency of the data. Due to occasional reporting errors and a few late or non-complying pharmacies, the CSRS data is not 100 percent accurate. It is probably an underestimation of the actual number of potentially addictive drugs that are legally available in North Carolina.

Epidemiologic Profile of Outpatient Controlled Substances

Almost half of the prescriptions in the CSRS database are for narcotic analgesics (mostly opioids). In 2008, more than 16 million outpatient prescriptions were dispensed for controlled substances. Of these, the most frequently prescribed were products with hydrocodone (4,146,484 prescriptions), benzodiazepines (3,782,112 prescriptions), oxycodone (2,029,604 prescriptions) and products to treat insomnia (1,416,840 prescriptions). The prescription **rates** varied greatly by county, with the highest prescription rates occurring most often (but not always) in our state's most rural areas (see **Figure 1**).

Although these findings have stimulated intense interest among the state's epidemiologists, there are no studies to date that can answer even the most basic questions, like "Is the overall state annual prescription rate of 17,787 prescriptions per 10,000 residents higher than best practices would expect?" or "Why are the controlled substances prescription rates in Watauga and Wilkes counties in the lowest and highest state quartiles, respectively, even though they are contiguous counties and both are in one of the most rural areas of the Appalachians?" The CSRS provides a tool to facilitate such research. However, only de-identified CSRS data are available for statistics, research or education.

Enrolling in the CSRS

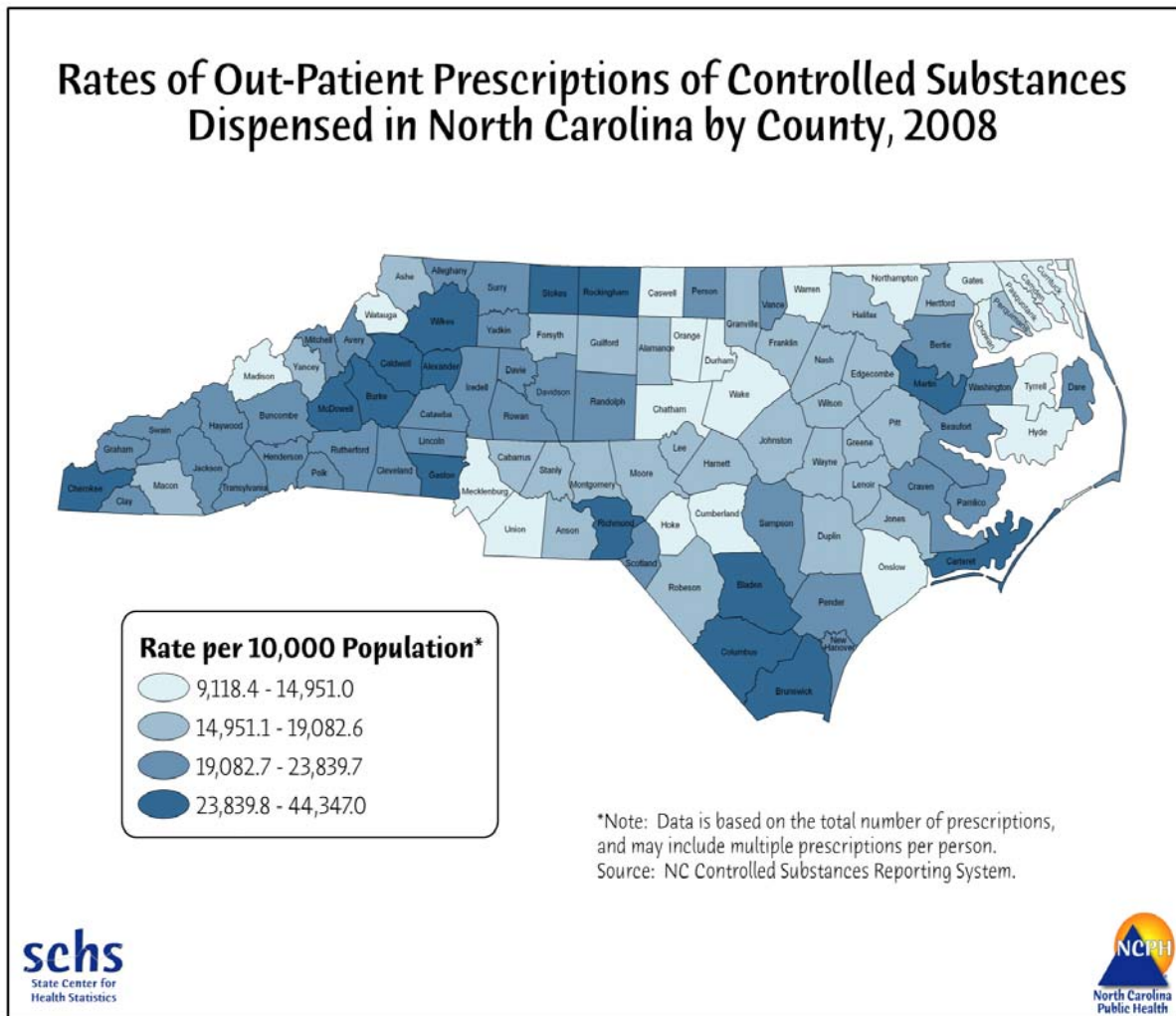
Medicaid and other medical providers who are practitioners with a current DEA registration and licensed pharmacists may easily apply for access to the CSRS by completing a short enrollment application available on the CSRS website (<http://www.ncdhhs.gov/MHDDSAS/controlledsubstance/>). Print, complete, sign and notarize the form and mail it to the CSRS at the address on the form. E-mail confirmation of access is often received in less than two weeks. The CSRS link is also available on the DMA Outpatient Pharmacy web page (<http://www.ncdhhs.gov/dma/pharmacy/>) under "Related Sites." Because of the strict confidentiality provisions in the Act, **only the registered practitioner may access the system**. The law prohibits other members of the practice from using it. Additionally, **it is unlawful to disclose CSRS findings with anyone** (including other practitioners) except the patient. (Pending legislation could change this provision.)

