



# North Carolina Medicaid Bulletin

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

**In This Issue.....Page#**

**All Providers:..... 1**  
 2006 Checkwrite Schedule ..... 16  
 Basic Medicaid Billing Seminars ..... 1  
 Citizenship/Identity Changes..... 2  
 Clinical Coverage Policies ..... 1  
 National Provider Identifier (NPI)..... 3  
 Tetanus and Diphtheria Toxoids (Td, CPT  
 Code 90718 - Ending Coverage.....3  
 Updated EOB Code Crosswalk to HIPAA  
 Standard Codes ..... 4  
 Updates to HIPAA 835 Transactions for Medicare  
 Crossovers ..... 5

**Adult Care Home Providers:..... 7**  
 Prior Approval Process for Medicaid Payment for  
 Recipients Residing in an Adult Care Home (ACH)  
 Special Care Unit for Persons with Alzheimer’s and  
 Related Disorders (SCU-A)..... 7

**Child Service Coordination Providers: ..... 9**  
 Infant-Toddler Program Referrals ..... 9

**Durable Medical Equipment Providers: ..... 9**  
 Addition of Adjustable Wheelchair Cushion  
 Codes to DME Fee Schedule..... 9  
 Fee Schedule Changes for Interim Rates and Other Rate  
 Changes ..... 10

**Hospital Outpatient Departments:..... 12**  
 Reminders Regarding the Referral Process for Outpatient  
 Behavioral Health Services.....12

**In This Issue.....Page#**

**Local Health Departments: ..... 12**  
 Reminders Regarding the Referral Process for Outpatient  
 Behavioral Health Services ..... 12

**North Carolina Health Choice Providers: ..... 10**  
 State Health Plan Delay in Payments ..... 10

**Nursing Facility Providers: ..... 11**  
 Electronic Records – Supplement to Supportive  
 Documentation Guidelines ..... 11

**Nurse Practitioners: ..... 13**  
 Cetuximab (Erbitux, J9055)—Update to  
 Billing Guidelines ..... 13  
 Triptorelin Pamoate (Trelstar Depot and Trelstar LA,  
 J3315) Billing Guidelines..... 14

**Outpatient Behavioral Health Service Providers**  
**School Based Health Centers: ..... 12**  
 Reminders Regarding the Referral Process for Outpatient  
 Behavioral Health Services ..... 12

**Physicians: ..... 13**  
 Cetuximab (Erbitux, J9055)—Update to  
 Billing Guidelines..... 13  
 Triptorelin Pamoate (Trelstar Depot and Trelstar LA,  
 J3315) Billing Guidelines ..... 14

**Psychiatric Residential Treatment Facilities: ..... 15**  
 Direct Enrollment and Direct Billing ..... 15

Providers are responsible for informing their billing agency of information in this bulletin.  
 CPT codes, descriptors, and other data only are copyright 2005  
 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.

**Attention: All Providers**

**Basic Medicaid Billing Seminars**

Seminars for Basic Medicaid billing guidelines are scheduled for October 2006. Registration information and a list of dates and site locations for the seminars will be published in the September 2006 general Medicaid bulletin.

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

---

**Attention: All Providers**

**Clinical Coverage Policies**

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

**5A—Durable Medical Equipment**

**5B—Orthotics and Prosthetics**

**8E—Intermediate Care Facility for Individuals with Mental Retardation**

**8I— Psychological Services in Health Departments and School-Based Health Centers  
Sponsored by Health Departments to the Under 21 Population**

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**

**Citizenship/Identity Changes**

First, Medicaid requirements to verify alien status have not changed. An undocumented alien will still be eligible for only emergency services while documented aliens must still provide verification of their alien status.

Effective September 1, most applicants for medical assistance who state they are United States citizens must provide citizenship/identity verification. Exceptions are: current and former SSI recipients and current and former Medicare recipients. Children in the NCHC program, ages 6 to 18, do not have to verify citizenship/identity. Medicaid applicants will not be approved until all eligibility requirements, including proof of citizenship/identity, are provided.

