



August 2008 Medicaid Bulletin

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Providers are responsible for informing their billing agency of information in this bulletin. CPT codes, descriptors, and other data only are copyright 2007 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.

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Attention: All Providers

National Provider Identifier Reminders

To assist with the transition to National Provider Identifiers (NPIs), please see the reminders below.

Carolina ACCESS

- Claims submitted for reimbursement of a service authorized by a recipient's Carolina ACCESS primary care provider (PCP) must include the PCP's referral authorization number. Prior to the implementation of NPIs, this referral authorization number was the PCP's Carolina ACCESS provider number. With the implementation of NPIs, the PCP's NPI number must now be used as the referral authorization number. Claims must be submitted with the Carolina ACCESS PCP's NPI number (unless the PCP is atypical) as the referral authorization number or the claim will be denied.
- DMA recommends that when billing for a service authorized by a recipient's Carolina ACCESS PCP, both the PCP's Carolina ACCESS provider number and the PCP's NPI should be listed on the claims.
- A taxonomy is not required for the referral authorization NPI.
- There is no change to the Carolina ACCESS override process. An NPI is not required for the override process.
- Carolina ACCESS PCPs must provide their NPI when authorizing a service. Refer to the following guidance from CMS on sharing NPIs.

Health care providers should share their NPIs with other providers with whom they do business, and with health plans that request their NPIs. All health care providers who conduct standard transactions as adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) are covered health care providers. These providers must share their NPI with other providers, health plans, clearinghouses, and any entity that may need those NPIs for use in standard transactions. Providers should also consider letting health plans or institutions for whom they work, share their NPIs for them.

CMS strongly encourages providers to share their NPI with other health care providers to whom they refer patients; pharmacies that fill their prescriptions; i.e. health plans in which they are enrolled and to whom they submit claims; and organizations where they have staff privileges.

Mismatch Letters

If you receive a mismatch letter, please call EDS Provider Services before taking any action. Provider Services will verify whether the NPI on your claim or the NPI on the provider file needs to be changed. (Some providers have changed the NPI on file when it did not need to be changed.)

Multiple NPIs for Multiple Medicaid Provider Numbers

There seems to be some confusion regarding when a provider can obtain multiple NPIs. Some providers believe that only one NPI is allowed per tax identification number. This is not true. If you have multiple Medicaid Provider Numbers (for different service types), you may have an NPI for each one. This is called "subparting." Subparting applies only to an organization; individual providers cannot subpart.

Examples of subparting include different departments of a hospital, or separate physical sites for a group. N.C. Medicaid strongly recommends one-to-one enumeration, which is the process of obtaining a separate NPI for each Medicaid Provider Number.

EDS Provider Services Hours of Operation

Hours of operation for EDS Provider Services were extended to assist with NPI-related calls. Effective August 1, 2008, hours of operation will return to 8:00 a.m. to 4:30 p.m.

NPI – Get it! Share It! Use It! Getting one is free – Not having one can be costly!

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

Attention: All Providers

Chest X-ray Unit Limitation Denials

The following CPT procedure codes for x-rays have a limit of five per day:

CPT Code	Description
71010	Radiologic examination, chest; single view, frontal
71015	Radiologic examination, chest; stereo, frontal
71020	Radiologic examination, chest, two views, frontal and lateral
71021	Radiologic examination, chest, two views, frontal and lateral; with apical lordotic procedure
71022	Radiologic examination, chest, two views, frontal and lateral; with oblique projections
71023	Radiologic examination, chest, two views, frontal and lateral; with fluoroscopy
71030	Radiologic examination, chest, complete, minimum of four views
71034	Radiologic examination, chest, complete, minimum of four views; with fluoroscopy
71035	Radiologic examination, chest, special views
75970	Transcatheter biopsy, radiological supervision and interpretation

Providers who received a denial with EOB 5351 (Units cutback, exceeds maximum allowed units per day) or EOB 7771 (Exceeds five procedures per day limitation) can file an adjustment with documentation verifying the medical necessity.

When billing for more than one unit of a code listed in the table above on the same date of service, providers should bill all units for a single code on one detail on the claim.

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

Attention: All Providers

Basic Medicaid Seminars

Basic Medicaid seminars are scheduled for the month of October 2008. Seminars are intended to educate providers on the basics of Medicaid billing. The seminar sites and dates will be announced in the September 2008 general bulletin (<http://www.ncdhhs.gov/dma/bulletin.htm>). The October 2008 Basic Medicaid Billing Guide will be used as the training document for the seminars and will be available on DMA's website at <http://www.ncdhhs.gov/dma/medbillcaguide.htm> prior to the seminars.

Pre-registration will be required. Due to limited seating, registration will be limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

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 DMA's website at <http://www.ncdhhs.gov/dma/mp/mpindex.htm>:

- 1M-2, Childbirth Education
- 1-O-3, Keloid Excision and Scar Revision
- 1R-1, Phase II Outpatient Cardiac Rehabilitation Programs
- 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

CPT Procedure Code 32551 and Modifiers 50 and 51

CPT procedure code 32551 (Tube thoracostomy, includes water seal, when performed) was covered as a new code effective with the 2008 CPT code update for dates of service January 1, 2008, and after. Modifiers 50 (Bilateral procedure) and 51 (Multiple procedures) were not included in the system update causing claims to be denied.

Claims payment system changes have been made to correct the problem. Providers who received claim detail denials related to EOB 0024 (Procedure code, procedure/modifier combination or revenue code is missing, invalid or invalid for this bill type) for CPT code 32551 with modifiers 50 and/or 51 for dates of service January 1, 2008, and after, may resubmit the denied charges as a new claim (not as an adjustment request) for processing.

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

Attention: All Providers

Groups with Multiple Medicaid Provider Numbers

A “group” is defined as an affiliation of individual providers in a group practice (for example, a dental practice) or a service agency that employs or contracts with staff to provide services (for example, a home health agency). Group providers with multiple site locations are required to enroll each site and bill for the group with the Medicaid Provider Number (MPN) assigned to that site. (Please note that groups enrolled to provide Community Alternatives Program services are exempt from the requirement to enroll each site separately.)

