



North Carolina Medicaid Bulletin

Visit DMA on the Web at: <http://www.dhhs.state.nc.us/dma>

All Providers:

Clinical Coverage Policies 2
 Coverage of Orthotic and Prosthetic Devices 2
 Medicaid Family Planning Waiver Training Schedule 4
 Directions to the Family Waiver Seminar 5
 Registration for the Family Waiver Seminar 7
 Meningococcal Conjugate Vaccine Billing Guidelines 8
 NCLeads Update 9

All Child Services Coordination Providers:

Intermediate Assessment Process 9

Area Mental Health Centers:

Billing Update and Population Groups for CAP-MR/DD
 Services 11

CAP – MR/DD Case Managers and Service Providers:

Billing Update and Population Groups for CAP-MR/DD
 Services 11

Dialysis Facilities:

Epogen for End-Stage Renal Disease- Changes to Billing
 Guidelines 13

Direct Enrolled DD/MR Targeted Case Management

Providers:

Clarification to July 2005 Special Bulletin IV for
 Targeted Case Management for MR/DD 3

Durable Medical Equipment Providers:

Limitations on Medicaid Services Provided to Hospice
 Recipients-Clarification of Policy 16

Enhanced Mental Health Services:

Enhanced Mental Health Services Seminar Schedule 17
 Directions and Registration to the Seminar 18

General Hospitals:

Revenue Codes Correction 19
 Revenue Codes for Piedmont Participants 20

Home Health Services:

Limitations on Medicaid Services Provided to Hospice
 Recipients-Clarification of Policy 16

Home Infusion Therapy (HIT) Providers:

Limitations on Medicaid Services Provided to Hospice
 Recipients-Clarification of Policy 16

Hospice Providers:

Limitations on Medicaid Services Provided to Hospice
 Recipients-Clarification of Policy 16

Hospital Discharge Planners:

Limitations on Medicaid Services Provided to Hospice
 Recipients-Clarification of Policy 16

Hospitals:

Preadmission Screening Annual Resident Review Seminars 21

Hospital Outpatient Departments:

Outpatient Behavioral Health Services 22

Independent Laboratories:

CLIA Certification Related Claim Denials 23

Local Management Entities:

Outpatient Behavioral Health Services 22

Mental Health Practitioners Who are Employed in

Physicians Offices/Clinics:

Outpatient Behavioral Health Services 22

Nursing Facility Providers:

Minimum Data Set Supportive Documentation Guidelines 24
 Preadmission Screening Annual Resident Review Seminars 21
 Restorative Nursing Defined for Case Mix 25

OB/GYN Providers:

OB/GYN Billing Seminars 26

Optical Providers:

Changes in Eye Examination and Visual Aid Frequency 10

Outpatient Hospitals:

Epogen for End-Stage Renal Disease – Changes to Billing
 Guidelines 13

Personal Care Services (PCS) Providers:

Limitations on Medicaid Services Provided to Hospice
 Recipients Clarification of Policy 16
 PCS Recoupments 26

Physicians:

CLIA Certification Related Claim Denials 23
 Epogen for End-Stage Renal Disease – Changes to Billing
 Guidelines 13

Private Duty Nursing (PDN) Providers:

Limitations on Medicaid Services Provided to Hospice
 Recipients- Clarification of Policy 16

Psychiatric Hospitals:

Revenue Codes – Correction 19
 Revenue Codes for Piedmont Participants 20

Providers are responsible for informing their billing agency of information in this bulletin.
 CPT codes, descriptors, and other data only are copyright 2004
 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.

Attention: All Providers

Clinical Coverage Policies

The following new or amended clinical coverage policies are now available on the Division of Medical Assistance's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm>:

- 1A1 – Compression Garments**
- 5A – Durable Medical Equipment**
- 5B – Orthotics and Prosthetics**
- 8J - Children's Developmental Service Agency**
- 10C – Local Education Agencies**

These policies supersede previously published policies and procedures. Providers may contact EDS at 1-800-688-6696 or 919-851-8888 with billing questions.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

Coverage of Orthotic and Prosthetic Devices

Effective with date of service August 1, 2005, Medicaid will begin coverage of orthotic and prosthetic devices to include recipient's age birth through 115 years. Prior to date of service August 1, 2005, coverage was limited to recipients ages birth through 20 years. Providers must follow clinical policy guidelines for these devices located on DMA's website at:

<http://www.dhhs.state.nc.us/dma/mp/mpindex.htm>.

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

Attention: Direct Enrolled DD/MR Targeted Case Management Providers
Clarification to July 2005 Special Bulletin IV for Targeted Case Management for MR/DD

Effective with the implementation of DD/MR Targeted Case Management, employees of provider agencies who have a baccalaureate degree in other than a human service field and have a minimum of 5 years documented targeted case management experience with this population will be “grandfathered” to allow them to continue to provide MR/DD case management services. This “grandfathering” will be permitted for employees of any MR/DD Targeted Case Management agency that directly enrolls to provide the service by 12/31/05. The endorsement process for these agencies has been accelerated and should be completed no later than 12/31/05. For the period 9/1/05 forward until a case management agency has been endorsed, the agency may bill Targeted Case Management through the LME. Upon endorsement, the agency must directly enroll, and will no longer be able to bill through the LME. By 12/31/05, all agencies must be direct enrolled. LMEs who wish to provide TCM must also enroll as a case management agency with a new type and specialty. The billing code for this service is T1017 HI.

If you have questions, please call the Behavioral Health Section at 919-855-4290.

Behavioral Health Section
DMA, 919-855-4290

Attention: All Providers

Medicaid Family Planning Waiver Training Schedule

On October 1, 2005, the N.C. Medicaid program will implement the new Family Planning Waiver program. The program is designed to reduce unintended pregnancies and to improve the well being of children and families in North Carolina by providing family planning services to eligible men and women.

Training on the Waiver program is scheduled for September 2005 and will focus on recipient eligibility, covered services, and billing for family planning services covered through the Waiver program.

Preregistration for the training is required. Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend if space is available. Lunch will not be provided at the training.

Providers may register for the training by completing and submitting the registration form or by registering online at <http://www.dhhs.state.nc.us/dma/provsem.htm>.

Providers may choose to attend either the morning session or the afternoon session. The morning session begins at 9:00 a.m. and ends at 12:00 p.m. The afternoon session begins at 1:30 p.m. and ends at 4:30 p.m. Please arrive 30 minutes prior to the beginning of the training to complete registration. Providers may also choose either a land or teleconference site. Please indicate on the registration form the session you plan to attend.

