August 2009 Medicaid Bulletin

Attention: All Providers

Web-based Provider Enrollment Applications Available Online Beginning August 31, 2009

CSC is pleased to announce that on August 31, 2009, providers will have the option to enroll online in the Medicaid and Community Care of North Carolina/Carolina ACCESS (CCNC/CA) programs. Providers may use the online applications to enroll, re-enroll, report a change of ownership, report a change of group name/tax name, report a change in tax number or to add services.

We are optimistic that the interactive web application will reduce the number of incomplete applications currently being received by the State. In addition, the following enhancements have been added to the current applications:

- When completing an Individual or Organization Provider Enrollment Application, applicants can simultaneously enroll as a Primary Care Provider (PCP) in the DHHS Community Care of North Carolina/Carolina ACCESS (CCNC/CA) program if the applicant's provider type qualifies the provider to participate.
- A help feature is available on each screen to assist applicants with completing the online application.
- Once an applicant has completed minimal required information, a Reference ID number will be generated. The applicant must retain this Reference ID number to retrieve and complete a saved application. Applications must be retrieved within 90 calendar days.

At the end of the online enrollment application process, the applicant will have the option to print a copy of the submitted application for future reference.

Applicants who use the online application must submit supporting hard-copy documentation to CSC. The applicant will be given instructions for mailing the supporting documentation. Until the supporting documentation (with original signatures) is received, the application is not considered complete.

We encourage applicants to use the online application process. However, applicants who choose not to enroll online will have the option to download an application in Adobe Acrobat PDF format and mail the completed application and supporting documentation to CSC. Please note that any application received after October 1, 2009, must be submitted using the new web-based application or the downloaded Adobe Acrobat version of the new application. Previous versions of the Provider Enrollment Packets will not be accepted after October 1, 2009.

Applicants with questions regarding the completion of the online application should contact the CSC EVC Center by phone (866-844-1113), fax (866-844-1382), or e-mail (NCMedicaid@csc.com).

CSC, 1-866-844-1113

Attention: All Providers

D MA Budget Initiative Web Page

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

Provider Services
DMA, 919-855-4050

Attention: All Providers

Electronic Claim Submission Exceptions

The list of exceptions (originally published in the July 2009 Medicaid Bulletin) to the proposed requirement for electronic claim submissions is available on DMA's website at http://www.ncdhhs.gov/dma/provider/ECSExceptions.htm. Providers should be aware that as budget initiatives are revised, the list of exceptions may also change. Please refer to exceptions list frequently to stay up to date on the electronic claim submission initiative and the exceptions.

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

Attention: All Providers

Notice of Possible Legislative Mandate for Uniform Screening Program Tool for PASARR Screenings

The N.C. Legislature has indicated that they might mandate the use of the Uniform Screening Program by all providers who are required to conduct a Preadmission Screening and Annual Resident Review (PASARR) before admitting individuals to North Carolina nursing facilities. If this legislative mandate is enacted, all facilities submitting PASARR screenings will need to begin using the PASARR component of the Medicaid Uniform Screening Tool (MUST).

Information on the MUST application, helpful hints, and tutorials to assist you in registering for and getting started using the MUST are available on the NC MUST website at http://www.ncmust.com/. Providers will be informed of training options if and when they become available.

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

Attention: All Providers

CPT Procedure Code 89049

According to MLN Matters (MM5113), CMS Manual System Transmittal 984, Change Request #5113, a CLIA number is not needed on claims billed with CPT procedure code 89049 (caffeine halothane contracture test [CHCT)] for malignant hyperthermia susceptibility, including interpretation and report). Providers who received denials with EOB 0024 (Procedure code, procedure/modifier combination or revenue code is missing, invalid or invalid for this bill type. Correct and rebill denied detail as a new claim) or with EOB 1204 (CLIA number is either incorrect/missing from the claim or you have billed a test/dos outside your CLIA certification), may resubmit the denied charges as new claims (not as adjustment requests) for processing for dates of service within the established time limits for filing claims.

EDS, 1-800-688-6696 or 919-855-8888

Attention: All Providers

Notice of Medicaid Identification Card Changes

Upon approval of the State budget, the N.C. Medicaid Program will begin issuance of one Medicaid identification (MID) card per year to each recipient. The effective date of this change may be as early as September 8, 2009. The annual cards will be printed on gray card stock; DMA will no longer have blue, pink, green, and buff-colored MID cards. The cards will include the individual's name, MID number, and CCNC/CA primary care provider information (if applicable).