DMA has identified a number of group providers with more than one service-specific MPN for a physical site. Only one group provider number that is specific to the service being provided should be maintained for each physical site location. Therefore, effective July 1, 2008, all group providers are required to maintain one service-specific MPN to ensure that claims process correctly when billing with National Provider Identifiers (NPIs). DMA will end-date all but one of the provider’s MPNs.

Group providers who have been identified as having more than one service-specific MPN will be notified by mail prior to this administrative action. The letter will inform the provider that all previously assigned MPNs will be end-dated and will identify the MPN that is assigned to the provider for the service the group is enrolled to provide.

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

Attention: All Providers

D **Diagnosis Code V82.9 and Pediatric Recipients**

The annual fiscal year visit limit for Medicaid recipients does not apply to office visits for pediatric recipients. Do not submit CMS-1500 claims for pediatric recipients with ICD-9-CM diagnosis code V82.9 code in block 21 of the form. Using diagnosis code V82.9 on claims for recipients under 21 years of age will delay processing of the claims and may result in claim denials that require the claims to be resubmitted. Diagnosis code V82.9 is intended only for office visits for recipients ages 21 and older.

Effective with date of processing August 1, 2008, the instructions for filing claims for office visits for dates of service July 1, 2007, and after, have changed for recipients ages 21 and older. Refer to the article titled *New Annual Visit Limit Legislated by the N.C. General Assembly* on page 10 for revised instructions.

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

Attention: All Providers

S **Sterilizations for Recipients with Medicaid for Pregnant Women Coverage**

DMA has become aware of the need for clarification on coverage of sterilizations for women with Medicaid for Pregnant Women (MPW). MPW postpartum benefits begin on the last day of the pregnancy and extend through the end of the last day of the month in which the 60th postpartum day occurs according to 42 CFR 447.53(b)(2).

Section 1920(b) of the Social Security Act allows for a pregnant woman who is determined by a qualified provider to be presumptively eligible for Medicaid to receive ambulatory antepartum care, including pharmacy, laboratory, and diagnostic tests, while her eligibility status is being determined. Presumptive eligibility does not cover delivery or any services in the postpartum period. Because eligibility status is still being determined and sterilization procedures are completed during the postpartum period, pregnant women who meet the requirements for presumptive eligibility for Medicaid are not covered.

The Essure procedure is covered for recipients with MPW coverage benefits when rendered during the postpartum period. Because the hysterosalpingogram (HSG) procedure is performed three full months (90 days) after the placement of the Essure micro-inserts, the HSG procedure is not covered for recipients with MPW coverage benefits. Providers are encouraged to inform MPW recipients that the HSG procedure will not be covered by Medicaid and that payment for HSG services is the responsibility of the recipient.

For additional information on the Essure and the HSG procedure, refer to the July 2008 general Medicaid bulletin (<http://www.ncdhhs.gov/dma/bulletin.htm>) and to the article on page 6.

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

Attention: All Providers**R**evision to Essure and Hysterosalpingogram Implementation

Please note the following changes to the article titled *Essure and Hysterosalpingogram (HSG) Implementation* published in the July 2008 general Medicaid Bulletin.

1. The article stated “All claims must be billed with ICD-9-CM diagnosis V25.2 (Sterilization) as the primary or secondary diagnosis on the claim.” This statement is revised to state “Only claims billing for CPT procedure code 58579 (Unlisted hysteroscopy procedure, uterus) **are required** to have diagnosis code V25.2 as the primary or secondary diagnosis on the claim.”

Claims billed with other appropriate CPT codes for Essure and HSG **do not** require diagnosis code V25.2 as the primary or secondary diagnosis on the claim. However, diagnosis code V25.2 **must be** indicated in block 21 on the CMS-1500 claim form or form locator 67 on the UB-04 claim form.

2. CPT procedure code **58340** [Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography] **and** procedure code **74740** (Hysterosalpingography, radiological supervision and interpretation) **must be billed on the same day of service.**
3. The Essure procedure is covered when rendered during the postpartum period. Regular Medicaid covers both Essure and HSG procedures while Medicaid for Pregnant Women (MPW) covers only the Essure procedure. Because the HSG procedure is performed three full months (90 days) after the placement of the Essure micro-inserts, the HSG procedure is not covered for recipients with MPW coverage benefits. Providers are encouraged to inform MPW recipients that the HSG procedure will not be covered by Medicaid and that payment for HSG services is the responsibility of the recipient. Neither the Essure procedure nor the HSG procedure is covered for recipients with Family Planning Waiver (MAFD) coverage benefits.
4. Inpatient and outpatient hospital claims billed on the UB-04 claim form should be billed using ICD-9-CM procedure codes 66.29 (Other bilateral endoscopic destruction or occlusion of fallopian tubes) or 66.39 (Other bilateral destruction or occlusion of fallopian tubes).

Refer to the July 2008 general Medicaid Bulletin (<http://www.ncdhhs.gov/dma/bulletin.htm>) for a complete list of billing codes and additional information.

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

Attention: All Providers

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

All individuals admitted to a nursing facility must be screened before admission and annually thereafter, according to federal regulations. This is called the Pre-admission Screening and Annual Resident Review (PASARR). Regional training sessions for the PASARR segment of the new N.C. Uniform Screening Program (USP) and the N.C. Medicaid Uniform Screening Tool (MUST) application are taking place now through September 3, 2008. These training sessions will focus on the PASARR screening segment of the MUST that will be implemented in September 2008.

A total of twelve half-day sessions are scheduled throughout the state. The morning training sessions begin at 8:30 a.m. and end at 12:00 noon. The afternoon sessions begin at 1:00 p.m. and end at 4:30 p.m. Providers should arrive at least 30 minutes early to complete the registration process. Because meeting room temperatures vary, dressing in layers is strongly advised.