For those currently receiving Medicaid, citizenship and identity must be verified at next redetermination scheduled on or after September 1. This includes the newborn children automatically eligible for Medicaid. If verifications is not provided during redetermination process, the recipient will be recertified and given 3 months to provide proof of citizenship/identity. Children eligible in foster care will be considered recipients and given 3 months to verify citizenship/identity. If applicant/recipient requests help in obtaining the documents, the county department of social services must help, especially if there is a fee involved.

Many counties have electronic data matches with the local register of deeds to verify births. CMS has said we can allow data matches. The State is currently working with State Vital Records to do an electronic match. However, that won't be ready by September 1.

Copies of certified birth certificates are acceptable.

Another program's evidence of citizenship/identity, such as Food Stamps, can be used to verify citizenship/identity for Medicaid.

There is a chart on the DMA website under county links, letters to county directors that gives the hierarchy on how CMS wants states to verify citizenship/identity. CMS will monitor states to ensure the lowest hierarchy is not always used to verify citizenship.

Hospitals or the companies they have hired to take applications must not hold these applications if they wish to pursue verification of citizenship/identity. Several companies now try to manipulate the date of application for the company's benefit rather than the applicant's benefit. This violates federal regulations in 42 CFR 435.906 that provides individuals must have the right to apply for medical assistance without delay. While county agencies and the applicants appreciate assistance in pursuing verifications, an applicant's right to apply without delay must not be impeded. These verifications can be provided at a later date.

**Eligibility Unit  
DMA, 919-855-4000**

**Attention: All Providers**

**National Provider Identifier (NPI)**

Beginning September 1, 2006, the N.C. Medicaid Program will begin collecting the National Provider Identifier(s) (NPI) from currently enrolled Medicaid providers. The N.C. Medicaid NPI form will be published in the September general Medicaid bulletin and will also be available on DMA's website at: <http://www.dhhs.state.nc.us/dma/forms.html>. The form can be returned by fax or mail to the address listed on the form. Providers must also include with the NPI form a copy of the notification letter from the National Plan and Provider Enumeration System (NPPES).

DMA is pursuing options for e-mail, web-based and electronic batch submission. Details will be provided in future bulletins.

Providers are encouraged to apply for their NPI immediately. Please go to the website <http://nppes.cms.hhs.gov>. Please indicate North Carolina as your state name and include your Medicaid provider number(s). Claims submitted after May 23, 2007, will deny without an NPI number.

Remember, applying for an NPI does not replace any enrollment or credentialing processes for N.C. Medicaid.

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

---

**Attention: All Providers**

**Tetanus and Diphtheria Toxoids (Td, CPT Code 90718) – Ending Coverage**

Effective with date of service November 1, 2006, the N.C. Medicaid program will no longer recognize CPT code 90718 (the old Td vaccine) as a VFC vaccine, nor reimburse for the administration fee (CPT codes 90471, 90472, 90465, or 90466) for this vaccine for VFC recipients through 18 years of age. Effective with date of service November 1, 2006, DMA will no longer recognize CPT 90718 for recipients over 18 years of age nor reimburse for the administration of this vaccine. Providers who report CPT 90718 for VFC recipients or bill for the administration of the vaccine after date of service October 31, 2006, and those who bill for the vaccine and administration fee for recipients over 18 years of age after date of service October 31, 2006, will have those claims denied.

Refer to page 3 of the December 2005 general Medicaid bulletin for coverage information on DECAVAC (the new Td preservative-free vaccine), CPT code 90714.

**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 the Division of Medical Assistance's website at <http://www.dhhs.state.nc.us/dma/prov.htm>.

With the implementation of standards for electronic transactions mandated by the Health Insurance Portability and Accountability Act (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 list is current as of the date of publication. Providers will be notified of changes to the list through the general Medicaid bulletin.

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

**Attention: All Providers**

**Updates to HIPAA 835 Transactions for Medicare Crossovers**

Beginning September 1, 2006, Medicare crossover claims will be reported differently on the HIPAA 835 transaction set, the Unsolicited 277 transaction set and the HIPAA 277 Claim Status Response transaction set for North Carolina Medicaid. It may be necessary for providers to work with their software vendors regarding this change.