Providers must print the PDF version of the August 2005 Special Bulletin xxx, *Medicaid Family Planning Waiver Program* from DMA’s website at <http://www.dhhs.state.nc.us/dma/bulletin.htm> and bring it to the training.

Land Locations

<p>Thursday, September 1, 2005 McKimmon Center 1101 Gorman S. Raleigh, NC</p>	<p>Wednesday, September 7, 2005 Bo Thomas Auditorium Blue Ridge Community College Flat Rock, NC</p>
<p>Thursday, September 8, 2005 Holiday Inn Conference Center 530 Jake Alexander Blvd.S. Salisbury, NC</p>	<p>Thursday, September 22, 2005 Greenville Hilton 207 SW Greenville Blvd. Greenville, NC</p>

Teleconference Locations

The teleconference is accessible from each of the sites listed below on **Wednesday, September 21, 2005** and **Wednesday, September 28, 2005**.

<p>Albemarle Regional Health Services 711 Roanoke Avenue Elizabeth City, NC</p>	<p>Cooper Building 225 North McDowell Ground Floor Raleigh, NC</p>	<p>Jackson County Health Department Community Services Building 538 Scotts Creek Road, Suite 100 Sylva, NC</p>
<p>Catawba County Health Department 3070 11th Avenue Drive, SE Hickory, NC</p>	<p>Cumberland County Health Department E. Newton Smith Public Health Center 227 Fountainhead Lane Fayetteville, NC</p>	<p>Wilson County Health Department 1801 Glendale Drive Wilson, NC</p>

Directions to the Medicaid Family Planning Waiver Land Training

Jane S. McKimmon Center – Raleigh

Traveling East on I-40

Take exit 295 and turn left onto Gorman Street. Travel approximately one mile. The McKimmon Center is located on the right at the corner of Gorman Street and Western Boulevard.

Traveling West on I-40

Take exit 295 and turn right onto Gorman Street. Travel approximately one mile. The McKimmon Center is located on the right before you reach Western Boulevard.

Blue Ridge Community College, Bo Thomas Auditorium – Flat Rock, North Carolina

Take I-40 to Asheville. Travel east on I-26 to exit 22. Turn right and then take the next right. Follow the signs to Blue Ridge Community College. Turn left at the large Blue Ridge Community College sign. The college is located on the right. Take the first right-hand turn into the parking lot for the Bo Thomas Auditorium.

Holiday Inn Conference Center – Salisbury, North Carolina

Traveling South on I-85

Take exit 75. Turn right onto Jake Alexander Boulevard. Travel approximately ½ mile. The Holiday Inn is located on the right.

Traveling North on I-85

Take exit 75. Turn left on Jake Alexander Boulevard. Travel approximately ½ mile. The Holiday Inn is located on the right.

Hilton Hotel - Greenville, North Carolina

Take Highway 264 east to Greenville. Turn right onto Allen Road in Greenville. Travel approximately 2 miles. Allen Road becomes Greenville Boulevard/Alternate 264. Follow Greenville Boulevard for 2 ½ miles to the Hilton Greenville, which is located on the right.

Directions to the Medicaid Family Planning Waiver Teleconference Training

(Maps and directions can also be accessed online at <http://www.sph.unc.edu/phtin/locations/index.cfm>.)

Albemarle Regional Health Services – Elizabeth City

Take US 17 north to Elizabeth City. Take US 17 Business (Ehringhaus Street) to Halstead Boulevard (beside Burger King). Turn right on Halstead Boulevard and travel approximately $\frac{3}{4}$ miles to Roanoke Avenue. Turn left onto Roanoke Avenue and travel approximately $\frac{1}{2}$ mile. The Albemarle Regional Health Services building is located on the right.

Catawba County Health Department – Hickory

Take I-40 to Hickory. Take Exit 128 onto Fairgrove Church Street. Travel approximately $\frac{3}{4}$ miles to the second stoplight. Turn left onto Eleventh Avenue Drive. The Catawba County Health Department is located on the right just past the Catawba Memorial Hospital. Parking is available in the first parking lot in front of the building. Teleconference room 117 is located at the end of the first hallway on the right.

Cooper Building – Raleigh

Traveling East on I-40

Take I-40 into Raleigh. After the Harrison Boulevard exit, get into the right-hand lane and follow the signs for Wade Avenue. Follow Wade Avenue until it ends at Capital Boulevard. Exit to the right onto Capital Boulevard. Capital Boulevard becomes Dawson Street. Stay in the left lane and continue around the curve to the second stoplight. Turn left onto Jones Street. Travel one block and then turn left onto McDowell Street. The visitor's parking lot is located on the right just past the intersection of McDowell Street and Lane Street. The Cooper Building is located on the corner of McDowell Street and Lane Street adjacent to the parking deck.

Traveling West on I-40

Take I-440 Beltline to exit 289, Wade Avenue. Turn right at the bottom of the exit ramp. Follow Wade Avenue until it ends at Capital Boulevard. Exit to the right onto Capital Boulevard. Capital Boulevard becomes Dawson Street. Stay in the left lane and continue around the curve to the second stoplight. Turn left onto Jones Street. Travel one block and then turn left onto McDowell Street. The visitor's parking lot is located on the right just past the intersection of McDowell Street and Lane Street. The Cooper Building is located on the corner of McDowell Street and Lane Street adjacent to the parking deck.

E. Newton Smith Public Health Center, Cumberland County Health Department – Fayetteville

Traveling South on I-95

Take I-95 south to Fayetteville. Near Fayetteville, bear right onto I-95 Business/US 301 Business. Travel on I-95 Business/US 301 Business to E. Russell Street (third stoplight). Turn right onto E. Russell Street and follow it to the end. Turn left onto McIver Street. Bear right onto McGilvary Street. Turn right at the first street to the right onto Fountainhead Lane. The Public Health Center is the four-story, tan building on the right.

Traveling North on I-95

Take I-95 north to I-95 Business/US 301 Business. Turn left onto Gillespie Street. Turn left onto W. Russell Street and follow it to the end. Turn left onto McIver Street. Bear right onto McGilvary Street. Turn right at the first street to the right onto Fountainhead Lane. The Public Health Center is the four-story, tan building on the right.

Community Services Building, Jackson County Health Department – Sylva

From Asheville, take I-40 west to Waynesville. From Waynesville, take US 19/US 23 South/US 74 West to Sylva. Take exit 78. Travel approximately 3 miles to Harris Regional Hospital and turn right. Travel approximately 1/2 miles to the Community Services Building on the right. The teleconference center is located in the brown colonial-style modular unit beside the main building.