Using the CSRS in Medical Practice

The CSRS is quick to use and excels in collating information that can promote safer prescribing of opioids and other controlled substances. Running a CSRS profile should be seen as a universal precaution when prescribing any controlled substance; like the universal precautions for blood drawing, it should be done for every patient every time the prescribing of a controlled substance is likely. By running a CSRS prescription profile that documents what and how many prescriptions for controlled substances have been dispensed to a patient, Medicaid providers have an additional tool by which to decide whether to write or refill a prescription. Practitioners may choose, for example, to refer the patient for more sophisticated pain management, or refer the patient for substance abuse treatment while also considering other options for pain management.

The CSRS was not designed as a means by which to "fire" a patient because of a less-than-optimal prescription profile. Because the CSRS is new and the potential for error always exists, the system cannot be assumed to be infallible. Always discuss the findings with the patient. If the patient contests the findings or the practitioner is concerned about the validity of the profile or has other questions, the practitioner may contact John Womble or William Bronson, at the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, Drug Control Unit (telephone 919-733-1765, Monday through Friday between 9:00 a.m. and 5:00 p.m.).

Figure 1



**William D. Bronson, Manager
DMH Drug Control Unit, 919-733-1765**

**Catherine (Kay) Sanford
Injury Epidemiology Consultant**

**Susan Albert, MD, Medical Director
Wilkes County Health Department**

Attention: All Providers**CSC to Initiate 12-Month Provider Verification and Credentialing Activities**

CSC is ready to begin the 12-month process to verify information and credential enrolled Medicaid providers who have not been credentialed in the last 18 months. CSC will notify providers by mail when verification and credentialing activities will begin for their provider types. The notification packet will be mailed to the provider's billing/accounting address and will include a pre-printed report of information currently on file with N.C. Medicaid plus a checklist of credentialing-related documents that must be returned to CSC. (Providers may verify their billing/accounting address via the DMA Provider Services NPI and Address Database at <http://www.ncdhhs.gov/dma/WebNPI/default.htm> or by calling the EVC Call Center.)

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

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

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

EVC Call Center Contact Information

EVC Call Center Toll-Free Number	866-844-1113
EVC Call Center Fax Number	866-844-1382
EVC Call Center E-Mail Address	NCMedicaid@csc.com
EVC Call Center Mailing Address	N.C. Medicaid Provider Enrollment CSC PO Box 300020 Raleigh NC 27622-8020
EVC Call Center Site Address	N.C. Medicaid Provider Enrollment CSC 2610 Wycliff Road, Suite 102 Raleigh NC 27607-3073
EVC Call Center Website	http://www.nctracks.nc.gov

Refer to DMA's website at <http://www.ncdhhs.gov/dma/provider/mmis.htm> for more information about CSC and the development and implementation of the Replacement Medicaid Management Information System (MMIS).