Medicare Part B crossover claims are processed in the Medicaid system using a billed amount that is built during claims adjudication. This billed amount consists of the Medicare coinsurance and deductible. Currently, this is the billed amount being reported on the 835 transaction. Providers have had difficulty reconciling their records because this is not the amount they actually billed Medicaid. Claims received and processed for the first checkwrite cycle in September will begin to report the actual billed amount on the claim.

In addition, the Claim Status Indicator (CLP02) will also be modified to reflect if Medicaid processed the claim as primary, secondary, or tertiary on paid claims. These codes are represented in the 835 as follows:

- 1 – Processed as Primary
- 2 – Processed as Secondary
- 3 – Processed as Tertiary

Other Claim Status Indicator codes used will remain unchanged.

Older Medicare crossover claims that adjudicated prior to September 1, 2006, that are being reported as reversed on HIPAA 835 transactions due to an adjustment, or that are being reported on the 277 Claim Status Response transactions, will continue to have their Billed Amount data element set to the NC Medicaid billed amount.

Medicare crossover claims that adjudicate on or after September 1, 2006 can be found using the Original Billed Amount specified in the 276 transaction only if it matches the claims' Original Billed Amount. Medicare crossover claims that adjudicated prior to September 1, as well as all non-crossover claims, will continue to be found using the Original Billed Amount specified in the 276 transaction only if it matches the NC Medicaid Original Billed Amount.

Please reference the chart below:

**Medicare Crossover Claims**

	<b>Prior to September 1, 2006</b>	<b>September 1, 2006 and after</b>
835 Transaction will report	Medicaid Bill amount	Medicare Billed Amount
Unsolicited 277 Transaction	Medicaid Bill Amount	Medicare Billed Amount
Regular 276/277 using "Amount Billed" as search criteria use	Medicaid Bill Amount	Medicare Billed Amount
Paid claims with no TPL, Claim Status Code on 835 will report	1 = Primary	2 = Secondary
Paid claims with other TPL, Claim Status Code on 835 will report	1 = Primary	3 = Tertiary

**Non – Crossover Claims**

	<b>Prior to September 1, 2006</b>	<b>September 1, 2006 and after</b>
835 Transaction will report	Medicaid Billed Amount	Medicaid Billed Amount
Unsolicited 277 Transaction	Medicaid Billed Amount	Medicaid Billed Amount
Regular 276/277 using "Amount Billed" as search criteria use	Medicaid Billed Amount	Medicaid Billed Amount
Claims with no TPL, Claim Status Code on 835 will report	1 = Primary	1 = Primary
Claims with Medicare TPL and/or other TPL, the Claims Status Code on 835 will report	1 = Primary	2 = Secondary Or 3 = Tertiary

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

## **Attention: Adult Care Home Providers**

# **Prior Approval Process for Medicaid Payment for Recipients Residing in an Adult Care Home (ACH) Special Care Unit for Persons with Alzheimer's and Related Disorders (SCU-A)**

Session Law 2005- 276 provided for additional Medicaid funding for the care of residents residing in Special Care Units for Persons with Alzheimer's and Related Disorders (SCU-A) located in Adult Care Homes. Effective with the date of service October 1, 2006, the N.C. Medicaid Program will implement a special care rate for ACH providers Operating Special Care Units for Persons with Alzheimer's and Related Disorders.

Medicaid will reimburse providers according to the following procedure:

1. ACH providers who admit Medicaid recipients who receive State and County Special Assistance and have an Ambulation Code of "C" on their eligibility file are eligible to apply for prior approval to receive a special Medicaid enhanced service rate through the Division of Medical Assistance when that recipient is admitted to a SCU-A.
2. Providers must obtain prior approval from DMA before admitting a new resident to a SCU-A. No retroactive prior-approval will be provided.
3. Providers must obtain prior approval from DMA within 7 days of admitting a Resident who currently resides in another unit of the ACH into the home's SCU-A in order to receive the SCU-A rate from the date of admission. Otherwise, if approved, prior approval will be effective retroactive to the date received by DMA.
4. Providers must send the following information to obtain prior approval from DMA:
  - a. Completed DMA SCU-A Prior Approval Request Form<sup>1</sup>.
  - b. Current FL-2, signed by a physician, with a primary diagnosis of Alzheimer's and Related Disorders.<sup>2</sup>
  - c. Copy of the Pre-Admission Screening by the facility to evaluate the appropriateness of an individual's placement in the SCU-A as required by current rule.
  - d. Copy of current 3050R if resident is not new to the home.
  - e. Copy of the Provider's current ACH License with SCU-A designation<sup>3</sup>.
  - f. Copy of Provider's current ACH SCU-A Disclosure statement.