Wilson County Health Department – Wilson

Take US 264 east to Wilson. After crossing I-95, turn at the third stoplight onto Forest Hill Road. Turn left at the second stoplight onto Tarboro Street. Turn right at the first stoplight onto Glendale Drive. The Wilson County Health Department is located immediately after the next stoplight. Turn into the second drive after the stoplight. Enter the building through the doors under the blue awning. The teleconference room is located on the right.

Registration Form for the Medicaid Family Planning Waiver Training

(cut and return registration form only)

**Medicaid Family Planning Waiver
Training Registration
(No Fee)**

Provider Name _____ Provider Number _____

Address _____

City, Zip Code _____ County _____

Contact Person _____ E-mail Address _____

Telephone Number (____) _____ Fax Number (____) _____

1 or 2 (circle one) person(s) will attend the training at _____ on _____
(location) (date)

Check the box to indicate the training session(s) you will be attending:

Morning Session

Afternoon Session

Deadline for Registration is August 18, 2005.

If the afternoon session (1:30 a.m.-4:30 p.m.) has less than 25 providers, then you may be registered for the morning Session (9:00 a.m.-12:00 noon). Providers will be notified via phone if registration is changed.

Return to: Provider Services
EDS
P.O. Box 300009
Raleigh, NC 27622

Attention: All Providers

Meningococcal Conjugate Vaccine, MCV4 (Menactra, CPT code 90734 0.5 ml) Billing Guidelines

Effective March 1, 2005, N.C. Medicaid program covers Menactra (MCV4), the new FDA approved meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetavalent), for intramuscular use, under the Physicians Drug Program according to the February 10, 2005 guidelines of the Advisory Committee on Immunization Practices (ACIP) and the Centers for Disease Control and Prevention (CDC).

Two meningococcal vaccines are available in the U.S.:

- **Meningococcal polysaccharide vaccine (MPSV4, Menomune)** has been available since the 1970s, and is billed with CPT code 90733.
- **Meningococcal conjugate vaccine (MCV4, Menactra)** was licensed in 2005, and is billed with CPT code 90734.

Both vaccines can be given for the prevention of four types of meningococcal disease, including two of three types most common in the United States and a type that causes epidemics in Africa. Meningococcal vaccines cannot prevent all types of disease, but they do protect many people who might become sick if they had not received the vaccine.

Menactra is recommended for:

- All children at their routine pre-adolescent visit (11 through 12 years of age).
- Adolescents before high school entry (approximately 15 years of age) if not received previously.
- College freshmen living in dormitories.
- Anyone who has a damaged spleen, or whose spleen has been removed.
- Anyone who has terminal complement component deficiency (an immune system disorder).
- People who might have been exposed to meningitis during an outbreak.

MCV4 (Menactra) is the preferred vaccine for people 11 through 55 years of age in these risk groups, but MPSV4 can be used if MCV4 is unavailable. MPSV4 should be used for children 2 through 10 years old and adults over 55 who are at risk.

To review the complete Menactra recommendations of the Advisory Committee on Immunization Practices (ACIP), go to <http://www.cdc.gov/mmwr/PDF/rr/rr5407.pdf>.

Billing Guidelines

- The procedure code for billing Menactra is CPT code 90734.
- Diagnosis code V01.84 must be used when billing for Menactra, if applicable. Providers should refer to the April 2005 Special Bulletin III, Health Check Billing Guide 2005, for additional information on billing Medicaid for vaccines.
- The maximum reimbursement rate for purchased Menactra per unit (0.5 ml) is \$88.56. Providers must bill their usual and customary charge. Add this vaccine to the list published in the November 2004 general Medicaid bulletin.

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

Attention: All Providers

NCLeads Update

Information related to the implementation of the new Medicaid Management Information System, *NCLeads*, scheduled for implementation in mid-2006 can be found online at <http://ncleads.dhhs.state.nc.us>. Please refer to this website for information, updates, and contact information related to the *NCLeads* system.

Thomas Liverman, Provider Relations
Office of MMIS Services,
919-647-8315

Attention: All Child Services Coordination Providers

Intermediate Assessment Process

Effective August 1, 2005, Child Service Coordination Providers (CSCs) are no longer required to provide an Intermediate Assessment at 15 to 18 months and at 30 to 36 months. CSC providers must ensure that parents or legal guardians are aware of the importance all age appropriate EPSDT developmental screenings and refer parents or guardians to physicians or clinics for these services for their children. Education and referral efforts must be documented in accordance with CSC policies.

Clinical Policy
DMA, 919-855-4320

Attention: All Optical Providers

Changes in Eye Examination and Visual Aid Frequency for Recipients 21 through 24 Years of Age

Effective with date of service September 1, 2005, Medicaid coverage for eye examinations and visual aids for recipients who are 21 through 24 years of age has been changed. Previously, Medicaid covered one eye examination and one set of visual aids once every year for this age group. According to the Center for Medicare and Medicaid Services, the Code of Federal Regulations requires that all services available to categorically needy individuals be equal in amount, duration, and scope within the group. Therefore, the following changes have been made to comply with federal guidelines.

Eye Examinations and Refractions

Routine eye examinations with a refraction, or a refraction only, are allowed once every two years for recipients 21 years of age and older.

Visual Aids

Visual aids are allowed once every two years for recipients 21 years of age and older. All visual aids continue to require prior approval.

Request for Exception

When justified by medical necessity, the provider may request prior approval for a second refraction or additional visual aids. Each request is reviewed on a case-by-case basis. Refer to the Optical Services Provider Manual on DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for detailed instructions regarding prior approval requests for exceptions.

Note: No changes have been made in coverage for Medicaid recipients that are under 21 years of age.

EDS 1-800-668-6696 or 1-919-851-8888

Attention: Area Mental Health Centers, and CAP-MR/DD Case Managers and Service Providers

Billing Update and Population Groups for CAP-MR/DD Services

The July 2003 general Medicaid bulletin listed the new national codes and descriptions for the CAP-MR/DD program. With the implementation of the new CAP-MR/DD 1915C waiver scheduled for implementation on September 1, 2005, several rate adjustments will be made, as well as the addition of new local code descriptions. Please note that the memo descriptions for this waiver may not be exactly the same as the HIPAA compliance variables and that we have cross walked this information for your convenience. These changes will be effective on September 1, 2005.