Linda Pruitt
DMA, 919-855-4106

Attention: All Providers**Time Limit Overrides**

Federal guidelines require that all Medicaid claims, except hospital inpatient and nursing facility claims, must be received by EDS within 365 days of the first date of service in order to be accepted for processing and payment. All Medicaid hospital inpatient and nursing facility claims must be received within 365 days of the last date of service on the claim. If a claim was filed within the 365-day time period, providers have 18 months from the remittance advice (RA) date to refile a claim.

If the claim is a crossover from Medicare or any other third-party commercial insurance, regardless of the date of service on the claim, the provider has 180 days from the date listed on the explanation of benefits (EOB) to file the claim to Medicaid from that insurance (whether the claim was paid or denied). The provider must include the Medicaid Resolution Inquiry Form, copy of the claim, and a copy of the Third-Party or Medicare EOB in order to request a time limit override with EDS.

Claims initially received for processing within the 365-day time limit may be resubmitted to EDS on paper or electronically. The claim information must match exactly to the original claim for the recipient Medicaid identification number (MID), provider number, from date of service, and total billed. Claims that do not have an exact match to the original claim in the system will be denied for one of the following Explanation of Benefits (EOB):

- **0018** Claim denied. No history to justify time limit override. Claims with proper documentation should be resubmitted to EDS Provider Services Unit.
- **8918** Insufficient documentation to warrant time limit override. Resubmit claim with proof of timely filing—a previous RA, time limit override letter, or other insurance payment or denial letter within the previous six months.

Requests for time limit overrides must be sent to EDS with documentation showing that the original claim was submitted within the initial 365-day time period.

Examples of acceptable documentation for time limit overrides include:

- Dated correspondence from DMA or EDS about the specific claim received that is within 365 days of the date of service
- An explanation of Medicare benefits or other third-party insurance benefits dated within 180 days from the date of Medicare or other third-party payment or denial.
- A copy of the RA showing that the claim is pending or denied; the denial must be for reasons other than time limit.

Examples of unacceptable documentation may include, but not limited to:

- The billing date on the claim or a copy of an office ledger.
- The date that the claim was submitted does not verify that the claim was received by EDS within the 365-day time limit.

The **Medicaid Resolution Inquiry Form** is used to submit claims for Time Limit Overrides. The instructions for completing the Medicaid Resolution Inquiry Form can be found in the Basic Medicaid Billing Guide at <http://www.ncdhhs.gov/dma/basicmed/> in Section Eight – Resolving Denied Claims on page nine.

When submitting inquiry forms, always attach the claim and a copy of any paper RAs related to the inquiry form, as well as any other information related to the claim (provider-generated RAs or electronic RAs are not acceptable). Each inquiry request requires a separate form and copies of documentation (vouchers and attachments). Because these documents are scanned for processing, attach only single-sided documents to the inquiry request. Do not attach double sided documents to the inquiry request. A copy of the Medicaid Resolution Inquiry Form is on DMA's website at <http://www.ncdhhs.gov/dma/provider/forms.htm>.

Retro Eligibility and Retroactive Prior Approval

In some instances an application for Medicaid benefits is initially denied and then later approved due to a reversal of a disability denial, a state appeal, or a court decision. A time limit override may be needed in some cases; the county department of social services (DSS) is responsible for requesting this override based on date of approval. When a time limit override is warranted, the county department of social services will provide written notice to the recipient outlining the specific dates of service when the Time Limit Override is approved. Recipients are instructed to immediately notify the provider of retroactive approval. When this occurs, providers can file claims for these specific dates of service outlined in the recipient letter. The provider must file these claims within six months of determination as outlined in the recipient letter.

Retroactive prior approval is considered when a recipient, who does not have Medicaid coverage at the time of the procedure, is later approved for Medicaid with a retroactive eligibility date. Because some of these appeals and reversals are not final for many months, the county DSS can request an override of the claims filing time limit from DMA.

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

Attention: Nurse Practitioners and Physicians**Bevacizumab (Avastin, HCPCS Procedure Code J9035): Update to Billing Guidelines**

Effective with date of service May 5, 2009, the N.C. Medicaid Program added the FDA-approved diagnosis of glioblastoma to the required list of diagnoses for bevacizumab (Avastin) when billed through the Physician's Drug Program. Avastin is indicated as a single agent for patients whose glioblastoma progressed despite prior therapy.

Certain ICD-9-CM diagnosis codes are required when billing for Avastin.