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

Training materials are available from the MUST website at <http://www.ncmust.com>. **Please print the Provider Training Manual and bring it with you to the training.** Although an online training will also be available, attendance at a regional training session is strongly recommended. In the event all staff are not able to attend a regional training session, a “train the trainer” approach may be utilized. All users of the MUST application will be required to pass an online exam before access will be granted.

Access to the PASARR component of the MUST will require each provider to create a user account with North Carolina Identity Management (NCID) and then use that account to register their organization within the PASARR component. Providers are strongly advised to register their organization prior to the September implementation. Instructions for creating an NCID account and registering an organization in the PASARR application are available at <http://www.ncmust.com>.

<p>Hickory July 31, 2008 Park Inn Gateway Conference Center 909 US Highway 70SE Hickory NC 28602 828-328-5101</p>	<p>Charlotte August 6, 2008 Queens University of Charlotte 1900 Selwyn Ave. Charlotte NC 28274 704-337-2560</p>	<p>Raleigh August 14, 2008 Jane S. McKimmon Center N.C. State University 1101 Gorman St. Raleigh NC 27606 919-515-2277</p>
<p>Wilmington August 21, 2008 Coastline Convention Center 503 Nutt St. Wilmington NC 28401 910-763-2800</p>	<p>Greenville August 27, 2008 Hilton Greenville 207 SW Greenville Blvd. Greenville NC 27834 252-355-5099</p>	<p>Asheville September 3, 2008 Holiday Inn Crowne Plaza and Resort One Holiday Inn Dr. Asheville NC 28806 828-254-3200</p>

Directions to the MUST PASARR Seminars:

ASHEVILLE

Holiday Inn Crowne Plaza and Resort

Traveling West on I-40

Take I-40 West to exit 53B. Merge onto I-240 towards downtown Asheville. As you cross the French Broad River Bridge, merge into the far right-hand lane for exit 3B (Westgate and Resort Drive). Merge into the right lane as you pass the Westgate Shopping Center. The entrance to the hotel is on the right immediately as you round the curve in the road.

Traveling East on I-40

Take I-40 East. Follow the signs for I-240 East towards downtown Asheville. The exit is on the left. Merge into the left lane and take exit 3A, which merges onto Patton Avenue. At the 2nd traffic light, turn right onto Regent Park Boulevard (between Denny's and Pizza Hut). The road will bear to the right. The entrance to the hotel is on the left just before the entrance to the Sam's Club parking lot. Follow the road past the golf course to the main entrance of the hotel.

CHARLOTTE

Queens University of Charlotte

Traveling North from South Carolina

Take I-85 North. Exit onto I-77 North. Take Exit 6A (Woodlawn Road/Queens University of Charlotte). Cross South Boulevard and Park Road. Turn left onto Selwyn Avenue. Travel on Selwyn Avenue for approximately one mile. The campus is located on the left after the intersection of Wellesley Avenue with Selwyn Avenue.

Traveling South from Greensboro

Take I-85 South. Exit onto I-77 South. Take Exit 6A (Woodlawn Road/Queens University of Charlotte). Cross South Boulevard and Park Road. Turn left onto Selwyn Avenue. Travel on Selwyn Avenue for approximately one mile. The campus is located on the left after the intersection of Wellesley Avenue with Selwyn Avenue.

Traveling North or South on I-77

Take Exit 6A (Woodlawn Road/Queens University of Charlotte). Cross South Boulevard and Park Road. Turn left onto Selwyn Avenue. Travel on Selwyn Avenue for approximately one mile. The campus is located on the left after the intersection of Wellesley Avenue with Selwyn Avenue.

Traveling West from Monroe

Take US 74 West. Turn left onto Sharon Amity. Turn right on Providence. Turn left onto Queens Road. After the first stoplight, Queens Road becomes Selwyn Avenue. The campus is located on the right after the stoplight.

GREENVILLE

Hilton Greenville

Take US 64 East to US 264 East to Greenville. Turn right at the 2nd traffic light as you come into the city onto Allen Road/US Alternate 264. Travel approximately two miles. Allen Road becomes Greenville Boulevard/US Alternate 264. Follow Greenville Boulevard for 2½ miles. The Hilton Greenville is located on the right.

HICKORY

Park Inn Gateway Conference Center

Take I-40 to exit 123. Follow the signs to Highway 321 North. Take the first exit (Hickory exit) and follow the ramp to the traffic light. Turn right at the light onto US 70. The Gateway Conference Center is located on the right.

RALEIGH

Jane S. McKimmon Center – N.C. State University

Traveling East on I-40

Take I-40 to exit 295. Turn left at the bottom of the exit ramp onto Gorman Street. Travel approximately 2½ miles. The McKimmon Center is located on the right at the corner of Gorman Street and Western Boulevard.

Traveling West on I-40

Take I-40 to exit 295. Turn right at the bottom of the exit ramp onto Gorman Street. Travel approximately 2½ miles. The McKimmon Center is located on the right at the corner of Gorman Street and Western Boulevard.

WILMINGTON

Coastline Convention Center

Traveling East on I-40

Take I-40 East towards Wilmington. As you approach Wilmington, turn right onto MLK Parkway/NC 74 West/Downtown. Continue on this route towards downtown Wilmington. The road becomes Third Street. Follow Third Street for five blocks until you reach Red Cross Street. Turn right onto Red Cross Street and continue for two blocks. Turn right onto Nutt Street. The entrance to the Coastline Convention Center is the second driveway on the left.

Traveling South on US 17

As you approach Wilmington, US 17 becomes Market Street. Continue on Market Street until you see the sign for MLK Parkway/NC 74 West/Downtown. Take NC 74 West (MLK Parkway) towards downtown Wilmington (approximately four miles). Turn right onto Red Cross Street and continue for two blocks. Turn right onto Nutt Street. The entrance to the Coastline Convention Center is the second driveway on the left.

Traveling North on US 17 or NC 74/76

After crossing the Cape Fear Memorial Bridge into Wilmington, turn left at the first stoplight onto Third Street. Turn left onto Red Cross Street. At the bottom of the hill (approximately three blocks), turn right onto Nutt Street. The entrance to the Coastline Convention Center is the second driveway on the left.