Procedure Code	Rate Current	Production Description	HIPAA National Code Description	Memo Description	New Rate
S5102	\$36.51/Day	Day Care Services, Adult; per diem	Day Care Services, Adult; per diem	Adult Day Health	\$36.51/Day
T2028	*	Specialized Supply, not Otherwise Specified, Waiver	Specialized Supply, not Otherwise Specified, Waiver	Augmentative Communication Device - Purchase	*
V5336	*	Repair/Modification of Augmentative Communication System or Device	Repair/Modification of Augmentative Communicative System or Device (Excludes Adaptive Hearing Aid)	Augmentative Communication Device – Repair and Service	*
H2011	\$6.04/per 15 minutes	Crisis Intervention Service, per 15 minutes	Crisis Intervention Service, per 15 minutes	Crisis Services	\$6.04/per 15 minutes
T2021	\$5.57/per 15 minutes	Day Habilitation, Waiver; per 15 minutes	Day Habilitation, waiver; per 15 minutes	Day Supports Individual	\$5.94/per 15 minutes
T2021HQ	\$3.68/per 15 minutes	Day Habilitation, Waiver, per 15 minutes	Day Habilitation, waiver; per 15 minutes	Day Supports Group (2 or more clients)	\$3.31/per 15 minutes
S5125	\$3.60/per 15 minutes	Attendant Care Services; per 15 minutes	Attendant Care Services; per 15 minutes	Personal Care Services	\$3.60/per 15 minutes
T1999	*	Miscellaneous Therapeutic Items and Supplies, Retail Purchases, not otherwise classified	Miscellaneous Therapeutic Items and Supplies, Retail Purchases, not otherwise classified; identify product in remarks	Specialized Equipment and Supplies	*
S5161	\$29.67/Month	Emergency Response System; Service Fee, per Month (Excludes Installation and Testing)	Emergency Response System; Service Fee, per Month (Excludes Installation and Testing)	PERS (Personal Emergency Response System)	\$29.67/Month
H0045	\$222.96/Day	Respite Care Services, not in the home, per diem	Respite Care Services, not in the home, per diem	Respite Institutional	\$222.96/Day
S5150	\$3.60/per 15 minutes	Unskilled Respite Care, not Hospice; per 15 minutes	Unskilled Respite Care, not Hospice; per 15 minutes	Respite Non-Institutional – Individual	\$3.60/per 15 minutes
S5150HQ	\$2.78/per 15 minutes	Unskilled Respite Care; not Hospice, per 15 minutes, Groups	Unskilled Respite Care, not Hospice, per 15 minutes, Groups	Respite Non-Institutional – Group (2-3 clients)	\$2.78/per 15 minutes
T1005	New service	Respite Care Services, up to 15 Minutes	Respite Care Services, up to 15 Minutes	Enhanced Respite Care – Non Institutional	\$5.00/per 15 minutes
T1005TE		Respite Care Services – LPN, up to 15 minutes	Respite Care Services up to 15 minutes	Respite Nursing – LPN	\$9.11/per 15 minutes
T1005TD		Respite Care Services – RN, up to 15 minutes	Respite Care Services up to 15 minutes	Respite Nursing – RN	\$9.11/per 15 minutes
H2025	\$7.61/per 15 minutes	Ongoing Support to Maintain Employment, per 15 minutes	Ongoing Support to Maintain Employment, per 15 minutes	Supported Employment – Individual	\$7.61/per 15 minutes
H2025HQ	\$1.97/per 15 minutes	Ongoing Support to Maintain Employment; per 15 minutes; Group	Ongoing Support to Maintain Employment; per 15 minutes	Supported Employment – Group	\$1.97/per 15 minutes
T2025	\$18.75/per 15 minutes	Waiver Services; not Otherwise Specified (NOS)	Waiver Services; not Otherwise Specified (NOS)	Specialized Consultative Services	\$18.75/per 15 minutes
T2001	\$1,200.00/per waiver year	Non-Emergency Transportation; Patient Attendant/Escort	Non-Emergency Transportation; Patient Attendant/Escort	Transportation	\$1,200.00/per waiver year
S5165	\$2,500.00/per waiver year	Home Modifications; per service	Home Modifications; per service	Home Modifications	\$15,000.00 over 3 year waiver duration
S5110	\$9.00/per 15 minutes	Home Care Training, Family; per 15 minutes	Home Care Training, Family; per 15 minutes	Individual/caregiver Training and Education	\$9.00/per 15 minutes

Procedure Code	Rate Current	Production Description	HIPAA National Code Description	Memo Description	New Rate
H2016	\$84.00/daily	Comprehensive Community Support Services, per diem	Comprehensive Community Support Services, per diem	Residential Supports Level I	\$102.33/daily
T2014	\$113.40/daily	Habilitation Services, per diem	Habilitation Services, per diem	Residential Supports Level II	\$125.45/daily
T2020	\$141.75/daily	Day Habilitation, per diem	Day Habilitation, per diem	Residential Supports Level III	\$145.17/daily
H2016HI	\$157.50/daily	Comprehensive Community Support Services, per diem, Level 4	Comprehensive Community Support Services, per diem	Residential Supports Level IV	\$175.35/daily
H2015	\$5.57/per 15 minutes	Comprehensive Community Support Services, per 15 minutes	Comprehensive Community Support Services, per 15 minutes	Home and Community Supports – Individual	\$5.65/per 15 minutes
T1019	New Service	Personal care services, per 15 minutes	Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)	Enhanced Personal Care Services	\$5.00/per 15 minutes
T2039	\$15,000.00/per duration of waiver – 3 years	Vehicle Modifications, waiver; per service	Vehicle Modifications, waiver; per service	Vehicle Adaptations	\$15,000.00 per duration of waiver – 3 years
H2015HQ	\$3.68/per 15 minutes	Comprehensive Community Support Services, per 15 minutes	Comprehensive Community Support Services, per 15 minutes	Home and Community Supports – Group (2 or more clients)	\$3.15/per 15 minutes

Note: The asterisk (*) indicates as needed, variable cost.

Population Groups

DMA implemented population groups in 2001 to control and track specific benefit packages for designated groups of Medicaid recipients. For a provider, population groups mean two things:

1. The provider must be enrolled to provide services to members of the CAP-MR/DD population group for claims to be paid. Existing CAP providers were enrolled in the appropriate CAP population group(s) according to current enrollment information on file with DMA as of July 11, 2003. Providers wishing to provide the new Residential Supports services must enroll with DMA Provider Services. Provider Enrollment Packages may be found on the DMA Website under Provider Links or contact Provider Services at 919-855-4050.
2. The Remittance and Status Report (RA) provides information by population group. The population payer code is printed at the beginning of each claim detail line on the RA. The code denotes the special program/population group from which a recipient is receiving Medicaid benefits. The code for CAP-MR/DD is “CAPMR.” (The CAP-MR/DD indicator on the recipient’s Medicaid identification card will remain “CM.”) This information helps providers track receipts in their accounting systems by each CAP population group for which they are providing services.