1. One of the following diagnosis codes must be billed with V58.11 (encounter for chemotherapy):
 - a. **153.0** through **154.8** (malignant neoplasm of the colon, rectum, recto-sigmoid junction, and anus)
OR
 - b. **162.2** through **162.9** (unresectable, locally advanced, recurrent or metastatic non-squamous, non-small-cell lung carcinoma)
OR
 - c. **174.0** through **175.9**; **198.2**; **198.81**; or **238.3** (breast cancer)
OR
 - d. **191.0** through **191.9** (malignant neoplasm of brain)
2. Diagnosis code **362.52** (wet age-related macular degeneration) may be billed for Avastin, but does **not** require V58.11.

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

Attention: Nurse Practitioners and Physicians**Bendamustine (Treanda, HCPCS Procedure Codes J9999 and J9033):
Corrected Diagnosis Code List**

There was an error in the table published in the April 2009 Medicaid Bulletin article that provided guidance on the ICD-9-CM diagnosis codes required when billing bendamustine (Treanda, HCPCS procedure codes J9999 and J9033) for non-Hodgkin's lymphoma. For "other malignant neoplasms of lymphoid and histiocytic tissue," the range of codes should have been listed as 202.00 through 202.98.

Refer to the corrected table below when billing for Treanda.

Dates of Service	HCPCS Procedure Code	ICD-9-CM Diagnosis Code	ICD-9-CM Diagnosis Code Description
March 1, 2008, through September 30, 2008	J9999	V58.11 AND 204.10 through 204.11	Encounter for antineoplastic chemotherapy Lymphoid leukemia, chronic, without mention of remission, in remission
October 1, 2008, through October 31, 2008	J9999	V58.11 AND 204.10 through 204.12	Encounter for antineoplastic chemotherapy Lymphoid leukemia, chronic, without mention of remission, in remission or in relapse
November 1, 2008, through December 31, 2008	J9999	V58.11 AND 204.10 through 204.12 OR one of these non-Hodgkin's lymphoma diagnosis codes: <ul style="list-style-type: none"> • 200.00 through 200.88 • 202.00 through 202.98 	Encounter for antineoplastic chemotherapy Lymphoid leukemia, chronic, without mention of remission, in remission or in relapse Lymphosarcoma and reticulosarcoma and other specified malignant tumors of lymphatic tissue Other malignant neoplasms of lymphoid and histiocytic tissue
January 1, 2009, and after	J9033	V58.11 AND 204.10 through 204.12 OR one of these non-Hodgkin's lymphoma diagnosis codes: <ul style="list-style-type: none"> • 200.00 through 200.88 • 202.00 through 202.98 	Encounter for antineoplastic chemotherapy Lymphoid leukemia, chronic, without mention of remission, in remission or in relapse Lymphosarcoma and reticulosarcoma and other specified malignant tumors of lymphatic tissue Other malignant neoplasms of lymphoid and histiocytic tissue

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

Attention: Nurse Practitioners and Physicians**Factor VIII (Xyntha, HCPCS Procedure Code Q2023): Billing Guidelines**

Effective with date of service July 1, 2009, the N.C. Medicaid Program covers factor VIII (antihemophilic factor, recombinant) (Xyntha) per IU for use in the Physician's Drug Program when billed with HCPCS procedure code Q2023. Xyntha is available in vials containing 250, 500, 1000, and 2000 IUs.

Xyntha is indicated for patients with hemophilia A. Xyntha, administered intravenously, may be used for the control and prevention of bleeding episodes or for surgical prophylaxis.

For Medicaid Billing

- The ICD-9-CM diagnosis code required for billing Xyntha is **286.0** (congenital factor VIII disorder).
- Providers must bill Xyntha with HCPCS procedure code Q2023.
- One Medicaid unit of coverage is 1 IU. The maximum reimbursement rate per 1 IU is \$1.05.
- Providers must bill NDC codes and NDC units. For each IU administered, report the number of NDC units as "F2," for international unit. For example, for 250 units, report "F2250." Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III*, on DMA's website at <http://www.ncdhhs.gov/dma/bulletin/> for instructions. **Medicaid covers only rebatable NDCs.**
- Providers must indicate the number of HCPCS procedure code units used in block 24G on the CMS-1500 claim form or on the electronic equivalent.
- Providers must bill their usual and customary charges.

The fee schedule for the Physician's Drug Program is available on DMA's website at <http://www.ncdhhs.gov/dma/fee/>.

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

Attention: Pharmacists**Prescription Origin Code**

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

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

Zero and null values will not be accepted. **This requirement will apply only to new prescriptions and will not apply to refills.** The information entered into the prescription origin code field is required to assist with auditing processes.

