



July 2015 Medicaid Bulletin

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Attention: All Providers

NCTracks ICD-10 Updates

Common ICD-10 Error - ICD Qualifier on 837 Transactions

Provider and Trading Partner testing for ICD-10 has revealed common errors that can become stumbling blocks this fall. **Beginning October 1, 2015**, every X12 837 transaction submitted to NCTracks must include one or more ICD qualifiers that indicate whether the claim is using ICD-9 or ICD-10 codes.

A single claim may include either ICD-9 codes or ICD-10 codes, depending on the dates of service, **but not both**. An X12 837 transaction **may include both** ICD-9 and ICD-10 claims.

Errors observed in testing include:

- Claims did not contain any ICD qualifier
- Claims contained an ICD-9 qualifier with a date of service after October 1 (or vice versa)

Claims with a missing or incorrect ICD qualifier will be denied with EOB 02671 - ICD VERSION INVALID FOR DATE OF SERVICE.

An X12 List of ICD Qualifiers has been posted to the Quick Links section of the [Trading Partner Information page](#) on the NCTracks Provider Portal. This list includes information to correctly populate the ICD Version on each type of claim in an X12 837 transaction as referenced in the Technical Report Type 3 (TR3).

Providers who submit X12 837 transactions to NCTracks are encouraged to review the X12 List in preparation for the upcoming implementation of ICD-10.

How to Recognize an ICD-9 Code from the Other Codes

Only ICD-9 codes are changing to ICD-10 codes. CPT and HCPCS codes are **not** affected by this transition.

Based on the problems some providers are having with the [NCTracks ICD-10 Crosswalk \(http://ncmmis.ncdhhs.gov/icdxwalk.asp\)](#) and the questions received in the [NCTracks ICD-10 inbox](#), it is clear that code type recognition is a challenge for some providers.

This [screen shot](#) from the NCTracks Provider Portal illustrates the difference between an ICD code and a CPT code, in terms of where they go on a professional claim.

Background Information about Coding

The Healthcare Common Procedure Coding System (HCPCS) was established in 1978 to provide standardization for describing specific items and services provided in the delivery of healthcare. HCPCS includes two levels of codes:

- Level I consists of the American Medical Association's (AMA) Current Procedural Terminology (CPT) and is numeric. CPT coding identifies the medical, surgical and diagnostic services rendered on the claim. New editions are released each October.
- Level II codes are alphanumeric and primarily include non-physician services such as ambulance services and prosthetic devices, and represent items and supplies and non-physician services not covered by CPT codes Level I.

HCPCS/CPT codes are the procedure codes used by most non-inpatient providers when billing Medicaid through NCTracks. Other than normal annual updates, HCPCS/CPT codes are **not** changing.

The International Classification of Diseases (ICD) is maintained by the World Health Organization (WHO). The International Classification of Diseases, Clinical Modification is an adaptation of the ICD code set created by the U.S. National Center for Health Statistics (NCHS) and used in assigning diagnostic and procedure codes in the United States, which is updated annually on October 1. This year, that update is the transition from ICD-9 to ICD-10 codes.

The ICD-9 code set includes volumes 1 and 2 (diagnosis codes) and volume 3 (procedure codes.) ICD-9 **diagnosis codes** are used by most providers, except dentists (unless the patient is dually eligible) and will be replaced by ICD-10.

ICD-9 **procedure codes** are only used in inpatient settings. ICD-10 Procedure Coding System (PCS) will replace volume 3 of the ICD-9 for inpatient procedure codes. In review, the code sets currently used are:

- CPT – procedure codes (physicians, radiology, labs)
- HCPCS – procedure codes (drugs, supplies, prosthetics, vision)
- ICD-9 volumes 1 and 2/ICD-10 – diagnosis codes
- ICD-9 volume 3/ICD-10-PCS – procedure codes used in hospitals only

The Difference Between a Diagnosis Code and a CPT Code

An ICD-9 code (which will become an ICD-10 code this year on October 1) is used to describe a symptom, condition, or disease that is being treated, also known as the **diagnosis code**.

For Example: A patient was seen in the physician's office with chest congestion and a cough. After examination the physician diagnosed the patient with an acute upper respiratory infection. The ICD-9 diagnosis code for today's patient visit would be represented by the ICD-9 code digits 465.9, which represent the acute URI.