**Billing Update and Population Groups for CAP-MR/DD Services
DMA, 919-855-4290**

Attention: Dialysis Facilities, Outpatient Hospitals and Physicians

Epogen for End-Stage Renal Disease- Change to Billing Guidelines

Effective with date of service September 1, 2005, the N.C. Medicaid program will cover Epogen (EPO) for recipients with end-stage renal disease (ESRD) who are on dialysis when billed with HCPCS code Q4055 rather than codes Q9920-Q9940. HCPCS codes Q9920 – Q9940 will be end-dated effective with date of service August 31, 2005. Details billed with Q9920 – Q9940 after August 31, 2005 will be denied.

The description of HCPCS code Q4055 is epoetin alfa, 1000 units (for ESRD on dialysis). One Medicaid unit of Q4055 equals 1000 units of EPO.

Dialysis Facilities

For dates of service September 1, 2005, and after, the following billing guidelines must be followed or the claim will deny.

- ICD-9-CM diagnosis code 585, chronic renal failure, must be entered on the claim (UB-92) as the primary diagnosis,
along with one of the following additional diagnosis codes:
 - ◆ 285.8, Other specified anemia,
 - ◆ 285.9, Anemia, unspecified, and
 - ◆ 285.21, Anemia in end-stage renal disease.

- Bill one unit for each 1000 units of EPO administered.
- EPO must be billed with either RC 634 or RC 635 (placed in form locator 42).
- RC634 and RC635 must be billed with Q4055 (placed in form locator 43) for EPO.
- Bill RC634 if EPO administered is up to and including 10,000 units.
- Bill RC635 if EPO administered is over 10,000 units.
- Enter the service date in form locator 45.
- Enter the number of units administered in form locator 46.
- Enter the total charge in form locator 47.
- All EPO charges for the same date of service must be billed as one detail on the claim. If EPO charges are billed on two or more details on the claim for the same date of service, each of the details will deny.
- Value code 49 (for HCT) or 48 (for HGB) must be billed to represent the HCT or HGB blood level at the beginning of the billing period (the date of service on the claim). Place the number “49” and the HCT value in form locator 39a. Place the number “48” and the HGB value in form locator 40a.
- Value code 68 must be billed to represent the total amount of EPO given during the billing period. Place the number “68” and the value for the total amount of EPO given during the billing period in form locator 41a.
- Billing must be done on a calendar month basis. Do not bill for dates of service spanning more than one calendar month: Bill on two separate claims.

Dialysis Facilities (cont.)

Note: If there is more than one claim in one month, follow this example:

1. Claim #1 is for dates of service 1-1-2005 thru 1-15-2005 (billing period). EPO 20,000 units were given during this time period and are billed as a total of 20 units on various details of the claim. Value code 68 on the claim would have 20 units.
2. Claim #2 is for dates of service 1-16-2005 thru 1-31-2005 (billing period). EPO 15,000 units were administered during that time. The claim is billed with a total of 15 units of EPO on various details of the claim. Value code 68 for this claim would show 15 units.

Monthly EPO unit totals will be monitored and providers should maintain documentation to be used for calculation of a 90-day rolling average of the HCT and/or HGB. This documentation may be requested to review for medical necessity.

Outpatient Hospitals

For dates of service September 1, 2005, and after, the following billing guidelines must be followed or the claim will deny.

- Bill on the UB-92 claim form.
- ICD-9-CM diagnosis code 585, chronic renal failure, must be entered on the claim (UB-92) as the primary diagnosis,
along with one of the following additional diagnosis codes:
 - ◆ 285.8, Other specified anemia,
 - ◆ 285.9, Anemia, unspecified, and
 - ◆ 285.21, Anemia in end-stage renal disease.
- Bill one unit for each 1000 units of EPO administered.
- EPO must be billed with either RC 634 or RC 635 (placed in form locator 42).
- RC634 and RC 635 must be billed with Q4055 (placed in form locator 43) for EPO.
- Bill RC634 if EPO is up to and including 10,000 units.
- Bill RC635 if EPO is over 10,000 units.
- Enter the service date in form locator 45.
- Enter the number of units in form locator 46.
- Enter the service date in form locator 47.
- All EPO charges for the same date of service must be billed as one detail on the claim. If EPO charges are billed on two or more details on the claim for the same date of service, each of the details will deny.
- Value code 49 (for HCT) or 48 (for HGB) must be billed to represent the HCT or HGB blood level at the beginning of the billing period (the date of service on the claim). Place the number "49" and the HCT value in form locator 39a. Place the number "48" and the HGB value in form locator 40a.
- Value code 68 must be billed to represent the total amount of EPO given during the billing period. Place the number "68" and the value for the total amount of EPO given during the billing period in form locator 41a.
- Billing must be done on a calendar-month basis. Do not bill for dates of service spanning more than one calendar month: Bill on two separate claims.

Outpatient Hospitals (cont.)

Note: If there is more than one claim in one month, follow this example:

1. Claim #1 is for dates of service 1-1-2005 thru 1-15-2005 (billing period). EPO 20,000 units were given during this time period and are billed as a total of 20 units on various details of the claim. Value code 68 on the claim would have 20 units.

2. Claim #2 is for dates of service 1-16-2005 thru 1-31-2005 (billing period). EPO 15,000 units were administered during that time. The claim is billed with a total of 15 units of EPO on various details of the claim. Value code 68 for this claim would show 15 units.

Monthly EPO unit totals will be monitored and providers should maintain documentation to be used for calculation of a 90-day rolling average of the HCT and/or HGB. This documentation may be requested to review for medical necessity.

Physicians

The following billing guidelines must be followed for dates of service September 1, 2005 and after or the claim will deny.

- ICD-9-CM diagnosis code 585, chronic renal failure, must be entered on the claim (UB-92) as the primary diagnosis,
along with one of the following additional diagnosis codes:
 - ◆ 285.8, Other specified anemia,
 - ◆ 285.9, Anemia, unspecified, and
 - ◆ 285.21, Anemia in end-stage renal disease.
- Bill HCPCS code Q4055 for EPO; enter the number of units given in block 24-G on the CMS-1500 claim form.