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

Attention: Nurse Practitioners and Physicians**Lacosamide Single-Use Vials (20 ml) for Injection (Vimpat, HCPCS Procedure Code J3490): Billing Guidelines**

Effective with date of service July 1, 2009, the N.C. Medicaid Program covers lacosamide injectable (Vimpat) for use in the Physician's Drug Program when billed with HCPCS procedure code J3490 (unclassified drugs). Vimpat is available as 200-mg/20-ml single-use vials with a concentration of 10 mg/ml. Vimpat is indicated as adjunctive therapy in the treatment of partial-onset seizures when oral administration is temporarily not feasible.

Vimpat is initially administered intravenously with a dosage of 50 mg twice daily. The dosage may be increased at weekly intervals by 100 mg/day and is administered intravenously as two divided doses up to the recommended maintenance dosage of 200 to 400 mg/day. This recommended maintenance dosage is based on individual patient response and tolerability. When switching from oral to IV lacosamide, the initial total daily IV dosage of lacosamide should be equivalent to the total daily dosage and frequency of oral lacosamide and should be infused intravenously over a period of 30 to 60 minutes.

For Medicaid Billing

- The ICD-9-CM diagnosis codes required for billing Vimpat are:
 - ◆ **345.40** through **345.41** (localization-related [focal] [partial] epilepsy and epileptic syndromes with complex partial seizures)
- OR
- ◆ **345.50** through **345.51** (localization-related [focal] [partial] epilepsy and epileptic syndromes with simple partial seizures)
- Providers must bill Vimpat with HCPCS code J3490 (unclassified drugs).
- One Medicaid unit of coverage is 10 mg. The maximum reimbursement rate, per 10 mg, is \$1.97.
- Providers must indicate the number of units used in block 24G on the CMS-1500 claim form or the electronic equivalent. An entire single-use vial may be billed.
- Providers must bill NDC codes and NDC units. The NDC units for Vimpat should be reported as "ML." For example, for a 200-mg dose the NDC units should be reported as "ML20." Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III*, on DMA's website at <http://www.ncdhhs.gov/dma/bulletin/> for instructions. **Medicaid covers only rebatable NDCs.**
- Providers must bill their usual and customary charge.

The fee schedule for the Physician's Drug Program is available on DMA's website at: <http://www.ncdhhs.gov/dma/fee/>.

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

Attention: Nurse Practitioners and Physicians**Golimumab (50 mg per 0.5 ml) for Injection (Simponi, HCPCS Procedure Code J3590): Billing Guidelines**

Effective with date of service July 1, 2009, the N.C. Medicaid Program covers golimumab injectable (Simponi) for use in the Physician's Drug Program when billed with HCPCS code J3590 (unclassified biologicals). Simponi is available as either pre-filled syringes (50 mg per 0.5 ml) or pre-filled SmartJect autoinjectors (50 mg per 0.5 ml).

Simponi is a human monoclonal antibody that is indicated for the treatment of active moderate-to-severe rheumatoid arthritis (RA), active psoriatic arthritis (PsA), and active ankylosing spondylitis (AS).

Simponi is administered as a subcutaneous (SC) injection once a month. The recommended dose for Simponi is 50 mg.

Prior to initiating Simponi and periodically during therapy, patients should be evaluated for active tuberculosis and tested for latent infection. For patients with RA, Simponi should be given in combination with methotrexate; for patients with PsA or AS, Simponi may be given with or without methotrexate or other non-biologic disease-modifying antirheumatic drugs (DMARDs). For patients with RA, PsA, or AS, corticosteroids, non-biologic DMARDs, and/or nonsteroidal anti-inflammatory drugs (NSAIDs) may be continued during treatment with Simponi.

For Medicaid Billing

- The ICD-9-CM diagnosis codes required for billing Simponi are:
 - ◆ **714.0** through **714.9** (rheumatoid arthritis and other inflammatory polyarthropathies)
 - OR**
 - ◆ **696.0** (psoriatic arthropathy)
 - OR**
 - ◆ **720.0** (ankylosing spondylitis)
- Providers should bill Simponi with HCPCS code J3590 (unclassified biologics).
- One Medicaid unit of coverage is 50 mg. The maximum reimbursement rate, per 50 mg, is \$3,543.75.
- Providers must indicate the number of HCPCS procedure code units used in block 24G on the CMS-1500 claim form or the electronic equivalent.
- Providers must bill NDC codes and NDC units. The NDC units should be reported as "ML." For example, for each 50 mg administered (0.5 ml from either the disposable pen or the disposable syringe), the NDC units should be reported as "ML0.5." Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III*, on DMA's website at <http://www.ncdhhs.gov/dma/bulletin/> for instructions. **Medicaid covers only rebatable NDCs.**
- Providers must bill their usual and customary charge.