---

<sup>1</sup> See Attachment A

<sup>2</sup> ICD-9-CM Acceptance Indicator – A list of diagnosis codes relating to Alzheimer's and Related Disorders--- Alzheimer's Disease 331, Multi-Infarct Dementia 290.4, Parkinson's disease 332, Huntington's disease 333.4, Creutzfeldt - Jakob disease 294.10, Pick's Disease 331.11, Lewy Body Dementia 331.82. One of these diagnosis codes must be listed as the primary diagnosis on the claim for payment of SCU-A codes.

<sup>3</sup> Complete facility information is only due once per year –as per schedule or upon facility status change or as needed.



5. Providers send the requested information via US Mail to:  
DMA ACH Unit  
NC DHHS  
Division of Medical Assistance  
Facility and Community Care Section  
1985 Umstead Drive  
2501 Mail Service Center  
Raleigh, NC 27699-2501

Other important information for ACH Providers to know related to the Prior Approval for SCU-A Payment:

1. Providers will not receive payment for Enhanced ACH/PCS services for a recipient receiving payment for SCU-A.
2. Recipients must receive Basic PCS at the same time as SCU-A services.
3. DMA will mail a decision notice to the ACH provider within 15 working days of receipt of prior approval request.
4. DMA will contact fiscal agent and authorize Medicaid reimbursement for days approved.
5. In order to avoid payment processing delays, beginning August 1, 2006, providers may begin to submit the required prior approval information to DMA for residents who currently reside in a SCU-A and are expected to remain until October 1, 2006. Upon approval, the new rate will begin effective with date of service October 1, 2006.

**Instructions for completing the Adult Care Home SCU-A form:**

1. This form is only to be used by Adult Care Homes with Special Care Unit Designations which is available on DMA's website at <http://www.ncdhhs.gov/dma/forms.html#prov>.
2. Print clearly.
3. All copies of items submitted must be legible.
4. The complete facility information is only due once per year- as per schedule or upon facility status change or as otherwise needed.

**5. THIS IS A HIPAA REQUIREMENT: The completed form and information must be sent in a sealed envelope with "confidential" written in red and then placed in another envelope and addressed as in #6 below. DMA will not accept faxed records.**

6. Completed form must be sent via US Mail to the following address:  
NC DHHS – DMA  
ACH Unit  
Facility and Community Care  
1985 Umstead Drive  
2501 Mail Service Center, Raleigh, NC 27699-2501

7. For questions contact:  
Nancy Roberts @ 919-855-4116 or [Nancy.Roberts@ncmail.net](mailto:Nancy.Roberts@ncmail.net) or  
Julie Budzinski @ 919-855-4368 or [Julie.Budzinski@ncmail.net](mailto:Julie.Budzinski@ncmail.net)

**Clinical Policy and Programs  
DMA, 919-855-4116 and /or 919-855-4368**

**Attention: Child Service Coordination Providers**

**Infant-Toddler Program Referrals**

Effective July 1, 2006, the new eligibility definition for the North Carolina infant-toddler program at <http://www.ncei.org/ei/index.html> should be used when determining the appropriateness of a referral to the program. Clinical Coverage Policy #1M-1, *Child Service Coordination*, has been updated to direct providers to the North Carolina early intervention services webpage for eligibility requirements.