Reminder: HCPCS code Q0136 must be billed for the administration of EPO for non-ESRD use.

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

Attention: Durable Medical Equipment (DME), Home Health Services, Home Infusion Therapy (HIT), Hospice, Hospital Discharge Planners, Personal Care Services (PCS), and Private Duty Nursing (PDN) Providers

Limitations on Medicaid Services Provided to Hospice Recipients- Clarification of Policy

Medicaid recipients choosing to receive hospice benefits must elect hospice before receiving the service. The recipient or the recipient's representative must confirm the choice of hospice election by signing an election statement or informed consent form. The recipient waives his/her right to Medicaid coverage of certain other Medicaid services that replicate the services covered under the hospice benefit. The clarification of this policy is as follows:

1. Medicaid coverage for home health, DME, and HIT services is not allowed for hospice recipients when the service pertains to the treatment of terminal illness or related conditions.
2. Medicaid coverage for PDN and PCS services is not available for recipients receiving hospice services. The recipient must choose the most appropriate service to fit his/her individual medical needs.

Hospice providers should be aware of all of the home care services being provided to a recipient electing the hospice benefit. The hospice agency should contact or notify the other service providers prior to accepting the recipient as a hospice patient. This policy is inclusive of Medicare covered hospice benefits for dually eligible recipients.

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

Attention: Enhanced Mental Health Services Providers

Enhanced Mental Health Services Seminar Schedule

Enhanced Benefit Mental Health Services seminars are scheduled for September 2005. Seminars are intended for provider agencies who meet the approval and endorsement criteria to bill for one or more of the Enhanced Benefit Mental Health Services on or after October 1, 2005. Topics to be discussed will include, but are not limited to, provider enrollment requirements, eligibility issues, billing instructions, and clinical coverage policies. Those who will be billing for these services to N.C. Medicaid are encouraged to attend.

The seminars are scheduled at the locations listed below. **Pre-registration is required.** It is recommended that the operations manager, clinical professional and a billing person from each “Community Intervention Agency” provider office attend these seminars. Due to limited seating, registration is limited to three staff members per office. Unregistered providers are welcome to attend if space is available.

Provider agencies may register for the Enhanced Benefit Mental Health Services seminars by completing and submitting the registration form available or by registering online at <http://www.dhhs.state.nc.us/dma/provsem.htm>. The seminars will begin at 9:00 am and will end at 4:45 pm with a break for lunch from 12:00 pm to 1:00 pm. Providers are encouraged to arrive by 8:45 a.m. to complete registration. Refreshments will not be provided during the seminar.

The September 2005 Special Bulletin VII Providers of Enhanced Benefit Mental Health/Substance Abuse Services will be used as the primary training document for the seminars. The special bulletin will be available on DMA’s website beginning September 1, 2005 at <http://www.dhhs.state.nc.us/dma/bulletin.htm>. Please print the special bulletin and bring it to the seminar.

<p>Monday, September 12, 2005 Blue Ridge Community College Bo Thomas Auditorium Flat Rock, NC</p>	<p>Tuesday, September 13, 2005 Holiday Inn Statesville 1215 Garner Bagnal Blvd. Statesville, NC</p>	<p>Wednesday, September 14, 2005 Nash Community College 522 North Old Carriage Road Rocky Mount, NC</p>
<p>Thursday, September 15, 2005 Robeson Community College Lewis Auditorium 5160 Fayetteville Rd. Lumberton, NC</p>	<p>Friday, September 16, 2005 Jane S. McKimmon Center 1101 Gorman Street Raleigh, NC</p>	

Community Intervention Agency Providers of the Enhanced Mental Health Benefit(s) Service who meet the endorsement and enrollment criteria and would like to provide the array of available services must direct enroll with the N.C. Medicaid program. You may access Medicaid enrollment information by going to DMA’s website at <http://www.dhhs.state.nc.us/dma/Forms/provenroll/cis.htm>. Enrollment applications can be found at this location.

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

Directions to the Enhanced Mental Health Services Seminars

Blue Ridge Community College, Bo Thomas auditorium – Flat Rock, North Carolina

Take I-40 to Asheville. Travel east on I-26 to exit 53, Upward Rd. Turn right at end of ramp. At second light, turn right onto S. Allen Drive. Turn left at sign onto College Drive. First building on right is the Sink Building. Bo Thomas Auditorium is on the left side of the Sink Building.

Holiday Inn - Statesville, North Carolina

I-77 North or South to Exit 49A

Rocky Mount location- Rocky Mount, North Carolina

From Raleigh (West)

Take 64 East. Take the Red Oak exit. Turn right off ramp at stop sign (Old Carriage Rd). Go approximately 1/4 mile. Nash Community College will be on your right.

From Rocky Mount (East)

Take 64 West. Take the Red Oak Exit (exit past the 95 overpass). Turn left off ramp at stop sign. Go approximately 1/4 mile. Nash Community College will be on your right.

Robeson Community College- Lumberton, North Carolina

I-95 to exit 22. Turn onto Fayetteville Rd.

Jane S. McKimmon Center – Raleigh, North Carolina

Traveling East on I-40

Take exit 295 and turn left onto Gorman Street. Travel approximately one mile. The McKimmon Center is located on the right at the corner of Gorman Street and Western Boulevard.

Traveling West on I-40

Take exit 295 and turn right onto Gorman Street. Travel approximately one mile. The McKimmon Center is located on the right at the corner of Gorman Street and Western Boulevard.

Registration Form for the Enhanced Mental Health Services Seminar

(cut and return the registration form only)

Enhanced Mental Health Services Seminars Seminar Registration

(No Fee)

Provider Name _____ Provider Number _____

Address _____

City, Zip Code _____ County _____

Contact Person _____ E-mail Address _____

Telephone Number (____) _____ Fax Number (____) _____

1 or 2 (circle one) person(s) will attend the seminar at _____ on _____
(location) (date)

Return to: Provider Services
EDS
P.O. Box 300009
Raleigh, NC 27622

Attention: General Hospitals and Psychiatric Hospitals

Revenue Codes – CORRECTION

Effective July 1, 2005, corrections have been made to the following Revenue Codes for Behavioral Health Treatments/Services. The facility component for inpatient and outpatient services must be billed on the UB-92 claim form. Professional services must be billed on a CMS-1500 claim form.

The Revenue Codes listed below replace the Revenue Codes listed in the June 2005 General Medicaid Bulletin.