The fee schedule for the Physician's Drug Program is available on DMA's website at <http://www.ncdhhs.gov/dma/fee/>.

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

Attention: CCNC/CA Primary Care Providers, Durable Medical Equipment Providers, and Pharmacists***I*nsulin Syringes**

Effective date of service July 17, 2009, insulin syringes will be covered as an over-the-counter product in the N.C. Medicaid Outpatient Pharmacy Program. Recipients must have a prescription for the insulin syringes and there must be an insulin prescription on file within the last 90 days in order to bill using the pharmacy point-of-sale system. Syringes are supplies that must be billed in multiples of 10 and a National Drug Code (NDC) must be used when billing through point-of-sale. Rates apply to syringes; therefore, no copayments or dispensing fees apply. Medicare Part D continues to cover insulin syringes for dual eligible recipients.

Syringes do not have to be purchased at the same pharmacy as the insulin unless the patient is locked into a pharmacy. Recipients identified for the Focused Risk Management (FORM) Program who require more than 11 unduplicated prescriptions each month are restricted to a single pharmacy. In these cases, the insulin syringes must be purchased at the same pharmacy.

Insulin syringes will no longer require authorization by a recipient's CCNC/CA primary care provider. Lancets and strips **will not** be paid through point-of-sale. These items will continue to require authorization by a recipient's CCNC/CA primary care provider.

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

Attention: Community Alternatives Program Case Managers, Home Health Agencies, and Private Duty Nursing Providers***P*rovision of Diapers and Non-Sterile Gloves**

Medicaid coverage of incontinent supplies (i.e., diapers and Chux) is limited to recipients ages 3 years and older. Diapers for recipients under the age of 3 years are age-appropriate and, therefore, do not meet the medical necessity criteria for coverage. All Medicaid-covered medical supplies must meet medical necessity criteria, be specifically ordered by the physician, and be indicated on the recipient's plan of care. Medical necessity criteria include the item being age-appropriate.

Non-sterile gloves for use by agency staff in providing services to the recipient are considered an administrative cost to the agency and are included in the Medicaid reimbursement rate for the service. The gloves cannot be billed to Medicaid as a separate charge. Non-sterile gloves are covered for family members and similar caregivers only if the caregiver is in contact with the patient's blood or other potentially infectious body fluids. The gloves must be specifically ordered by the physician in the plan of care. The medical record must contain documentation regarding the condition or illness that requires the medical supplies and reflect usage to support the quantity being delivered.

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

Attention: Anesthesia Providers**Anesthesia Modifier AD**

Effective with date of service December 1, 2007, DMA implemented the use of anesthesia modifier AD (medical supervision by a physician of more than four concurrent anesthesia procedures). System changes are now complete. The following guidelines must be used when billing the AD modifier.

Anesthesiologists who provide supervision to more than four anesthesia procedures performed by Certified Registered Nurse Anesthetists (CRNAs) will bill for the procedure using only the AD modifier. The QZ modifier (CRNA service: without medical direction by a physician) must be appended to the anesthesia CPT procedure code on the CRNA's claim. The anesthesiologist will be reimbursed 45 base units for every procedure being supervised, and may bill a one-time 15-minute block of time if the anesthesiologist can document presence at anesthetic induction in the medical record.

Example

The anesthesiologist bills 0 units for supervision (this translates to 45 units) and 15 units when present during induction of anesthesia (this translates to 60 units [45 + 15]).

The anesthesiologist's claim form will list the procedure code plus modifier AD and 0 (zero) units. The provider will be reimbursed for 45 base units. If present during anesthetic induction: list procedure code plus modifier AD and 15 units. Reimbursement will be for 60 base units. Only one claim detail for each procedure, with either 0 or 15 units appended, will be accepted. All other combinations of AD modifier and number of units will be denied. Medical record documentation must support claims billed. Normal timely filing guidelines apply.

The supervised CRNA's claim form will list the procedure code and modifier QZ plus the time.

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

Attention: CCNC/CA Primary Care Providers, Local Management Entities, Outpatient Behavioral Health Providers, and Psychiatrists**CCNC/CA Override for Mental Health Services Provided by a Direct-Enrolled Mental Health Practitioner**

Direct-enrolled mental health practitioners who provide services to a CCNC/CA enrollee under the age of 21 years must have a referral from the CCNC/CA primary care provider, a Medicaid-enrolled psychiatrist or the Local Management Entity (LME). When the service is provided without an appropriate referral, an override cannot be given by CCNC/CA.