**Clinical Policy and Programs**  
**DMA, 919-855-4260**

**Attention: Durable Medical Equipment Providers**

**Addition of Adjustable Wheelchair Cushion Codes to DME Fee Schedule**

Effective with date of service August 1, 2006, the following codes are added to the capped rental section of the Durable Medical Equipment (DME) Fee Schedule:

<b>K0734</b>	Skin protection wheelchair seat cushion, adjustable, width less than 22 inches, any depth
<b>K0735</b>	Skin protection wheelchair seat cushion, adjustable, width 22 inches or greater, any depth
<b>K0736</b>	Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 inches, any depth
<b>K0737</b>	Skin protection and positioning wheelchair seat cushion, adjustable, with 22 inches or greater, any depth

The codes may be covered if the recipient has a diagnosis or a condition that may cause breakdown of the skin due to immobility and sitting in a wheelchair for long periods of time. The recipient must be wheelchair bound. The codes do not require prior approval, however, medical necessity must be documented on the Certificate of Medical Necessity/Prior Approval (CMN/PA) form. The lifetime expectancy for all these codes is 3 years.

For current pricing on these and all DME codes, refer to DMA’s web page at <http://www.dhhs.state.nc.us/dma/fee/fee.htm>.

For all billings, providers are reminded to bill their usual and customary rates. Do not automatically bill the established maximum reimbursement rate. Payment will be the lesser of the billed usual and customary rate or the maximum reimbursement rate.

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

**Attention: Durable Medical Equipment Providers**

**Fee Schedule Changes for Interim Rates and Other Rate Changes**

Effective with dates of service on or after August 1, 2006, rates were changed for the Durable Medical Equipment (DME) HCPCS code listed below which was previously added with an interim rate.

Medicare pricing has now become available for this code:

E0705	TRANSFER BOARD OR DEVICE, ANY TYPE, EACH
-------	--

Effective with the same date, other DME rates were changed based on the normal annual review of DME rates.

For current pricing on all DME codes, refer to DMA’s web page at <http://www.dhhs.state.nc.us/dma/fee/fee.htm>.

For all billings, providers are reminded to bill their usual and customary rates. Do not automatically bill the established maximum reimbursement rate. Payment will be the lesser of the billed usual and customary rate or the maximum reimbursement rate.

**Rate Setting**  
**DMA, 919-855-4200**

**Attention: North Carolina Health Choice Providers**

**State Health Plan Delay in Payments**

Due to the recent notification of changes in the professional fees and code schedule for Medicaid, which became effective July 1, the State Health Plan of North Carolina will be delayed in processing payments for July 2006 dates of service. We apologize for any inconvenience this has caused.

**Becky Murray**  
**North Carolina State Health Plan, 919-881-2300**

**Attention: Nursing Facility Providers**

**E**lectronic Records – Supplement to Supportive Documentation  
Guidelines

Nursing Facilities that choose to keep resident records electronically must meet the following requirements to facilitate the Minimum Data Set (MDS) Validation Review process:

1. The facility must have an electronic signature policy. The reviewer may request to see the policy.
2. The facility must have an identified procedure for making corrections to electronic entries.
3. Computer access to the residents' information must be available to the reviewer.
4. Hard copies of documentation are not routinely required; however, the State reserves the right to request that certain records be printed or produced at the time of the review.
5. All Supportive Documentation Guidelines must be followed, including signatures, initials, and dates.
6. The entire medical record is subject to review.
7. The facility must have written policies in place to ensure the privacy and integrity of the record.

**Clinical Policy and Programs**  
**MDS Validation Review Consultant**  
**DMA, 919-855-4356**

**Attention: Outpatient Behavioral Health Service Providers School Based Health Centers, Local Health Departments and Hospital Outpatient Departments**

**Reminders Regarding the Referral Process for Outpatient Behavioral Health Services**

Prior to the initial outpatient behavioral health visit, recipients under the age of 21 require a referral by a Carolina Access (CA) Primary Care Provider (PCP), the LME or a Medicaid enrolled psychiatrist. Practitioners who are employed and working for a CA Primary Care Physician or Medicaid enrolled psychiatrist billing under the “incident to” guidelines will not need a referral. Services provided by a physician do not require a referral.

Referrals may be made by telephone, fax or in writing to the mental health provider. The referring provider will give the mental health provider a referral number that must be placed in block 19 of the CMS 1500 claim form in order for the claim to be paid. Failure to put the referral number on the claim when filing will result in denial of payment.

Recipients age 21 and over do not require a referral.