Behavioral Health Treatments/Services	
0901 Electroshock Treatment	BH/ELECTRO SHOCK
0902 Milieu Therapy	BH/MILIEU THERAPY
0905 Intensive Outpatient Services- Psychiatric	BH/INTENS OP/PYSCH
0906 Intensive Outpatient Services-Chemical	BH/INTENS OP/CHEM DEP
0911 Rehabilitation	BH/REHAB
0914 Individual Therapy	BH/INDIV RX
0915 Group Therapy	BH/GROUP RX
0916 Family Therapy	BH/FAMILY RX
0918 Testing	BH/TESTING
0919 Other Behavioral Health Treatments/Services	BH/OTHER

Behavioral Health Treatments/Services – Not covered in current benefit package	
0903 Play Therapy	BH/PLAY THERAPY
0904 Activity Therapy	BH/ACTIVITY THERAPY
0917 Bio Feedback	BH/BIOFEED

Note: 909 and 910 are no longer covered. Claims submitted with these codes for dates of service July 1, 2005 and after will deny.

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

Attention: General Hospitals and Psychiatric Hospitals

Revenue Codes for Piedmont Participants

Effective July 1, 2005, corrections have been made to the following Revenue Codes for Behavioral Health Treatments/Services. The facility component for inpatient and outpatient services must be billed on the UB-92 claim form. Professional services must be billed on a CMS-1500 claim form.

The Revenue Codes listed below replace the Revenue Codes listed in the June 2005 General Medicaid Bulletin.

Behavioral Health Treatments/Services	
0901 Electroshock Treatment	BH/ELECTRO SHOCK
0902 Milieu Therapy	BH/MILIEU THERAPY
0903 Play Therapy	BH/PLAY THERAPY
0904 Activity Therapy	BH/ACTIVITY THERAPY
0905 Intensive Outpatient Services-Psychiatric	BH/INTENS OP/PYSCH
0906 Intensive Outpatient Services-Chemical	BH/INTENS OP/CHEM DEP
0911 Rehabilitation	BH/REHAB
0914 Individual Therapy	BH/INDIV RX
0915 Group Therapy	BH/GROUP RX
0916 Family Therapy	BH/FAMILY RX
0918 Testing	BH/TESTING
0919 Other Behavioral Health Treatments/Services	BH/OTHER

Behavioral Health Treatments/Services – Not covered in current benefit package	
0917 Bio Feedback	BH/BIOFEED

Note: 909 and 910 are no longer covered. Claims submitted with these codes for dates of service July 1, 2005 and after will deny.

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

Attention: Nursing Facilities and Hospitals

Preadmission Screening Annual Resident Review Seminars

Seminars on the Preadmission Screening Annual Resident Review (PASARR) process have been scheduled for September and October 2005. The seminars will be conducted by the First Health Services Corporation (FHSC), the agent contracted by the N.C. Medicaid program to conduct PASARR. The seminars will provide an overview of the screening process, helpful tips and hints for completing requests, and a brief overview of the free web-based request system available through FHSC. Registration and training information is available of FHSC's website at <http://northcarolina.fhsc.com>.

The PASARR training schedule is as follows:

Monday, September 12, 2005 8:00 a.m. -12:00 p.m. Holiday Inn Sunspree Resort Asheville, NC	Tuesday, September 13, 2005 1:00 p.m.-4:30 pm Sheraton at Four Seasons Greensboro, NC
Thursday, September 15, 2005 8:00 a.m.-12:00 p.m. Sheraton Capital Center Downtown Raleigh, NC	Friday, September 16, 2005 8:00 a.m.-12:00 p.m. Hilton Greenville, NC
Monday, October 3, 2005 8:00 a.m.-12:00 p.m. Marriott Executive Park Charlotte, NC	Wednesday, October 5, 2005 8:00 a.m.-12:00 p.m. Holiday Inn I-95 Fayetteville, NC
Friday, October 7, 2005 8:00 a.m.-12:00 p.m. Shell Island Resort Wrightsville Beach, NC	

For additional information, please call FHSC at 1-800-639-6514 or visit their website at <http://northcarolina.fhsc.com>.

FHSC, 1-800-639-6515

Attention: Mental Health Practitioners Who are Employed in Physicians Offices/Clinics, Hospital Outpatient Departments, Local Management Entities, Local Health Departments/School Based Health Centers, and All Other Direct Enrolled Mental Health Practitioners

Outpatient Behavioral Health Services

The following clarifications are in response to questions from providers attending the seminar on Expansion of Provider Types for Outpatient Behavioral Health Services in May, 2005.

- In addition to the documentation requirements listed in the May 2005 Special Bulletin IV, the Medicaid identification number and the recipients name must be included on each page in the recipient's record.
- "When a Mental Health Practitioner is an employee of a physician group and is working "incident to," the supervising physician can be any physician in the group practice.

The difference between Psychotherapy and Behavioral Counseling is:

- Behavioral Counseling- The approach used for people who are in crisis or experiencing stressors that impede their ability to function and/or make decisions as they normally would.
- Psychotherapy- The use of certain psychological interventions by trained clinicians in treating diagnosed mental and emotional disorders.

Billing for dually eligible Medicare/Medicaid recipients:

- If you are a Physician, a Licensed Clinical Psychologist (PhD, PsyD), a Licensed Clinical Social Worker, a Clinical Nurse Specialist (Certified) or a Psychiatric Nurse Practitioner, you may bill Medicare for the same services using the appropriate CPT codes that you are enrolled with Medicaid to bill.
- If you are a master's level psychologists/ (LPA), a Licensed Professional Counselor/LPC, Licensed Marriage and Family Therapist/LMFT, Certified Clinical Supervisor/CCS or a Certified Clinical Addictions.

Specialist/ CCAS and are seeing Medicare recipients, you must bill "incident to" a physician, a PhD, LCSW, CNS or Psychiatric Nurse Practitioner for the Medicare recipients. However, you still bill Medicaid for services provided to Medicaid only recipients under your own individual or group Medicaid number.

If you have any questions, please contact the Behavioral Health Section of Clinical Policy and Programs at 919-855-4290.

Clinical Policy and Programs
DMA, 919-855-4290

Attention: Independent Laboratories and Physicians

CLIA Certification Related Claim Denials

This is additional clarification to the article published in the May 2005 general Medicaid bulletin entitled CLIA Certification Related Claim Denials.