It is the responsibility of the provider to make sure they have a referral before services are rendered. If treatment is provided without a referral from one of the three entities listed above, the service provider's claim will be denied with EOB 2270 (Service must be referred by Carolina ACCESS PCP, LME, or Medicaid-enrolled psychiatrist. Enter referral number on claim or contact EDS Provider Services if referral number is correct.).

Managed Care

DMA, 919-855-4780

Attention: Hospital Outpatient Clinics**Immune Globulins Billed with HCPCS Level I Procedure Codes**

Effective with date of processing July 1, 2009, the N.C. Medicaid Program requires that immune globulins billed on institutional claims using Revenue Codes 250 or 636 plus CPT procedure codes 90281 through 90399 be reported with National Drug Codes (NDCs). Only rebatable NDCs are covered.

Providers must identify 340B drugs dispensed in an outpatient or clinic setting by using the UD modifier. This will allow Medicaid to identify claim details for 340B drugs and exclude them from the rebate collection process. All non-340B drugs are billed using the applicable HCPCS procedure code and NDC pair without the UD modifier. Refer to the article titled *UD Modifier and 340B Drugs* in the June 2009 Medicaid Bulletin for additional information on billing for 340B drugs.

Refer to the March 2009 Special Bulletin, *National Drug Code Implementation Phase III*, for additional information on NDC billing. Medicaid bulletins and special bulletins are available on DMA's website at <http://www.ncdhhs.gov/dma/bulletin/>.

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

Attention: Enhanced Behavioral Health Services (Community Intervention Services) Providers, CAP/MR-DD Providers, Local Management Entities, and Residential Child Care Treatment Facilities**Mental Health Cost Report Training Sessions**

Training is being offered for those providers who have a fiscal year end of March 31, 2009, or June 30, 2009. The training scheduled at several locations across the state during the month of July. Those providers with a fiscal year end of September 30, 2009, or December 31, 2009, should wait to go to training when sessions are offered this winter.

To learn more about training, locations, times, and information on how to register for training, visit the Office of the Controller's website at <http://www.ncdhhs.gov/control/amb/amhauth.htm> and click on the link to the Mental Health Cost Report Training Memo. The memo also provides the link to the website where you can register.

For questions concerning this training or the Mental Health Cost Report, contact Bill Caddell at Bill.Caddell@ncmail.net or 919-855-3681.

**Rate Setting
DMA, 919-647-8170**

Attention: Outpatient Behavioral Health Providers, Local Management Entities, and Provisionally Licensed Providers***E*xtension of Coverage for Provisionally Licensed Providers Billing Outpatient Behavioral Health Services through the Local Management Entity**

The deadline for coverage of provisionally licensed providers delivering outpatient behavioral health services as a reimbursable service under Medicaid and state funds and billed through the Local Management Entity (LME) **has been extended to June 30, 2010**. DMA and DMH will continue to pay for services delivered by the provisionally licensed individuals listed above when billed through LMEs under HCPCS procedure codes H0001, H0004, and H0005 until that date.

As outlined in Implementation Update # 32 (<http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/>), the LME may choose to provide this billing service on behalf of the provisionally licensed professional. If the provisionally licensed professional is employed by an agency, the agency must develop a contract directly with the LME to do this billing for them. If provisionally licensed professionals work independently, they should contact their licensure board prior to developing a contract with the LME to ensure compliance with each profession's scope of practice.

In addition to providing outpatient behavioral health services billed through an LME, there are various other means for provisionally licensed professionals to obtain the clinical experience required by their licensing boards. These include

- providing outpatient services working with a physician using Medicaid's "incident to" policy (see the March 2009 Medicaid Bulletin);
- providing enhanced behavioral health (Community Intervention) services as the Qualified Professional (QP) in order to receive family- and community-based clinical experience; and
- serving as the Licensed Professional in the Intensive In-Home service.

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

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

The Enhanced Behavioral Health Services Provider Seminars scheduled for August 2009 have been cancelled.

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

Attention: Outpatient Behavioral Health Providers, Local Management Entities, Physicians, and Provisionally Licensed Providers**Prior Authorization and Billing Guidelines for Outpatient Behavioral Health Services**

This is a reminder of current outpatient prior authorization and billing guidelines for outpatient behavioral health services outlined in the June 2009 Implementation Update/Medicaid Bulletin. ValueOptions has revised the current Outpatient Review Form (ORF2). Please see the ValueOptions website (http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm) for the revised form.