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

Attention: All Providers**New Annual Visit Limit Legislated by the N.C. General Assembly**

On August 1, 2008, DMA implemented a new annual visit limitation for Medicaid recipients effective with dates of service July 1, 2007, and after. This change is the result of Session Law 2007-323.

The Code of Federal Regulations (CFR) defines the services that must be provided by each state Medicaid program. These services are mandatory services. Each state may decide which, if any, optional services, as defined by the CFR, will also be covered. The optional services that are covered by the N.C. Medicaid Program are optometry, chiropractic services, and podiatry.

According to CMS, a visit limit may not combine both mandatory and optional services.

Mandatory Services

Annual Visit Limit Period	Number of Visits	Provider Types Included in Visit Count
July 1 through June 30	22	<ol style="list-style-type: none"> 1. Physicians (except for physicians enrolled in N.C. Medicaid with a specialty of oncology, radiology, or nuclear medicine) 2. Nurse practitioners 3. Nurse midwives 4. Health departments 5. Rural health clinics 6. Federally qualified health centers

Optional Services

Annual Visit Limit Period	Number of Visits	Provider Types Included in Visit Count
July 1 through June 30	8	<ol style="list-style-type: none"> 1. Chiropractors 2. Optometrists 3. Podiatrists

CPT Procedure Codes Subject to the Annual Visit Count

DMA has designated specific CPT procedure codes that are counted towards the annual visit limitation. The codes will be reviewed on a regular basis and updated as appropriate. The list of CPT procedure codes subject to the visit count is available on DMA's website at <http://www.ncdhhs.gov/dma/AnnualVisitLimit.htm>.

ICD-9-CM Diagnosis Codes That Are Not Subject to the Annual Visit Limitation

DMA has designated specific ICD-9-CM diagnosis codes that do not count towards the annual visit limitation. The codes will be reviewed on a regular basis and updated as appropriate. The list of ICD-9-CM diagnosis codes that are not subject to the annual visit limitation is available on DMA's website at <http://www.ncdhhs.gov/dma/AnnualVisitLimit.htm>.

Recipients Who Are Not Subject to the Annual Visit Limitation

The following recipients are exempt from the annual visit limitation.

1. Recipients under the age of 21
2. Recipients enrolled in a Community Alternatives Program (CAP)
3. Pregnant recipients who are receiving prenatal and pregnancy-related services

Claim Denials

- For dates of service July 1, 2007, through June 30, 2008, providers may re-file denied claims as new claims. These claims may be paid as they process through the new criteria. If the claims deny again, providers may submit an adjustment as outlined in the next bullet.
- For dates of service July 1, 2008, and after, providers may submit a claim adjustment. A copy of the recipient's medical record documenting the medical need to actively manage a life-threatening disorder or as an alternative to more costly care options must be submitted with the adjustment. The adjustment request and supporting documentation will be reviewed for medical necessity by the Medical Director.
- For dates of service July 1, 2007, and after, ICD-9-CM diagnosis code V82.9 should not be used on claims or on adjustments to indicate the need for a medical override.

Requesting an Exemption

An exemption for the annual visit limitation may be requested by a physician if medically necessary treatment for a specific condition will require multiple office visits. The instructions and guidelines for this process are currently being developed. DMA will notify providers through the general Medicaid Bulletin when the process has been implemented.

Notification Process

In addition to the visit limit change, the law requires the N.C. Department of Health and Human Services (DHHS) to

- establish a visit limitation threshold that indicates that a recipient is nearing the total allowed visits
- implement a process of notification to the appropriate Community Care of North Carolina/Carolina ACCESS (CCNC/CA) network or primary care provider when a recipient reaches the visit limitation threshold

Effective August 1, 2008, DMA implemented a process to assist primary care providers in managing their patients' visits that count toward the annual mandatory visit limitation. The CCNC/CA network will be notified when a recipient has used 15 visits (in any combination) of the mandatory services listed above. CCNC/CA will then notify the recipient's primary care provider.

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

Attention: Pharmacists and Prescribers

Prior Authorization Program for Brand-Name Narcotics – Update

On August 4, 2008, the N.C. Medicaid Outpatient Pharmacy Program will implement a new prior authorization (PA) program for brand-name schedule II (CII) narcotics. Brand-name short-acting and long-acting CII narcotics will require PA. This PA program will replace the current Oxycontin PA program. PA will not be required for recipients with a diagnosis of pain secondary to cancer.

If a pharmacy provider receives a point-of-sale message that PA is required for one of these medications, the prescriber must fax ACS at 866-246-8507 to request PA for the medication. **PA requests for these medications will be accepted by facsimile (fax) only.** The signature of the prescriber on the request form will be required as an important safeguard against fraud and abuse. The PA criteria and request form for brand-name narcotics will be available on the N.C. Medicaid Enhanced Pharmacy Program website at <http://www.ncmedicaidpbm.com>. Providers may call ACS at 866-246-8505 with questions concerning the PA program.

Refer to the June 2008 and July 2008 general Medicaid Bulletins (<http://www.ncdhhs.gov/dma/bulletin.htm>) for additional information.

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

Attention: Durable Medical Equipment Providers

Annual Fee Schedule Changes

Effective with date of service August 1, 2008, durable medical equipment (DME) rates have changed based on the normal annual review.

For current pricing on all DME codes, refer to DMA's website at <http://www.ncdhhs.gov/dma/fee/fee.htm>.

Providers are reminded to bill their usual and customary rates for all billing. Do not automatically bill the established maximum reimbursement rate. Payment will be the lesser of either the billed usual and customary rate or the maximum reimbursement rate.

**Financial Management
DMA, 919-855-4200**

Attention: Adult Care Home Providers**Updated Prior Approval Process for Medicaid's Enhanced Rate for a Special Care Unit for Alzheimer's and Related Disorders**

Effective October 1, 2006, DMA implemented a prior approval process for adult care home (ACH) providers to receive an enhanced Medicaid reimbursement rate for operating Special Care Units for persons with Alzheimer's and related disorders (SCU–As). This enhanced rate does not include any provisions for special care units for recipients with mental health and related disorders, as noted in the Adult Care Home Rules (10A NCAC 13F.1400).