This change means that the MID card will no longer serve as proof of recipient eligibility. At each visit, providers must verify the cardholder's:

- Identity (if an adult)

- Current eligibility

- Medicaid benefit category

- CCNC/CA primary care provider information

- Other insurance information

However, once eligibility has been verified during a particular month, the provider may assume that the cardholder's identity, eligibility, PCP and other insurance information remains valid for the remainder of that month.

To verify eligibility, a provider can choose to use the "real-time" Eligibility Verification System (EVS) to submit and receive the HIPAA 270/271 transactions through an approved Value Added Network (VAN), use the batch EVS to submit and receive the HIPAA 270/271, or call the EDS Automated Voice Response (AVR) system at 800-723-4337.

For additional information on health eligibility benefits inquiries and responses, refer to the article titled *Recipient Eligibility Benefit Inquiry and Response* on page 10. For information regarding real-time and batch eligibility, contact the EDS Electronic Commerce Services (ECS) unit at 1-800-688-6696 (option 1). Information about the AVR system is available in the July 2001 Special Bulletin, *Automated Voice Response (AVR) System Provider Inquiry Instructions*, which can be accessed at http://www.ncdhhs.gov/dma/bulletin/.

The methods listed above will not only serve to verify eligibility, but also to inform the provider as to whether the recipient is entitled to any special services, such as the Program of All-inclusive Care for the Elderly (PACE) or the Community Alternatives Program (CAP), or is enrolled in a restrictive program, such as Family Planning Waiver or Medicaid for Pregnant Women. Recipients enrolled in PACE receive their medical care exclusively through the PACE organization. When using the AVR system, it is therefore important that providers listen to the entire recorded message and follow prompts as directed or important parts of eligibility information may be missed.

An exception to the one-card-per-year rule will be made for those managed care recipients who change their primary care physician and for those recipients who legally change their name. Recipients will also be able to ask the county department of social services to submit requests for replacement cards, if needed.

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ANNUAL MEDICAID IDENTIFICATION CARD

N.C. DEPT. OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE

RECIPIENT I.D.	RECIPIENT NAME	ISSUE DATE
000-00-0000-N	JONNXXXXX Q. PUBLIC	JULY 1, 2009

CASEHEAD NAME
CASEHEAD ADDRESS LINE 1
CASEHEAD ADDRESS LINE 2
CASEHEAD ADDRESS LINE 3
CASEHEAD ADDRESS LINE 4
CASEHEAD ADDRESS LINE 5

PRIMARY CARE PROVIDER NAME
PRIMARY CARE PROVIDER ADDRESS LINE 1
PRIMARY CARE PROVIDER ADDRESS LINE 2
PRIMARY CARE PHONE NO. AND AFTER HOURS NO.

FOLD HERE

Recipient Signature_____
(Not valid unless signed)
USE OF THIS CARD BY ANYONE NOT LISTED ON THE CARD IS FRAUD
AND IS PUNISHABLE BY A FINE, IMPRISONMENT OR BOTH

For questions about your Medicaid coverage and/or to report Medicaid Fraud, Waste or Program Abuse , please contact CARE-LINE at 1-800-662-7030 or locally call 919-855-4400.

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NOTICE TO PROVIDERS

The Medicaid Identification card is not proof of Medicaid eligibility. It is the responsibility of the medical provider to verify the identity of the individual, if the individual is eligible for Medicaid covered services, and the primary care physician with whom the recipient is enrolled. The Automated Voice Response (AVR) system (800-723-4337) allows enrolled providers to readily access detailed information on Medicaid eligibility using a touch-tone telephone.

Eligible Provider: A provider must be enrolled in the NC Medicaid program to be paid for services rendered to NC Medicaid recipients. If not enrolled, go to www.nctracks.nc.gov to find enrollment information and forms or call the CSC Enrollment Verification and Credentialing (EVC) Center at 1-866-844-1113.

DMA-5005A (Rev. 08/09) Yearly

FOLD HERE

Prior Approval: Some Medicaid services must be approved in advance. Refer to the Basic Medicaid Billing Guide at http://www.ncdhhs.gov/dma/basicmed/index.htm for prior approval requirements. Changes are published the first of each month in Medicaid Provider bulletins http://www.ncdhhs.gov/dma/bulletin/index.htm Out of state providers must obtain approval prior to delivering Medicaid services unless there is a medical emergency. In cases of medical emergency, out of state providers must notify North Carolina Medicaid within 72 hours.