NOTE: In this case, the chest congestion and the cough are symptoms that are part of the diagnosis of acute upper respiratory infection and are not coded separately, unless warranted.

A CPT code is used to describe the evaluation and management (E/M) code (meaning the physician time, intensity of service, and complexity of the examination performed on a patient at each visit, when applicable.) It can also be used to describe any treatment or diagnostic services (lab tests, radiology tests, immunizations, and so forth) provided to the patient, also known as the **procedure code**.

As for the patient that was seen for the diagnosis of upper respiratory infection, in order to submit a claim to be paid by the patient's insurance carrier, such as Medicaid through NCTracks, the physician will submit a CPT code to describe the level of the evaluation and management that was performed on the patient.

For example, assume the physician selected the E/M CPT code of 99212 (meaning the patient is an established patient and the physician billed a lower level office visit) to describe the time, intensity, and complexity of the examination performed on the patient. The diagnosis code (ICD-9 code) 465.9 will be attached to the CPT code 99212 on the claim to tell the insurance carrier the reason for the patient's visit today at the physician office.

Remember that the physician must attach ICD-9 diagnosis code(s) – the reason for the visit – along with the CPT procedure code being submitted on the claim.

When ICD-10 codes become effective on October 1, instead of using an ICD-9 diagnosis code(s) on the claim, providers will start using ICD-10 diagnosis codes in their place. Everything else will remain the same.

For example, if the provider in the previous example saw the patient before Oct. 1, 2015, he would have submitted a claim with ICD-9 diagnosis code 465.9. If he saw the patient on Oct. 1 or after, he would have submitted the claim with ICD-10 diagnosis code J069.

Additional Resources

For additional information about the various code sets and ICD-10, providers can consult these resources from the Medical Group Managers Association (MGMA) and the AMA:

- [MGMA ICD-10 Implementation Guide](#)
- [AMA CPT Web Page](#)
- [CMS Guidebook: ICD-9-CM, ICD-10-CM, ICD-10-PCS, CPT, and HCPCS Code Sets](#) (4 pages)

Later this summer, NCTracks will offer training on how to submit ICD-10 codes, how they are used in the system, and the changes made to portal screens, reports, etc., but it will not cover basic coding.

For more coding education or training, check with your professional organizations and advocacy groups. Some community colleges are also offering courses on ICD-10 coding.

Thanks to Lee Ford, co-chair of the North Carolina Healthcare Information & Communications Alliance (NCHICA) ICD-10 Task Force, Tammy Norville, DHHS Office of Rural Health and Community Care, and Dr. Nancy Henley, Chief Medical Officer of DMA, for their insight and contributions to this article.

Multi-Payer Provider Expo August 6

A Multi-Payer Provider Expo will be held Thursday, August 6, at the Doubletree Asheville - Biltmore, 115 Hendersonville Rd., Asheville, from 8:00 a.m. to 1:00 p.m. The event is co-sponsored by BlueCross BlueShield of NC, Humana, Medcost, United Healthcare, and the NC Department of Health and Human Services. The Expo is for Physicians, Practice Managers, and Staff, and will include guest speakers and an opportunity to talk with healthcare payers about ICD-10 and the Affordable Care Act.

For more information and to register, see the [Expo registration form](#).

Q&As From the ICD-10 Inbox

The following questions from providers were received in the ICD-10 email Inbox:

Q: What is the soonest you will accept a claim with an ICD-10 code on it?

A: The federal government has mandated that October 1 is the earliest we can accept a claim with ICD-10 codes.

Q: If a date of service is prior to October 1, but the claim is not submitted until after October 1, which ICD codes should be used?

A: The codes to use will be based on date of service, not when the claim is submitted. Therefore, if the date of service occurred before October 1, but the claim is submitted after October 1, ICD-9 codes would be used.

Q: Can claims with ICD-9 codes and claims with ICD-10 codes be submitted in the same batch?

A: Yes. Claims for dates of service prior to October 1 (using ICD-9 codes) and claims for dates of service on or after October 1 (using ICD-10 codes) can be submitted in the same batch. However, ICD-9 codes and ICD-10 codes cannot be used on the same claim.