The following guidelines on requesting prior approval for the enhanced SCU–A rate supersede previously published guidelines.

1. ACH providers must obtain prior approval to qualify for the enhanced rate for the care of eligible recipients **if the potential resident**:
 - has a primary diagnosis of Alzheimer's or related disorders,
 - can benefit from the SCU–A program as described in 10A NCAC 13F.1300,
 - is not currently receiving hospice care, and
 - meets the diagnosis criteria documented below.
 - a. A documented primary diagnosis of Alzheimer's or related disorders, limited to those supported by the National Alzheimer's Association. Therefore, DMA no longer accepts a general diagnosis of "dementia." Only the primary diagnoses shown in the table below are acceptable to qualify for the enhanced rate.

Diagnosis	ICD-9-CM Code
Alzheimer's disease	331.0
Vascular dementia (multi-infarct dementia)	290.4
Jakob-Creutzfeldt disease	294.10
Pick's disease	331.11
Dementia with Lewy bodies	331.82
Paralysis agitans (Parkinson's disease)	332.0
Huntington's chorea	333.4

- b. If the resident also has a major psychiatric diagnosis, the physician must provide additional information indicating that the resident's psychiatric disorder is not active, that the resident is not a threat to other residents, and that the resident is suited for a unit such as that described in 10A NCAC 13F.1300 for fragile persons with a diagnosis of Alzheimer's disease. This documentation should be signed by the physician and written on his or her letterhead.
2. ACH providers in good standing who have a current ACH license with a SCU–A designation may apply for prior approval from Medicaid for the care of recipients who meet the diagnosis criteria listed above.
3. Providers must obtain prior approval from DMA **before** admitting a current resident of the ACH to an SCU–A bed.

4. Providers must obtain prior approval from DMA within 7 business days of admitting a new resident to the ACH to an SCU-A bed in order to receive the Medicaid SCU-A rate from the date of admission to that unit. Otherwise, if approved, prior approval will be effective the date the request was received by DMA.
5. Providers must send the following information with the request for prior approval. All information **must** be clear and legible.
 - a. **INITIAL CERTIFICATION**
 - Completed DMA SCU-A Prior Approval Request Form, with the accurate ACH Medicaid Provider Number and the recipient's Medicaid identification (MID) number, date of birth, and date of admission to the home indicated on the form.
 - Current FL-2 signed by a physician, with a primary diagnosis of Alzheimer's or one of the above-specified related disorders.
 - Copy of the completed Pre-Admission Screening that the home uses to evaluate the appropriateness of an individual's placement in the SCU-A as required by current Rule (10A NCAC 13F.1306).
 - Copy of the current individualized care plan that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. The care plan should specify programming that involves environmental, social, and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities as required by Rule (10A NCAC 13F.1307).
 - Copy of the provider's current ACH license with SCU-A designation.
 - Copy of the provider's current ACH SCU-A disclosure statement
 - b. **RECERTIFICATION**
 - Current FL-2 signed by a physician, with a primary diagnosis of Alzheimer's or one of the specified related disorders listed above.
 - Current individualized care plan that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. The care plan should specify programming that involves environmental, social, and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities as required by Rule (10A NCAC 13F.1307).
 - Copy of the provider's current ACH license with SCU-A designation.
6. Certification and recertification documents must be complete upon receipt at DMA. If documentation is incomplete or incorrect, the application will be denied.
7. If clarification is required, DMA will request additional information, and the approval date **may** be delayed. If the information is not received within 14 calendar days of the request for additional information, the resident's prior approval will be denied.
8. Once the prior approval request has been approved, DMA will notify the fiscal agent with the specific SCU-A effective date and end date. The end date is 1 year from the **date of the care plan** as submitted with the recipient's prior approval/recertification packet of information.
9. DMA will send an approval notification to the home indicating that the resident was approved and specifying the effective date and the end date of the approval. If prior approval is denied, notification will come from the fiscal agent.
10. Recertification is required annually. If the recertification/continued need review is not received by the end date, payment will stop.

11. In the event that the resident is discharged from the home due to death, a level of care change, or any other reason, the home must notify DMA by telephone and follow up by faxing the following information within 2 business days: the recipient's name, MID number, discharge date, and discharge destination. DMA will then notify the fiscal agent, as appropriate.
12. Providers send the requested information via U.S. Mail to
Division of Medical Assistance
Facility and Community Care Section, ACH Unit
1985 Umstead Drive
2501 Mail Service Center
Raleigh NC 27699-2501
13. **AS REQUIRED BY HIPAA REGULATIONS**, the completed form and information must be sealed in an envelope on which "CONFIDENTIAL" is written in red, and that envelope placed in another envelope and addressed. **DO NOT FAX** the original prior approval request or recertification information.
14. Only requested follow-up and/or discharge information may be faxed to DMA (919-715-2372). The fax should be addressed to the name of the individual at DMA who requested the follow-up or discharge information:

Attention:[Name], SCU-A Approval
15. The revised DMA SCU-A form and instructions are on the DMA website at <http://www.ncdhhs.gov/dma/formsprov.html#ach>.