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

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

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

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

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

Behavioral Health Section
DMA, 919-855-4290

Attention: Outpatient Behavioral Health Providers, Physicians, and Provisionally Licensed Providers**Prior Authorization for CPT Procedure Codes 99408 and 99409 Provided by Provisionally Licensed Providers Billing “Incident To” a Physician**

This is a clarification of the prior approval guidelines outlined in the March 2009 and May 2009 Medicaid Bulletins (<http://www.ncdhhs.gov/dma/bulletin/>). In order to facilitate best practice and integrated care for clients, CPT procedure codes 99408 and 99409 do not require prior authorization. These codes are also used by physicians and other medical professionals for substance abuse assessments and screenings. ValueOptions will not process prior authorization requests submitted for these CPT procedure codes.

Behavioral Health Section
DMA, 919-855-4290

Attention: Outpatient Behavioral Health Providers Who Are Employed in a Physician's Office or Clinic, a Hospital Outpatient Department, or a Local Health Department or School Based Health Center

Extension of Sunset Clause for Nurse Practitioners who Provide Outpatient Behavioral Health Services

DMA has extended the sunset clause for nurse practitioners who provide outpatient behavioral health services. DMA will allow nurse practitioners who possess an Advanced Certification in areas other than psychiatric nursing, and who have two years of mental health experience to enroll under this sunset clause. Under this clause, all nurse practitioners will be required to complete and submit the Advanced Psychiatric Certification to DMA Provider Services on or before June 30, 2015. Failure to complete the certification by June 30, 2015, will result in termination of participation in the N.C. Medicaid Program. It is DMA's expectation that all providers will practice within the scope of their licensure, training, and practice competencies.

As a reminder, nurse practitioners must direct enroll with Medicaid to be eligible to provide outpatient behavioral health services to adults and children. Nurse practitioners may also provide services "incident to" a physician if they are employed in a physician's office or a physician-directed clinic. However, all behavioral health practitioner services billed under "incident to" must meet the guidelines outlined in the May 2005 Special Bulletin, *Expansion of Provider Types for Outpatient Behavioral Health Services, Phase II*, and the article titled *Modification in Supervision When Practicing "Incident To" a Physician*, published in the October 2008 Medicaid Bulletin. (The Medicaid Bulletin and the Special Bulletin are available on DMA's website at <http://www.ncdhhs.gov/dma/bulletin/>.)

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

Attention: Hospitals

Grouper 25 Implementation

In April 2009, following approval from CMS, DMA implemented Grouper 25/MCE version 24 software for inpatient claim processing. As a result of the retroactive implementation of the grouper software, a recoup/repay of all hospital inpatient claims with discharge date of service after October 1, 2008, was necessary. These recoup/repays were processed based on the hospital fiscal year end (HFYE) date according to the table below.

Group	Hospital Fiscal Year End Date	Remittance and Status Report (RA) Dates
Group 1	12/31/2008	5/28/2009 and 6/9/2009
Group 2	4/30/2009 and 5/31/2009	6/16/2009 and 6/25/2009
Group 3	6/30/2009 and 7/31/2009	6/16/2009 and 6/25/2009
Group 4	8/31/2009 and 9/30/2009	6/25/2009 and 7/7/2009

Hospitals began to see these recoup/repays on their remittance status advices starting June 6, 2009.

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

Attention: Institutional (UB-04/837I) Billers

ICD-9-CM Procedure Codes Requirements Update

To comply with regulations mandated by HIPAA, in the February 2009 Medicaid Bulletin article titled *ICD-9-CM Procedure Codes*, DMA announced its intention to limit the use of ICD-9-CM procedure codes to the reporting of inpatient procedures by hospitals and to deny other claims submitted with ICD-9-CM procedure codes including outpatient, nursing home, adult care home, home health, hospice, and residential child care treatment facility services.

To allow providers to report surgical procedures previously reported using ICD-9-CM procedure codes, DMA planned to expand the detail level information required for Revenue Codes 36X (Operating Room Services) and 76X (Specialty Room Treatment/Observation Room) to include CPT/HCPCS procedure codes.

Implementation of these changes has been delayed until further notice.

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

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

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

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

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

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

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

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

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

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

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

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

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

Proposed Clinical Coverage Policies

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

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

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

2009 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
July	7/2/09	7/7/09
	7/9/09	7/14/09
	7/16/09	7/23/09
	7/30/09	8/4/09
August	8/6/09	8/11/09
	8/13/09	8/16/09
	8/20/09	8/27/09

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

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

Melissa Robinson
 Executive Director
 EDS, an HP Company