Q: Will we be given a list of common codes for our specific discipline? I am a speech-language pathologist and use a limited number of codes. A master list which shows the ICD-9 codes converted to the new ICD-10 codes would be helpful. Will there be a resource for this?

A: ICD-9 codes can be entered on the [NCTracks ICD-10 Crosswalk](#) to find the corresponding ICD-10 codes.

Q: This crosswalk does not locate any of my codes. I tried searching common codes such as 401.9, 250.02, 250.00, 789.00.

A: Those codes are on the crosswalk, but the decimal point should be removed. For example, enter ICD-9 code 707.10 as 70710.

Q: I work in an adult care home and used the crosswalk to find all of my diagnosis codes, but many have several ICD-10 codes that relate to the one ICD-9. For dates of service after October 1, do I just list all of the new ICD-10 codes?

A: No, providers will have to select the single correct ICD-10 code or codes that best describes the patient's diagnosis. Some claims have more than one diagnosis code, as they currently do.

Q: Since we only provide one type of service (personal care), we only have one procedure code (99509). The crosswalk is not showing a match for this code. Could you provide the ICD-10 for 99509?

A: 99509 is a CPT code, not an ICD-9 code. CPT codes are **not** changing as part of this ICD-10 implementation. The crosswalk is only for ICD-9 codes.

Q: From what I am gathering in all the information that you are sending out, these are only medical codes, correct? No dental codes involved.

A: Correct. Most dental practices use ADA codes, not ICD codes. More information is available in the NCTracks Provider Announcement titled [Dental Practices and ICD-10](#).

Q: Will there be an ICD-10 training held in Raleigh, N.C.?

A: No but there will be a virtual class. Using ICD-10 codes on NCTracks requires only a 30-minute webinar course. Training will be available closer to October 1, and can be accessed from home or office.

Q: After reading the emails and reviewing the resource sites for the switch to ICD-10 over the last several months, it seems like the codes being changed are the only real changes that need to be done to be able to file for services after October 1. Is this correct? It just seems a little too simple for the all build-up.

A: We salute you for being on top of the issue. The primary concern is to ensure that all aspects of the claim submission process – from business forms to practice management software to trading partners/billing agents – are ready to use ICD-10 codes, and to know which codes to use. For help with the latter, see the [NCTracks ICD-10 Crosswalk](#).

More Information about NCTracks and ICD-10

More information is available regarding NCTracks and ICD-10. Find ICD-10 codes on the [NCTracks ICD-10 Crosswalk](#). Questions about the transition to ICD-10 codes in NCTracks can be sent to NCTracks-Questioner@dhhs.nc.gov. Frequently asked questions will be posted on the portal.

CSC, 1-800-688-6696

Attention: All Providers**NCTracks Updates****Update on Pregnancy Medical Homes**

The N.C. Division of Medical Assistance (DMA), working in partnership with Community Care of North Carolina (CCNC) and other community stakeholders including providers, local health departments, and the Division of Public Health, created a program that provides pregnant N.C. Medicaid recipients with a Pregnancy Medical Home (PMH). The goals of the program are to improve the quality of prenatal care given to N.C. Medicaid recipients and improve birth outcomes.

To date, NCTracks has identified claims from PMH providers by use of the “AF” modifier. Using the “AF” modifier, the NCTracks system supports all three types of PMH claims that receive higher reimbursement, including the pregnancy risk screening, delivery, and postpartum plan.

As of May 3, 2015, the “AF” modifier is longer required for PMH providers to be reimbursed in NCTracks. NCTracks will now recognize which billing and rendering providers are PMH participants, making the “AF” modifier unnecessary.

To be identified in NCTracks as a PMH participant, the provider must have a current contract in place with the local CCNC network. Contracts can be established or updated by submitting a PMH Change Form, which can be obtained from the local CCNC obstetrics team. CCNC sends updates regarding PMH participation to DMA, which in turn updates the NCTracks system. Both billing and rendering providers must be identified as PMH participants in order for PMH incentives to be paid.

There is a 90 day transition period for this change, during which time the “AF” modifier may still be used. The “AF” modifier will be discontinued on July 31, 2015, after which a provider must have the designation of PMH participant in NCTracks in order to receive the incentive payments or enhanced reimbursement rate. For more information reimbursement, visit the DMA [Pregnancy Medical Home](#) web page.