Claim Filing: Bill other insurance first; Medicaid is last payor. Medicaid payment is full payment even if charges exceed the payment. Refer to the Medicaid Billing Guide for additional information regarding claim filing.

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Medicaid Eligibility Unit
DMA, 919-855-4000

Attention: All Providers

Mailing Correspondence and Inquiries

When sending forms or correspondence to N.C. Medicaid (DMA, EDS, CSC, ValueOptions, etc.), providers must ensure that the forms have been completed in full and that appropriate documentation has been included with the form. Incomplete forms or forms that are not submitted with appropriate documentation may result in delayed processing or may result in the form being returned to the sender. Refer to the guidelines below for additional information.

Medicaid Adjustment Request Form

The **Medicaid Claim Adjustment Request Form** is used to adjust a previously paid claim or a denied claim. When submitting an adjustment request, always attach a copy of any Remittance and Status Reports (RAs) related to the adjustment. If applicable, also include medical records that could justify the reason for paying a previously denied claim. It is suggested that providers include a corrected claim when submitting an adjustment, but it is not required if the claim was filed electronically. Please refer to Section 8 of the *Basic Medicaid Billing Guide* for instructions on completing the form and additional information on the claim adjustment process.

Note: Adjustments may also be transmitted electronically through the "void" and/or "replacement" HIPAA transactions. Although adjustments may be filed electronically, providers are advised to file adjustments on paper when paper documentation is required.

Medicaid Resolution Inquiry

The **Medicaid Resolution Inquiry Form** is used to submit claims for time limit overrides, Medicare overrides, third-party overrides, capitated payments, or CMS-1500 claim forms for Medicare HMO (Part C) services.

When submitting an inquiry request, always attach the claim and a copy of any paper RAs related to the inquiry request, as well as any other information related to the claim. **(Provider-generated RAs or electronic RAs are not acceptable.)** Each inquiry request requires a separate form and copies of documentation (vouchers and attachments). Refer to Section 5 of the *Basic Medicaid Billing Guide* for information on Medicare HMO claims and to Section 8 for instructions on completing the inquiry form.

Health Insurance Information Referral (DMA-2057)

If an insurance company or other third-party payer terminates coverage, providers can complete a **Health Insurance Information Referral Form** (DMA-2057) and attach a copy of the written denial. Send the form, denial, and the claim to DMA's Third-Party Recovery (TPR) section at the address shown on the form.

Please refer to the examples below of appropriate documentation for any of the commonly used Medicaid forms

- EDS-generated RAs
- Letter or EOB directly from a third-party insurance company
- Blue E print-outs (only for N.C. based plans)

Please refer to the examples below of inappropriate documentation for any of the commonly used Medicaid forms

- Screen shots of a provider's software
- Provider-generated RAs
- Electronic RAs
- Vendor or clearinghouse carrier reports

The *Basic Medicaid Billing Guide* is available on DMA's website at http://www.ncdhhs.gov/dma/basicmed/; forms are available at http://www.ncdhhs.gov/dma/provider/forms.htm.

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/:

- 1E-5, Obstetrics
- 9, Outpatient Pharmacy Program

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

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

Electronic Medicare Overrides

When a claim is denied by Medicare, providers may file the claim to Medicaid and request a Medicare override. Professional claim (837P/CMS-1500) billers are able to request a Medicare override through various methods:

NCECSWeb Tool

If a denial is received by Medicare, providers are able to utilize the radio button on the Claims Entry screen labeled "Paperwork on file at provider site for Medicare override" when applicable. Providers may refer to the July 2007 Special Bulletin, *NCECSWeb Instruction Guide,* for detailed information on the NCECSWeb Tool.

Vendor, Clearinghouse or Private Software

If a denial is received by Medicare, providers are able to utilize the 837 professional transaction using the instructions outlined in the PWK segment of the companion guide in the 2300 loop.

With cost saving and efficiency methods in effect, providers are encouraged to submit all claims electronically. If an electronic method to submit a Medicare override request is not available, providers are able to submit utilizing the Medicaid Resolution Inquiry Form on DMA's website at http://www.ncdhhs.gov/dma/provider/forms.htm.

Note: The above instructions do not apply to Medicare HMO (Part C services) and capitated plans.