**Tamara Derieux, Facility and Community Care
DMA, 919-855-4364**

**INSTRUCTIONS FOR COMPLETING THE
ADULT CARE HOME SCU-A PRIOR APPROVAL FORM**

1. Print this form in landscape orientation.
2. Print clearly.
3. All copies of items submitted must be legible.
4. The complete facility information is due only once per year according to the date on the care plan, or upon facility status change, or as otherwise needed.
5. AS REQUIRED BY HIPAA REGULATIONS, the completed form and information must be sealed in an envelope on which "CONFIDENTIAL" is written in red, and that envelope placed in another envelope and addressed. DMA will not accept faxed records.
6. Send the completed form via U.S. Mail to the following address:

Division of Medical Assistance
Facility and Community Care Section, ACH Unit
1985 Umstead Drive
2501 Mail Service Center
Raleigh NC 27699-2501
7. Direct questions to:
Tamara Derieux (1-919-855-4364) Tamara.Derieux@ncmail.net.
Linda Fisher, RN (1-919-855-4363) Linda.Fisher@ncmail.net

Must be mailed to:
N.C. Division of Medical Assistance
ACH Unit—Facility and Community Care
1985 Umstead Drive
2501 Mail Service Center
Raleigh, N.C. 27699-2501

North Carolina
Division of Medical Assistance
**SPECIAL CARE UNIT -A
PRIOR APPROVAL**



PRINT CLEARLY

ACH Name _____ Street Address _____ City/Town _____ County _____
 Telephone _____ E-Mail _____ DHSR License # _____ Total # ACH Beds _____
 ACH Provider # _____ # SCU-A Beds _____ Freestanding SCU-A Yes No Other Specialty Designation _____
 Resident Name _____ MID# _____ DOB: _____
 Date of Admission to SCU-A _____ New Admission to ACH Yes No Readmission to ACH Yes No
 Resident is currently receiving Enhanced ACH/PSC Yes No Case Manager _____ New Admission to SCU-A Yes No Readmission with change of condition Yes No
 Telephone: _____

The following information must be attached to this form for prior approval to be considered. (Submit only once a year according to the date on the care plan, or upon resident/facility status change, or as otherwise needed.)

A. Required Resident Information:

- ____ Current FL2 signed by a physician and showing a primary diagnosis of Alzheimer's and/or one of the following related disorders.
- Alzheimer's Disease 331.0 • Parkinson's Disease 332.0 • Creutzfeldt-Jakob Disease 294.10
- Multi-Infarct Dementia 290.4 • Huntington's Disease 333.4 • Pick's Disease 331.11
- Lewy Body Dementia 331.82

- ____ Pre-Admission Screening showing appropriateness for the recipient's placement in the SCU-A as required in 10A NCAC 13F.1306(2)
- ____ Copy of Care/Service Plan as required by policy as described in 10A NCAC 13F.1307

B. Required Facility Information:

- ____ SCU-A Disclosure Statement policy as described in 10A NCAC 13F.1306(3)
- ____ Current ACH License showing SCU-A designation as described in 10A NCAC 13F.1307

I certify that the above and attached information is correct and accurately represents the identified resident and the SCU-A program.

Signature of Administrator _____ Print Name Clearly _____ Date _____
 Revised 08/01/08

Attention: Behavioral Health Providers and Local Management Entities

Rate Update on 2008 CPT Codes for Behavioral Health Specialties

Effective with dates of service beginning July 1, 2008, rates for the 2008 CPT codes were revised for the behavioral health specialties listed below based on information from CMS.

- Licensed Psychologist
- Licensed Clinical Social Worker
- Licensed Professional Counselor
- Licensed Marriage and Family Therapist
- Certified Clinical Nurse Specialist
- Certified Nurse Practitioner
- Local Management Entity
- Licensed Psychologist Associate
- Certified Clinical Supervisor
- Licensed Clinical Addictions Specialist

Effective August 1, 2008, revised behavioral health fee schedules are available on the DMA website at <http://www.ncdhhs.gov/dma/fee/mhfee.htm> or providers may receive a current fee schedule by completing and submitting a copy of the Fee Schedule Request form (<http://www.ncdhhs.gov/dma/formsprov.html>).

Providers must always bill their usual and customary charges.

Financial Management
DMA, 919-855-4200

Attention: Anesthesiologists and Certified Registered Nurse Anesthetists

Anesthesia Base Units

Anesthesia base units are now posted on DMA's website at <http://www.ncdhhs.gov/dma/fee/fee.htm>.

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

Attention: Dialysis Providers**Dialysis Termination Dates**

Recipients who have had an acute illness involving the renal system, or receive successful kidney transplants that result in the return of normal renal function may no longer require continued dialysis treatments. It is imperative that providers notify EDS with the STOP date when dialysis treatments are terminated so the date of the last dialysis treatment can be entered in the dialysis file for the recipient. Services normally rendered to dialysis recipients such as physician visits, some laboratory tests, and medical supplies will be denied as included in the composite rate if the dialysis STOP date is not in the file.

To notify EDS, providers should send a completed Medicaid Resolution Inquiry Form (<http://www.ncdhhs.gov/dma/formsprov.html>) with the following information in the “specify reason for inquiry request” section:

- A statement that dialysis has been terminated.
- The actual dialysis STOP date.
- The reason for discontinuation of the dialysis treatments.

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

Attention: Hospitals**Billing of Self-administered Drugs Using Revenue Code 637 – Update**

The following article from the July 2008 general Medicaid Bulletin is being updated with additional information to clarify that this guideline is for providers in an outpatient hospital setting.

Billing of Revenue Code 637 (Pharmacy self-administratable drugs per *UB-04 Manual*) will be allowed effective with date of processing July 1, 2008, for any outpatient hospital claims submitted with dates of service on or after December 28, 2007. Charges should be listed as non-covered when using Revenue Code 637. Revenue Code 637 does not require HCPCS codes or National Drug Code (NDC) information to be included on the detail. Charges billed with Revenue Code 637 will not be considered when calculating hospital cost payments, cost settlements, or DSH payments. Charges billed with Revenue Code 637 can be listed as patient liability using Value Code 31.

To determine drug coverage under N.C. Medicaid, refer to Clinical Coverage Policy #9, *Outpatient Pharmacy Program*, and Clinical Coverage Policy # A-2, *Over-the-Counter Medications*, (<http://www.ncdhhs.gov/dma/pharmacy.htm>). If the drug is covered, it can be billed using Revenue Code 25X with a HCPCS code and NDC information. Non-covered over-the-counter drugs can be billed using Revenue Code 637.