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

**Attention: Physicians and Nurse Practitioners**

**Cetuximab (Erbix, J9055) – Update to Billing Guidelines**

The N.C. Medicaid program covers cetuximab (Erbix) for use in the Physician’s Drug Program for the diagnosis of colorectal carcinoma. Recently, the Food and Drug Administration also approved Erbix for the diagnosis of head and neck carcinoma.

In accordance with the new FDA approved diagnoses for Erbix, the following ICD-9-CM **diagnosis codes** are required when billing for Erbix:

- **V58.1** - admission or encounter for chemotherapy **must be billed**  
**and**
- An **ICD-9-CM** diagnosis code in one of the following groups:
  1. **153.0 through 154.8**
  2. **140.0 through 149.9**
  3. **160.0 through 161.9**
  4. **195.0**
  5. **162.0**
  6. **171.0**

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

**Attention: Physicians and Nurse Practitioners****Triptorelin Pamoate (Trelstar Depot and Trelstar LA, J3315) Billing Guidelines**

Effective with date of service July 1, 2006, the N.C. Medicaid program covers triptorelin pamoate (Trelstar Depot for injection and Trelstar LA for injection) for use in the Physician's Drug Program, when billed with HCPCS code J3315. Triptorelin is a synthetic hormone that stops the production of testosterone. It is approved by the FDA for palliative treatment of advanced prostate cancer. It is an alternative treatment for prostate cancer when orchiectomy or estrogen replacement administration is either not indicated or not acceptable to the patient. It is available in two forms as described below.

Drug name	HCPCS Code	Dosage	Frequency of Administration	Billing Unit
Trelstar Depot	J3315	3.75 mg	Monthly	1 unit
Trelstar LA	J3315	11.25 mg	Once every 12 weeks (3 months)	3 units

Both forms of Trelstar are to be reconstituted with sterile water only and administered as single intramuscular injections. Both forms are also available in the Clip'N'Ject single-dose delivery system use. ICD-9-CM diagnosis code **185, malignant neoplasm of prostate**, must be billed with Trelstar Depot or Trelstar LA.

**Billing Requirements:**

- Use the CMS-1500 claim form.
- Enter the appropriate ICD-9-CM diagnosis code in block 21.
- Enter the date of service in block 24A.
- Enter the place of service in block 24B.
- Enter HCPCS code J3315 in block 24D.
- Enter the usual and customary charge in block 24F.
- Enter the units given in block 24G.

**Example**

21 Diagnosis	24A Date(s) of Service	24B Place of Service	24D Procedures, Services or Supplies	24F Charges	24G Units
185	08212006	11	J3315	\$	1 Unit

For Medicaid billing, one unit of coverage is 3.75 mg. The maximum reimbursement rate per unit is \$260.23.

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

## **Attention: Psychiatric Residential Treatment Facilities**

### **Direct Enrollment and Direct Billing**

Effective September 1, 2006, local management entities (LMEs) will begin to endorse Level II (program type) and Levels III and IV psychiatric residential treatment facilities that have one, two, or three beds. As each facility obtains this endorsement, providers should submit an enrollment packet to DMA to obtain a Medicaid provider number. With the Medicaid provider number, providers may begin direct billing.

EDS will offer two workshops in September to train these providers on billing and the authorization process. Registration information will be published in the September general Medicaid bulletin.

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



**NCLeads Update**

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

Provider Relations  
 Office of MMIS Services  
 919-647-8315

**Proposed Clinical Coverage Policies**

In accordance with Session Law 2005-276, proposed new or amended Medicaid clinical coverage policies are available for review and comment on DMA’s website at <http://www.ncdhhs.gov/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.

**2006 Checkwrite Schedule**

July (d)	06/30/06	07/06/06
	07/07/06	07/11/06
	07/14/06	07/18/06
	07/21/06	07/27/06
August	08/04/06	08/08/06
	08/11/06	08/15/06
	08/18/06	08/22/06
	08/25/06	08/30/06
September (e)	09/01/06	09/06/06
	09/08/06	09/12/06
	09/15/06	09/19/06
	09/22/06	09/28/06

*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*

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

*Cheryll Collier*

Cheryll Collier  
Chief Operating Officer  
Division of Medical Assistance

---