Condition Codes

Institutional claim (837I/UB04) billers are also able to request a Medicare override through various methods. Providers may utilize the condition codes D7 and D9 on the claim. D7 is utilized to override Medicare Part A and D9 is utilized to override Medicare Part B, when applicable.

Refer to Section 5 of the *Basic Medicaid Billing Guide* (http://www.ncdhhs.gov/dma/basicmed/) for additional information on Medicare crossover claims.

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

Attention: All Providers

Billing with the North Carolina Electronic Claims Submission Web Tool

NCECSWeb is an online N.C. Medicaid claim submission tool available to providers at no cost. To obtain access to NCECSWeb, providers may call the Electronic Commerce Services (ECS) unit at 1-800-688-6696 or 919-851-8888, menu option 1, to obtain a submitter ID and password. Providers will receive their ID and password via the mail. Providers must have an Electronic Claims Submission Agreement on file, and receive a submitter ID and password, before submitting claims using NCECSWeb. Claims submitted before the electronic cut-off date (the Thursday before the checkwrite) will process on the following checkwrite.

NCECSWeb can also be used to submit electronic adjustments. The original claim does not have to have been submitted using NCECSWeb in order to be adjusted electronically. The two types of electronic adjustments are void and replacement. A void claim is a total recoupment. A replacement claim recoups the original claim and processes a new claim in its place. NCECSWeb can be used only to bill claims to N.C. Medicaid.

Providers may refer to the July 2007 Special Bulletin, *NCECSWeb Instruction Guide,* for detailed information on the NCECSWeb Tool. EDS also offers onsite NCECSWeb training to providers. To schedule training, please call Provider Services at 1-800-688-6696 or 919-851-8888, option 3. Providers should already have their submitter ID and password before requesting training. High-speed Internet access is strongly recommended.

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

Attention: All Providers

Services That Cannot Be Reimbursed By the N.C. Medicaid Program

In accordance with federal or state regulations or Medicaid policy, the N.C. Medicaid Program cannot reimburse for certain drugs or services. The following drugs and services cannot be reimbursed by Medicaid:

1. Erectile dysfunction drugs, such as Viagra, Cialis, etc. [42 USC 1396 r-8(d)]
2. Abortifacients (such as RU-486) unless an abortion review has been done **PRIOR** to the dispensing of this type of drug (42CFR441.200; 42CFR441.203; 42CFR441.206; 42CFR457.475)
3. Infertility drugs or services [42 UCS 1396 r-8 (d)]
4. Non-rebatable drugs or biologics [42 USC 1396 r-8 (a)]

     On rare occasions, DMA may reimburse for a drug that is non-rebatable. Once a rebatable National Drug Code (NDC) is created for the drug, however, DMA will no longer reimburse for the non-rebatable NDCs and providers must use the rebatable NDCs.

     Effective with date of service November 1, 2008, claims for non-rebatable baclofen NDCs will be denied.
5. Any drug or service that is experimental (10 NCAC 22O .0301), investigational or has been dispensed or performed solely for cosmetic purposes (42 USC 1396 r-8)

Except in the situation described above for the reimbursement of claims for baclofen, any claim submitted for reimbursement for any of the drugs or services listed above is subject to denial and/or recoupment.

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

Attention: All Providers

Medical Care Decisions and Advance Directives

Individuals who are 18 years and older, and are able to communicate and make health care decisions, have the right to make decisions about their medical and mental health treatment. The Medical Care Decisions and Advance Directive brochure outlines the steps that an individual can take to control decisions about their medical and mental health treatment should they become unable to make or express those decisions on their own.

DMA has recently updated the brochure. It can be downloaded from our website at http://www.ncdhhs.gov/dma/medicaid/rights.htm. Please share a copy of the brochure with your patients or direct them to the website for a copy of the brochure.

Director's Office
DMA, 919-855-4100

Attention: All Providers

Prior Authorization for Non-emergency Radiology Procedures

The N.C. Medicaid Program is planning to implement, effective with date of service September 1, 2009, a prior authorization process for certain radiology procedures including computed tomography (CT), magnetic resonance (MR), positron emission tomography (PET) scans, and ultrasounds. A policy will be posted on the DMA website at http://www.ncdhhs.gov/dma/services/radiology.htm prior to implementation.