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

Attention: Health Departments, Medical Diagnostic Clinics, Nurse Midwives, Nurse Practitioners, Outpatient Hospital Clinics, and Physicians

Childbirth Education Policy Revision

Effective with date of service January 1, 2008, Clinical Coverage Policy #1M-2, *Childbirth Education*, has been revised to incorporate the following changes:

- Coverage of childbirth education classes has increased from 8 hours to 10 hours per a 270-day period.
- Units of service have changed from 1 unit = 2 hours to 1 unit = 1 hour for HCPCS code S9442. Unit reimbursement has changed as outlined in the following table:

	Unit of Service/Hours	Reimbursement Rate
Previous Policy	1 unit = 2 hours	\$19.09 per unit
Amended Policy	1 unit = 1 hour	\$9.55 per unit

- Course content requirements for recipients have expanded to include additional topics as well as more in-depth information relative to childbirth.
- Provider agencies are required to employ childbirth educators who are certified by a nationally recognized organization for childbirth education or provide verification that state-approved childbirth education program requirements have been met. All current and future providers will be required to submit a letter of attestation to DMA Provider Services confirming compliance with this condition. For current providers, the deadline to submit the attestation is March 1 2009. A copy of this letter and staff certification copies must be maintained on-site for inspection and auditing by DMA and the Division of Public Health.

Providers can obtain a copy of the policy from DMA's website at <http://www.ncdhhs.gov/dma/babylove.html>.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: Hospitals**Clarification to the Outpatient Hospital Claim Processing Guidelines for National Drug Codes**

Effective with date of processing July 1, 2008, for dates of service on or after December 28, 2007, all **outpatient hospital** claims for pharmacy services must have National Drug Code (NDC) information. The tables below are a reference for **outpatient hospital** providers to use when determining HCPCS code and NDC claim requirements. **Outpatient hospital** providers have different claim filing guidelines and pricing logic than providers who file claims through the Physician Drug Program. The Physician Drug Program Fee Schedule should not be used by **outpatient hospital** providers to determine HCPCS and NDC requirements.

Table 1: Outpatient Hospital Pharmacy Claims Billing Guidelines

Revenue Code	Revenue Code Description	Covered Service	Require HCPCS Code?	Require NDC and NDC Units?
250	Pharmacy – General Classification	Yes	Yes	Yes
251	Pharmacy – Generic Drugs	Yes	Yes	Yes
252	Pharmacy – Non-Generic Drugs	Yes	Yes	Yes
253	Pharmacy – Take Home Drugs	No	No	No
254	Pharmacy – Drugs Incident to other Diagnostic Services	Yes **	Yes	Yes
255	Pharmacy – Drugs Incident to Radiology	Yes	Yes *	Yes *
256	Pharmacy – Experimental Drugs	No	No	No
257	Pharmacy – Non-Prescription	No	Yes	Yes
258	Pharmacy – IV Solutions	Yes	Yes	Yes
259	Pharmacy – Other Pharmacy	Yes	Yes	Yes
630	Pharmacy Extension of 25X – Reserved	No	No	No
631	Pharmacy Extension of 25X – Single Source Drug	No	No	No
632	Pharmacy Extension of 25X – Multiple Source Drugs	No	No	No
633	Pharmacy Extension of 25X – Restrictive Prescription	No	No	No
634	Pharmacy Extension of 25X – Erythropoietin (EPO) < 10,000 Units	Yes	Yes	Yes
635	Pharmacy Extension of 25X – Erythropoietin (EPO) ≥ 10,000 Units	Yes	Yes	Yes
636	Pharmacy Extension of 25X – Drugs Requiring Detailed Coding	Yes	Yes	Yes
637	Pharmacy Extension of 25X – Self-Administratable	No	No	No
638	Pharmacy Extension of 25X – Reserved	No	No	No
639	Pharmacy Extension of 25X – Reserved	No	No	No

* See table 2 for list of HCPCS codes that will require NDC and NDC units for payment.

** This revenue code was previously non-covered. N.C. Medicaid covers items billed under this revenue code as of date of service July 1, 2008.

Table 2: HCPCS Codes That Require NDC and NDC Units When Billed Under RC 255

A9517	A9530	A9543
A9545	A9563	A9564
A9600	A9605	A9699

Note: This table will be updated as needed. Providers will be notified of changes through the general Medicaid bulletins.

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

Attention: Nurse Practitioners and Physicians

Abatacept, 250mg (Orencia, HCPCS Procedure Code J0129) – Billing Guidelines

Effective with date of service April 10, 2008, the N.C. Medicaid program added the FDA-approved diagnosis codes 714.2 (Rheumatoid arthritis, other) and 714.30 through 714.32 (Juvenile rheumatoid arthritis) to the list of required diagnoses for abatacept (Orencia) when billed through the Physician's Drug Program with HCPCS procedure code J0129.

For Medicaid Billing

One of the following ICD-9-CM diagnosis codes is required for billing Orencia:

- **714.0** (Rheumatoid arthritis)
- **714.2** (Other rheumatoid arthritis with visceral or systemic involvement)
- **714.30** (Polyarticular juvenile rheumatoid arthritis, chronic or unspecified)
- **714.31** (Polyarticular juvenile rheumatoid arthritis, acute)
- **714.32** (Pauciarticular juvenile rheumatoid arthritis)

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

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

Attention: Nurse Practitioners and Physicians**Certolizumab Pegol (Cimzia, HCPCS Procedure Code J3590) – Billing Guidelines**

Effective with date of service April 1, 2008, the N.C. Medicaid program covers certolizumab pegol, 200 mg powder, for solution kits (Cimzia) for recipients ages 18 years and older for use in the Physician's Drug Program when billed with HCPCS procedure code J3590 (Unclassified biologics). Cimzia is indicated for treatment of moderately to severely active Crohn's disease in adult patients who have inadequate response to conventional therapy.

Each kit contains two 200-mg vials of certolizumab pegol powder, sterile water for reconstitution, syringes, needles, and alcohol swabs.

Treatment should be initiated with a 400-mg dose and repeated 2 to 4 weeks after the initial dose. Maintenance doses of 400 mg should be given every 4 weeks. Each 400-mg dose should be administered as two subcutaneous injections of 200 mg each.