New Claims Editing for Validation for Out of State Unique Product Providers

Certain out-of-state Durable Medical Equipment (DME), Orthotics and Prosthetics (O&P), and auditory implant parts providers are enrolled in NCTracks to provide unique products that are not available from in-state providers. The products (and associated HCPCS codes) that each out-of-state provider is authorized to provide are determined at the time of enrollment.

Effective May 3, 2015, NCTracks claims editing validates the requesting and billing providers’ enrollment and authorization to bill and be paid for specific procedure codes.

Claims submitted for these procedure codes by an unauthorized provider are denied at the detail level with explanation of benefits (EOB) 00426 – PROCEDURE CODE INVALID FOR BILLING PROVIDER. Additionally, if an authorized out-of-state provider bills a procedure code not identified at enrollment, the claim detail will deny with EOB 01732 – BILLING PROVIDER NOT ALLOWED TO SUBMIT CLAIMS FOR THIS PROCEDURE CODE.

This additional claims editing will ensure services are provided in accordance with existing DMA clinical coverage policies for DME, O&P, and auditory implant external parts providers.

The following policies outlining the unique products provided by the above referenced out-of-state providers can be found on the DMA [Clinical Coverage Policy web page](#):

- 5A, Durable Medical Equipment
- 5B, Orthotics and Prosthetics
- 13A, Cochlear and Auditory Implant External Parts Replacement and Repair
- 13B, Soft Band and Implantable Bone Conduction Hearing Aid External Parts and Repair

Reminder - CSC Regional Provider Relations Representatives

CSC has Regional Provider Relations Representatives, serving all regions of North Carolina. The representatives can assist providers with all aspects of the NCTracks system, including questions or issues about claims, prior approval and enrollment. In some cases, the representative may be able to resolve issues over the phone, or schedule a convenient time to visit a provider's office. There is no cost associated with this service.

Provider site visits can be requested online using the NCTracks Provider Portal. To request a site visit, click on the **Contact Us** link, found at the bottom of every NCTracks web page, complete the form, select the Subject "Request a Site Visit" from the drop down box, and click on the "Send" button. A Provider Relations Representative will be in contact to schedule a site visit.

Claim Edit for N.C. Health Choice (NCHC) Recipients With Third Party Coverage

Services are **not** covered for beneficiaries enrolled in the State Children's Health Insurance Program (SCHIP), also known as N.C. Health Choice (NCHC), who also have comprehensive major medical coverage through a third-party insurance carrier. As of May 3, 2015, claims submitted to NCTracks for Health Choice recipients who have comprehensive major medical insurance through a third-party carrier are denied with EOB 01813 - CLAIM DENIED. RECIPIENT'S ELIGIBILITY AND/OR CLAIM INDICATE RECIPIENT IS SUBJECT TO OTHER HEALTH CARE COVERAGE.

This is a new requirement for NCTracks, but is not a new state policy. Claims previously paid since July 1, 2013, will be reprocessed. No date has been set for the claim reprocessing. Additional information will be forthcoming.

If there is evidence the recipient beneficiary does not have comprehensive major medical coverage through a third-party insurance carrier, the provider can report changes to "other insurance" for a recipient by completing a form titled the *Online Submission for Health Insurance Information Referrals*, which is located on the DMA [Third Party Insurance web page](#) under the heading "Third Party Insurance Forms." The form is processed by HMS, which will verify the third party liability (TPL) information and the recipient's record will be updated, if appropriate.

For more information about NCHC, visit DMA's [NCHC web page](#).

NCCI Outpatient and Physician Edits Now Applied to Initial Claims

On June 7, 2015, NCTracks activated two National Correct Coding Initiative (NCCI) edits that apply to initial Outpatient and Professional claims that were submitted as electronic X12 837 transactions. Claims that fail the edits have EOBs 49270 - NCCI PHYSICIAN EDIT or 49280 - NCCI OUTPATIENT HOSPITAL SERVICES EDIT posted to their NCTracks paper Remittance Advice (RA).

The same edits are already in place and therefore have already been applied in the ordinary course for adjustment/replacement claims and claims submitted through the NCTracks Provider Portal, but were not applied to initial claims submitted as electronic X12 837 transactions. Therefore, applicable electronic X12 837 claims paid since July 1, 2013, will be reprocessed to apply these edits and adjust the claim accordingly. No date has been set for the claim reprocessing. Additional information will be forthcoming.