MedSolutions, a National Committee for Quality Assurance-certified company based in Nashville, Tennessee, will be administering this program. Claims on authorized studies will continue to be processed by EDS. Please verify final implementation dates, which will be posted on DMA's website, before requesting authorizations for Medicaid recipients.

MedSolutions will accept authorization requests by web, phone, and fax. To familiarize yourself with MedSolutions, please visit http://www.medsolutionsonline.com. Among the many online tools and services available, providers may also register for prior authorization services and view MedSolutions' imaging guidelines. Targeted informational training sessions will be made available to providers throughout the month of August. Check your mailboxes for MedSolutions' invitation.

Inpatient, emergency department, and emergent procedures are excluded from this program.

Practitioner and Clinic Services
DMA, 919-855-4320

Attention: All Providers

County of Residence for Adults in a Private-living Situation with Medicaid for the Aged, Blind or Disabled

Effective August 1, 2009, the county of residence for adult Medicaid (ABD/MQB) recipients in a private-living situation is the county in which the recipient actually lives. Recipients whose current Medicaid county of residence is not correct under the new policy will be transferred to the correct county of residence at redetermination.

Medicaid Eligibility Unit
DMA, 919-855-4000

Attention: All Providers

Recipient Eligibility Benefit Inquiry and Response

As a cost-saving measure and to increase efficiency, the N.C. Medicaid Program may begin issuance of no more than one Medicaid identification (MID) card per year to each recipient. If implemented, this change would mean that the MID card will no longer serve as proof of recipient eligibility. This article outlines the various electronic methods available for providers to verify eligibility.

Real Time Eligibility Verification (270/271 Transaction)

Providers may choose to process a real-time electronic eligibility inquiry transaction for a single Medicaid recipient through the Eligibility Verification System (EVS). Real-time transactions are only supported through Value Added Networks (VANs) with whom EDS and the DMA have agreements. There is a charge from EDS to the provider of $0.08 per transaction and applicable contract charges by the provider's VAN may also apply. This inquiry transaction is defined as an eligibility benefits inquiry, known as a 270 real-time transaction. The 271 transaction provides the electronic response to this request. Providers who are interested in utilizing the real-time 270/271 electronic transactions may refer to Section 10 of the *Basic Medicaid Billing Guide* for information on contacting an approved VAN.

Batch Eligibility Verification (270/271 Transaction)

The 270/271 transaction set is also available in batch mode, allowing trading partners to submit multiple eligibility requests for multiple recipients. Trading partners can submit batch transactions using an approved vendor-created software program directly to EDS without using a VAN. There is no charge from EDS to submit batch 270/271 transactions. Providers and software vendors may refer to the HIPAA Companion Guide (on DMA's website at http://www.ncdhhs.gov/dma/hipaa/compguides.htm) for information on all HIPAA-approved transactions.

Electronic Commerce Services Support

The EDS Electronic Commerce Services (ECS) unit offers support to providers, software vendors, billing services, VANs, and clearinghouses in matters related to electronic data interchange (EDI). This includes providing and supporting transactions implemented by HIPAA. Providers may contact the ECS unit at 1-800-688-6696, option 1.

Refer to the article titled *Notice of Medicaid Identification Card Changes* on page 4 for additional information on the Medicaid identification card and the verification of recipient eligibility.

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

Attention: Pharmacists and Prescribers

New Prior Authorization Requirements for Brand-name Muscle Relaxants

Effective with date of service July 20, 2009, the N.C. Outpatient Pharmacy Program began requiring prior authorization for brand-name muscle relaxants. Prescribers can request prior authorization by contacting ACS at 866-246-8505 (telephone) or 866-246-8507 (fax). The criteria and prior authorization request form for these medications are available on the N.C. Medicaid Enhanced Pharmacy Program website at http://www.ncmedicaidpbm.com.

Medications that now require prior authorization include Amrix, Fexmid, Parafon Forte DSC, Skelaxin, Soma, Soma Compound, Soma Compound with Codeine, and Zanaflex. Generic muscle relaxants do not require prior authorization.

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

Attention: Pharmacists and Prescribers

New Prior Authorization Requirements for Brand-name Nasal Steroids

Effective with date of service July 20, 2009, the N.C. Outpatient Pharmacy Program began requiring prior authorization for brand-name nasal steroids. Prescribers can request prior authorization by contacting ACS at 866-246-8505 (telephone) or 866-246-8507 (fax). The criteria and prior authorization request form for these medications are available on the N.C. Medicaid Enhanced Pharmacy Program website at http://www.ncmedicaidpbm.com.