For Medicaid Billing

- Cimzia is covered for recipients ages 18 years and older.
- One of the following ICD-9-CM diagnosis codes for Crohn's disease is required for billing Cimzia: **555.0 through 555.9**.
- Providers should bill Cimzia with HCPCS procedure code J3590 (Unclassified biologics).
- One Medicaid unit of coverage is one reconstituted 200-mg vial.
- An invoice is not required.
- For dates of service on and after December 28, 2007, providers must bill with the 11-digit National Drug Code (NDC) and the NDC units (quantity) must be indicated on the claim. Refer to the revised version (5/20/08) of the October 2007 Special Bulletin, *National Drug Code Implementation* (<http://www.ncdhhs.gov/dma/bulletinspecial.htm>), for instructions.
- When billing on paper, providers must indicate the number of units used in block 24G on the CMS-1500 claim form.
- Providers must bill their usual and customary charge.

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

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

Attention: Nurse Practitioners and Physicians

Ixabepilone Kit for Injection (Ixempra) - Billing Guideline Corrections

Effective with date of service October 1, 2007, the N.C. Medicaid program began covering Ixempra (15-mg and 45-mg single-use vials) for the diagnosis of breast cancer when billed with HCPCS procedure code J3490 (Unclassified drug). The billing guidelines published in the April 2008 general Medicaid bulletin listed ICD-9-CM diagnosis codes 175.0 through 175.9 and V58.11 as required diagnosis codes when billing for Ixempra. **The correct diagnosis codes are 174.0 through 175.9 and V58.11.** Providers with claims that were denied for dates of service October 1, 2007, and after, when billed with diagnosis codes 174.0 through 174.9 may refile the charges as a new claim.

The billing guidelines also indicated that Ixempra should be billed with HCPCS procedure code J3490. However, effective with date of service August 1, 2008, Ixempra should be billed with HCPCS procedure code J9999 (NOC, antineoplastic drug). Claims billed with HCPCS procedure code J3490 for dates of service August 1, 2008, and after, will be denied.

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

Attention: Optical Service Providers

Procedure Change for Eyeglasses That Cannot Be Dispensed

When a recipient fails to respond to verbal and written communications advising that eyeglasses are ready for dispensing, the provider is no longer required to send the eyeglasses with the claim for reimbursement of the dispensing fee. Providers may submit the claim within one year of the EDS approval date and retain the undelivered eyeglasses. For recipients under the age of 21, the provider must retain the eyeglasses for one year from the EDS approval date. For recipients ages 21 and over, the provider must retain the eyeglasses for two years from the EDS approval date.

If a recipient returns to pick up the eyeglasses during this retention period and the provider is unable to produce the eyeglasses for dispensing, the provider will be responsible for making an identical pair of eyeglasses for the recipient at the provider's expense. At the end of the retention period, the provider may dispose of the eyeglasses. This may include using the frame for replacement parts, donating the eyeglasses to the Lions Club, adding the frame to the provider's Medicaid fitting kit, etc.

As a reminder, the fitting and dispensing service is not complete until the eyeglasses are dispensed to the recipient. Therefore, providers must not bill for the dispensing fee until the eyeglasses have been dispensed to the recipient. Only when the provider has documented the attempts to contact the recipient, with the last attempt being in writing, can the provider bill for eyeglasses that were not able to be dispensed. Documentation of attempts to contact the recipient must be maintained with the recipient's records.

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

Attention: Personal Care Service Providers

Personal Care Services Provider Training Sessions

The Carolinas Center for Medical Excellence (CCME; <http://www2.thecarolinascenter.org/ccme/>) announces continued provider training for Personal Care Services (PCS) as approved by DMA.

The 3rd calendar quarter training sessions (PCS Provider Training Session IX) of 2008 are scheduled for September 2008. The training is recommended for registered nurses, agency administrators, and agency owners who have a working knowledge of the PCS program and applicable DMA policies. The training allows CCME to offer 4.25 Continuing Nursing Education (CNE) contact hours to all nurses at no cost to the participants.

Pre-registration is required and space is limited to 150 participants at each session. Registration will be provided online or by fax. Dates and locations will be posted on CCME's website.

To register online, visit CCME's website and click on the appropriate link in Upcoming Events. When you have completed the online registration, you will receive a computer-generated number to confirm your registration. Bring the number with you to the session.

To register by fax, complete the form following this announcement and fax it to the attention of Alisha Brister at 919-380-9457. A member of the PCS team will contact you with a registration number, which you should bring with you to the session.

If you need to **cancel** at any time, please contact Alisha Brister (919-380-9860, x2018) to allow others to register. Please e-mail Alisha Brister at CCME (abrister@thecarolinascenter.org) for further information on registering.

Sign-in will start at 8:00 a.m. at each location. The presentations will begin at 9:00 a.m. and run through 1:30 p.m., with one or two 15-minute breaks. Please plan ahead for the late lunch hour, as coffee, hot tea, and water will be the only refreshments provided. **Considering the variability in meeting room temperature, please dress in layers to ensure your personal comfort.**

CCME, 919-380-9860



The Carolinas Center *for* Medical Excellence

**CCME PCS Provider Training Session 9
September 2008
Registration Form**

Location requested: _____ Location Date: _____

First Name: _____

Last Name: _____

Credentials: _____

Position: _____

Organization: _____

Facility: _____

Address: _____

City: _____, NC Zip: _____

County: _____

UPIN/Provider #: _____

Phone #: _____ Ext: _____

Fax #: _____

Email: _____

Referred by/How did you hear about this event?

May we send you e-mail updates on new information, features, and tools on the CCME web site?
please check: Yes No

**Please fax completed form to the attention of
Alisha Brister at 919-380-9457**

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

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

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

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

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

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

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

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

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

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

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

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

Proposed Clinical Coverage Policies

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


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

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


2008 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
August	08/07/08	08/12/08
	08/14/08	08/19/08
	08/21/08	08/28/08
September	09/04/08	09/09/08
	09/11/08	09/16/08
	09/18/08	09/25/08

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



William W. Lawrence, Jr. M.D.
 Acting Director
 Division of Medical Assistance
 Department of Health and Human Services



Melissa Robison
 Executive Director
 EDS