In order to ensure claims are coded appropriately when submitting and resubmitting claims, providers should refer to the Clinical Laboratory Improvement Amendments (CLIA) website at <http://www.cms.hhs.gov/clia/> for a listing of CLIA tests along with correct procedure codes for waived and provider performed microscopy procedures (PPMP) certificate levels. The lists may be printed and retained for future reference. This information is periodically updated and new tests are added as they become approved for "waived" status.

CLIA Certificate Level	Tests Allowed	Website for List of Tests
Certificate Level 2	CLIA waived tests	http://www.cms.hhs.gov/clia/waivetbl.pdf
Certificate Level 4	CLIA waived tests PPMP	http://www.cms.hhs.gov/clia/waivetbl.pdf http://www.cms.hhs.gov/clia/ppmplst.asp

Billing Reminders

If the CPT code indicates that the code must be billed with a QW modifier, the modifier must be appended to the CPT code to process for reimbursement. Failure to append the QW will result in claims denying for EOB 0936, "Certification not valid for DOS/Level and a delay in payment."

Claims submitted incorrectly with CPT codes that are not considered "waived" will deny for EOB 0936, "Certification not valid for DOS/Level and a delay in payment."

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

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

Attention: Nursing Facility Providers

Minimum Data Set Supportive Documentation Guidelines

The revised Minimum Data Set (MDS) Supportive Documentation Guidelines (SDGs) from the Centers for Medicare and Medicaid Services (CMS) went into effect on June 15, 2005. All MDSs with an A3a date of June 15, 2005 or later must be reviewed using the revised guidelines. A copy of the new SDGs was mailed to all North Carolina nursing facilities on June 13, 2005, and is also available on DMA's website at <http://www.dhhs.state.nc.us/dma/prov.htm>.

MDS Help Desk
919-715-1872, ext. 214

Myers and Stauffer's Help Desk
1-800-763-2278

MDS Validation Program Oversight and Administration
Margaret Comin, RN, Facility Services Unit Manager
DMA, 919-855-4350

Attention: Nursing Facility Providers

Restorative Nursing Defined for Case Mix

Restorative nursing programs may be initiated when a Nursing Facility resident is discharged from formalized physical, occupational or speech rehabilitation therapy, or when a restorative need arises for a resident who is not a candidate for a more formalized therapy program. Because it is a nursing function, a restorative nursing program does not require a physician's order or oversight by a licensed therapist. However, accurate assessments are **crucial** to ensure that the nursing facility is appropriately providing and receiving reimbursement for restorative nursing programs to residents.

A nursing restorative program maintains or retains the level of function that is appropriate to the resident. To qualify for and to continue with a restorative nursing program, the recipient **must meet all of the following criteria:**

- The **individual** problem must be clearly identified (e.g., AROM, splint or brace application, transfer, ambulation, grooming, etc.).
- **Measurable** goals (objectives) and **measurable** interventions (actions) must be clearly documented (care planned) for each restorative program. (For something to be measurable it must have unit of measurement attached to it, e.g. time, weight, or distance and it must be measured against a particular goal or standard).
Goals should be "specific, reasonable, moderately challenging and attainable within a short space of time." These short-term goals should be seen in the context of long term achievement. Care plans that are "canned," "one-size-fits-most," or "pre-printed" are not acceptable. These do not address the individual or their specific needs.
- Nurse aides responsible for restorative programs must be trained in the techniques that promote resident involvement in the activity. This training must be documented. Evidence of training needs to include the trainer's name and credentials as well as the intervention that was taught.
- Restorative activities are supervised by a licensed nurse although the interventions may be carried out by nurse aides, other staff or volunteers.
- No more than four residents per supervising caregiver are permitted to participate in exercise "groups."
- The technique, procedure or activity must be practiced for a total of at least 15 minutes in a 24-hour period to record one day of restorative nursing.

Documentation Requirements for Case Mix

The Restorative Nurse Supervisor must care plan each problem, establish measurable goals and interventions, and provide periodic evaluation of **each individual restorative program** specific for **each individual resident** on a Restorative Nursing Program.

The MDS requirement is that each technique, procedure or activity practiced totals a minimum of 15 minutes during a 24-hour period. The MDS validation reviewers are required to review actual minutes provided each day that have been signed by the staff responsible for providing the programs. Although interventions may be carried out by nurse aides, other staff or volunteers, a periodic evaluation for each restorative program the resident is receiving must be documented by a licensed nurse.

Facility Services

DMA, 919-855-4350

Attention: OB/GYN Providers

OB/GYN Billing Seminars

Seminars on OB/GYN billing guidelines are scheduled for October 2005. Registration information and a list of dates and site locations for the seminars will be published in the September 2005 general Medicaid bulletin.

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

Attention: Personal Care Services (PCS) Providers

PCS Recoupments

In October 2004, EDS began recouping overpayments to Personal Care Services (PCS) since the implementation of PCS-Plus in November 2003. Some of the recoupments from this time period have not been completed. The recoupment process will start again in mid to late summer and will continue until all of the overpayments have been corrected. The overpayment amount will be automatically deducted from the provider's payment. Providers who have received PCS payments for services that exceeded the 3.5 hour per day limit (or 14 units) for PCS clients without PCS-Plus prior approval will have these payments recouped. Any providers who have received payments for services that exceeded 60 hours (or 240 units) a month for PCS clients without PCS-Plus prior approval will also have these payments recouped.

As a reminder, PCS is limited to 60 hours a month for each eligible Medicaid recipient. Medicaid recipients with prior approval from the Division of Medical Assistance for PCS-Plus services are eligible for up to 80 hours a month of PCS.

EDS will contact PCS providers with large overpayments before initiating a recoupment. EDS will arrange a recoupment plan with these providers to allow for repayment over several Checkwrite periods.

**PCS/PCS-Plus
DMA, 919-855-4360**

Proposed Clinical Coverage Policies

In accordance with Session Law 2003-284, proposed new or amended Medicaid clinical coverage policies are available for review and comment on DMA’s website at <http://www.dhhs.state.nc.us/dma/prov.htm>. To submit a comment related to a policy, refer to the instructions on the website. Providers without Internet access can submit written comments to the address listed below.

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

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

2005 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
August	7/29/2005	8/2/2005
	8/5/2005	8/9/2005
	8/12/2005	8/16/2005
	8/19/2005	8/25/2005
September	9/2/2005	9/7/2005
	9/9/2005	9/13/2005
	9/16/2005	9/20/2005
	9/23/2005	9/29/2005
October	10/7/2005	10/11/2005
	10/14/2005	10/18/2005
	10/21/2005	10/27/2005

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



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



Cheryll Collier
 Executive Director
 EDS