Medications that now require prior authorization include Beconase AQ, Flonase, Nasacort AQ, Nasarel, Nasonex, Omnaris, Rhinocort Aqua, and Veramyst. Generic fluticasone nasal spray and generic flunisolide nasal spray do not require prior authorization. Prior authorization is not required for patients under the age of four years.

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

Attention: Pharmacists and Prescribers

New Prior Authorization Requirements for Serotonin 5-HT$_1$ Receptor Agonists (Triptans)

Effective with date of service July 20, 2009, the N.C. Outpatient Pharmacy Program began requiring prior authorization for high quantities (more than 12 units per class per calendar month) of serotonin 5-HT$_1$ receptor agonists (triptans). Prescribers can request prior authorization for patients requiring greater than 12 units per calendar month by contacting ACS at 866-246-8505 (telephone) or 866-246-8507 (fax). The criteria and prior authorization request form for these medications are available on the N.C. Medicaid Enhanced Pharmacy Program website at http://www.ncmedicaidpbm.com.

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

Attention: Nurse Practitioners and Physicians

Interferon Beta-1a (Avonex, HCPCS Procedure Code Q3025): Billing Guidelines

Effective with date of service August 1, 2009, the N.C. Medicaid Program covers interferon beta-1a (Avonex) for use in the Physician's Drug Program when billed with HCPCS procedure code Q3025. Avonex is indicated for the treatment of patients with relapsing forms of multiple sclerosis (MS) to slow the accumulation of physical disability and decrease the frequency of clinical exacerbations. Patients with MS in whom efficacy has been demonstrated include patients who have experienced a first clinical episode and have magnetic resonance imaging (MRI) features consistent with MS. Safety and efficacy in patients with chronic progressive MS have not been established. Avonex is available in single-dose vials that contain 30 mcg per 1.0 ml when reconstituted, and prefilled syringes that contain 30 mcg per 0.5 ml.

For Medicaid Billing

- The ICD-9-CM diagnosis code required when billing for Avonex is **340** (multiple sclerosis).
- Providers must bill Avonex with HCPCS procedure code Q3025 (Injection, interferon beta-1a, 11 mcg for intramuscular use).
- One Medicaid unit of coverage is 11 mcg. The maximum reimbursement rate, per 11 mcg, is $178.75. An entire single-use vial may be billed.
- Providers must bill 11-digit NDC codes and NDC units. The NDC units for Avonex should be reported in "units." For example, for a 30-mcg dose given from a 1.0-ml reconstituted vial or 0.5-ml prefilled syringe, the NDC units should be reported as "UN1." Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III,* on DMA's website at http://www.ncdhhs.gov/dma/bulletin/ for instructions.
- **Medicaid covers only rebatable NDCs.**
- Providers must bill their usual and customary charge.

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

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

Attention: Dental Providers

Dental Seminars

Dental seminars have been scheduled for October 2009. Information presented at these seminars will include a review of dental clinical coverage guidelines including prior approval and billing procedures. The seminar sites and dates will be announced in the September 2009 Medicaid bulletin (http://www.ncdhhs.gov/dma/bulletin/).

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: Enhanced Behavioral Health Services (Community Intervention Services) Providers and Local Management Entities

Role of the Licensed Professional in a Community Support Provider Agency

The following serves as further clarification of Implementation Update #55 and #56 regarding the role of the Licensed Professional in a Community Support provider agency. As outlined in Implementation Update #56, an agency that provides Community Support services must have at a minimum, a full-time licensed professional on staff as of January 1, 2009, per Section 6.1, General Information, in DMA Clinical Coverage Policy 8A (http://www.ncdhhs.gov/dma/mp/).

Effective August 1, 2009, the licensed professional(s) will provide clinical expertise and oversight for the provision of medically necessary services. The licensed professional(s) will provide or make provisions for the following:

- Assure clinically appropriate assessment, person centered planning and therapeutic interventions are delivered within the specific service definition;
- Assure clinically appropriate services are delivered to eligible recipients within the service definition (right person, right treatment, right intensity, frequency and duration);
- Assure that staff operate within their appropriate scope of practice for service delivered;
- Coordinate with quality assurance and quality improvement functions of the agency;
- Assure that clinical supervision is provided to staff (QP, AP, PP and Certified Peer Specialist) delivering the specific service; and
- Monitor professional/ethical conduct of direct service staff (includes, but not limited to, confidentiality, client's rights, appropriate boundaries, etc.).