NOTE: Because these two NCCI edits were already in place for adjustment/replacement claims, some of the physician claims adjusted to apply the 3 percent rate reduction have already failed these edits, resulting in a recoupment of funds. Therefore, if a claim has failed the NCCI edits in connection with the 3 percent rate reduction adjustment, such claims will be excluded from any future claim reprocessing done specifically to apply the NCCI edits mentioned above.

New Job Aids for A+KIDS and ASAP

The Antipsychotic Safety Monitoring in Children through Age 17 (A+KIDS) and Adult Safety with Antipsychotic Prescribing (ASAP) programs were re-instated June 5, 2015. (See the [May 13 announcement](#) on the NCTracks Provider Portal.)

New A+KIDS and ASAP job aids for pharmacists and prescribers are available in Skillport, the NCTracks Learning Management System. The job aids provide instruction on accessing the online A+KIDS and ASAP drug type forms via the NCTracks secure

provider portal, as well as changes in the N.C. Medicaid and NCHC Prior Approval (PA) Criteria. (The A+KIDS and ASAP paper fax forms have been discontinued.) The job aids can be viewed online, printed, or downloaded to a computer.

To access the new job aids, logon to the secure NCTracks Provider Portal and click “Provider Training” to access Skillport. Open the folder labeled “User Guides” (reference library). Job aids can be found in the sub-folder labeled “Reference Documents”. Refer to the [Provider Training page](#) of the public Provider Portal for specific instructions on how to use SkillPort. The Provider Training page also includes a quick reference regarding how to download Java, which is required for the use of SkillPort.

Provider questions should be directed to the NCTracks Pharmacy PA Unit at 1-866-246-8505.

CSC, 1-800-688-6696

Attention: All Providers

Clinical Coverage Policies

The following new or amended combined N.C. Medicaid and N.C. Health Choice (NCHC) clinical coverage policies are available on the Division of Medical Assistance (DMA) [Clinical Coverage Policy web page](#).

- 1A-40, *Fecal Microbiota Transplantation* (6/1/15)
- 3L, *State Plan Personal Care Services (PCS)* (6/10/15)
- 10B, *Independent Practitioners (IP)* (7/1/15)
- 10C, *Local Education Agencies (LEAs)* (7/1/15)

These policies supersede previously published policies and procedures.

The following policy is open for public comment from June 30 through August 14, 2015. To submit a comment, visit the DMA [Proposed Medicaid and NCHC Clinical Coverage Policy web page](#).

- 10D, *Respiratory Therapy Services Independent Practitioner Providers*

Clinical Policy and Programs

DMA, 919-855-4260

Attention: All Providers**MedSolutions to Host Webinars for High-Tech Imaging**

Beginning July 13, 2015, MedSolutions will host a series of webinars for referring and rendering providers of high-tech imaging and ultrasounds.

The webinars provide information about claims payments for:

1. N.C. Medicaid providers who “refer or order” high-tech imaging and ultrasound services
2. N.C. Medicaid providers who “render” high-tech imaging and diagnostic ultrasound services

On July 10, 2015, details for these webinars will appear in a Frequently Asked Questions (FAQ) document on the [NCTracks Public Provider Portal](#).

MedSolutions will be emailing FAQ document to all N.C. Medicaid providers who are users of MedSolutions’ Online Services Portal at <https://myportal.medsolutions.com> (formerly <https://www.medsolutionsonline.com/>).

N.C. Medicaid high-tech imaging and ultrasound may request an on-site visit by MedSolutions’ representatives by following instructions in the FAQ document.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: Community Care of North Carolina/Carolina ACCESS (CCNC/CA) Providers

Additional Reminders on CCNC/CA Referral Authorizations and Overrides

To expedite claims processing, Community Care of North Carolina/Carolina ACCESS (CCNC/CA) providers must remember the following rules when requesting referral authorizations and overrides.

- CCNC/CA referral authorization is not the same as prior approval (PA). Some services require **both** PA and CCNC/CA referral authorization. CCNC/CA referral authorizations do not replace PAs required by [N.C. Division of Medical Assistance \(DMA\) clinical policies](#).
- A CCNC/CA referral authorization must be considered for medically necessary or urgent services, even when a member has failed to establish a medical record with the primary care provider (PCP) of record.
- When services are rendered to a CCNC/CA beneficiary without first obtaining authorization from the CCNC/CA PCP, and the PCP refuses to authorize retroactively, medical providers may request an override. CCNC/CA overrides are recorded in NCTracks. When a CCNC/CA override is granted, the claim must be submitted with the CCNC/CA referral field left blank in order to process correctly.
- In situations where beneficiaries have been assigned to the wrong PCP, refer the beneficiaries to their [local Departments of Social Services \(DSS\)](#) to correct the PCP assignment.
- For more information about CCNC/CA, visit DMA's [CCNC/CA web page](#) or contact a [regional consultant](#).

**CCNC/CA Managed Care Section
DMA, 919-855-4780**

Attention: Dental Providers and Health Department Dental Centers

Providers Must Be Enrolled to Participate in N.C. Medicaid and N.C. Health Choice

In accordance with federal and state rules, regulations, and policies, all providers must be enrolled in N.C. Medicaid and N.C. Health Choice (NCHC) to participate in those programs. This includes providers working in a group practice, local health department, federally qualified health center, or rural health center.

Only dental providers enrolled in N.C. Medicaid or NCHC can submit claims for reimbursement. Dental providers must not use another provider's National Provider Identifier (NPI) to bill for dental services. The claim must accurately reflect the NPI of the rendering dentist. No substitutions are allowed.

NCTracks On-line Application

Providers who are not enrolled and want to provide care to N.C. Medicaid or NCHC beneficiaries must complete the *Provider Enrollment Online Application*, which is available through the "[Getting Started](#)" page of the NCTracks provider portal. To login, a provider must have a North Carolina Identity Management (NCID) code. Information on registering or updating an NCID can be found on the "[NCTracks Tool Kit - NCID](#)" page of the NCTracks portal.

Licensure

Before beginning the application process, providers should confirm that they meet all program requirements and qualifications. Dental providers must be licensed by the N.C. State Board of Dental Examiners.

Out-of-State and Border Providers

The N.C. Medicaid program requires that out-of-state providers and border providers (providers who conduct business within 40 miles of the North Carolina border) be enrolled and active in their home state's Medicaid program.

Provider On-line Training

N.C. Senate Bill 496 108C-9.c states that an applicant's representative must attend training prior to the applicant being initially enrolled in the N.C. Medicaid or NCHC program. The training is subject to change every six months due to biannual updates to the [Provider Claims and Billing Assistance Guide](#).

Assistance Needed

For assistance with completing the *Provider Enrollment Online Application*, reference the following NCTracks enrollment guides, located on the NCTracks “[Provider User Guides and Training Page](#).”

- *How to Complete the Re-credentialing Re-verification Process in NCTracks*
- *How to Enroll in North Carolina Medicaid as an Individual Practitioner*
- *How to Enroll in North Carolina Medicaid as an Organization*

For additional assistance, contact the CSC Call Center at 800-688-6696 (phone), 919-851-4014 (fax), or NCTracksprovider@nctracks.com (email).

**Dental Program,
DMA, 919-855-4280**

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. To submit a comment related to a policy, refer to the instructions on [DMA's Proposed Clinical Coverage Policies web page](#). Providers without Internet access can submit written comments to:

Richard K. Davis
 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 substantively revised as a result of the initial comment period. If the adoption of a new or amended medical coverage policy is necessitated by an act of the General Assembly or a change in federal law, then the 45 and 15-day time periods shall instead be 30 and 10-day time periods.

2015 Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
July	7/02/15	7/07/15	7/08/15
	7/09/15	7/14/15	7/15/15
	7/16/15	7/21/15	7/22/15
	7/23/15	7/28/15	7/29/15
	7/30/15	8/04/15	8/05/15
August	8/06/15	8/11/15	8/12/15
	8/13/15	8/18/15	8/19/15
	8/20/15	8/25/15	8/26/15
	8/27/15	9/01/15	9/02/15

Sandra Terrell, MS, RN
 Director of Clinical
 Division of Medical Assistance
 Department of Health and Human Services

Paul Guthery
 Executive Account Director
 CSC