Some agencies provide services that require having a licensed professional as part of the staffing requirement (e.g., SAIOP, ACTT). This licensed professional cannot serve as the agency's licensed professional for Community Support. The agency must employ at a minimum full-time licensed professional(s) to carry out the above listed functions.

The provider agency assumes responsibility to employ the number of licensed professionals necessary to carry out the above clinical oversight functions at each enrolled service site.

Policies, procedures and protocols shall be in place to describe the agency's method for implementation of the required licensed professional functions and be able to demonstrate documented evidence of compliance

Documentation which provides evidence of the Licensed Professional's participation and compliance with this policy is required. Documentation may include:

- N.C. License (as stated in Section 6.2.1.1 of Clinical Coverage Policy 8A)
- Evidence of implementation of best practice standards
- Ongoing and periodic reviews of service records including assessments, person centered plans, service notes and outcomes to ensure the use of appropriate therapeutic interventions
- Review of staff supervision plans and supervision notes
- Quality Assurance (QA) and Quality Improvement (QI) activities to include:
  - ♦ Licensed professional signature on QA and QI plans and reports
  - ♦ Results of personnel record and staff credential reviews
  - ♦ Training records
  - ♦ Consumer surveys
  - ♦ Peer review results
  - ♦ Staff meeting minutes
- Other documentation to support compliance

Behavioral Health Section
DMA, 919-855-4290

Attention: All Providers

Basic Medicaid Seminars

Basic Medicaid seminars are scheduled for the month of September 2009 at the sites listed below. These seminars are intended to educate all providers on the basics of billing for N.C. Medicaid and will include information on the new annual Medicaid identification cards and the processes for eligibility verification. The September 2009 *Basic Medicaid Billing Guide* will be used as the primary training document for the seminar. Please review and print the Billing Guide (on DMA's website at http://www.ncdhhs.gov/dma/basicmed/) and bring it to the seminar.

Pre-registration 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.

Providers may register for the seminars online at http://www.ncdhhs.gov/dma/provider/seminars.htm. Sessions will begin at 9:00 a.m. and end at 4:00 p.m. Providers are encouraged to arrive by 8:45 a.m. to complete registration. Lunch will not be provided at the seminars. However, there will be a scheduled lunch break. **Because meeting room temperatures vary, dressing in layers is strongly advised.**

Date	Location
Wednesday, September 9, 2009	Greensboro Clarion Hotel Airport 415 Swing Road Greensboro NC 27409
Thursday, September 10, 2009	Salisbury Holiday Inn Salisbury 530 Jake Alexander Boulevard, South Salisbury NC 28147
Tuesday, September 15, 2009	Asheville Mountain Area Health Education Center 501 Biltmore Avenue Asheville NC 28801
Wednesday, September 16, 2009	Lenoir J.E. Broyhill Civic Center 1913 Hickory Boulevard, SE Lenoir NC 28645
Monday, September 21, 2009	Raleigh Hilton North Raleigh 3415 Wake Forest Road Raleigh NC 27609-7330
Wednesday, September 23, 2009	Williamston Martin Community College 1161 Kehukee Park Road Williamston NC 27892-4425
Tuesday, September 29, 2009	Wilmington Holiday Inn Wilmington 5032 Market Street Wilmington NC 28405
Wednesday, September 30, 2009	Fayetteville Holiday Inn Bordeaux 1707 Owen Drive Fayetteville NC 28304

Date	Location
Thursday, October 1, 2009	Raleigh The Royal Banquet and Convention Center 3801 Hillsborough Street Raleigh NC 27607

Directions to the Basic Medicaid Seminars

ASHEVILLE
Mountain Area Health and Education Center
Traveling East on I-40: Take I-40 East to Exit 50. Turn onto Hendersonville Road. Stay in the right-hand lane through five traffic lights. At the 6th traffic light, turn left onto the Mission Hospitals emergency entrance. Take the first right and then another immediate right into the parking deck.

Traveling West on I-40: Take I-40 West to Exit 50B onto Hendersonville Road. Stay in the right-hand lane through five traffic lights. At the 6th traffic light, turn left into the Mission Hospitals emergency entrance. Take the first right and then another immediate right into the parking deck.

Traveling East on I-26: Take I-26 to I-240 East to Exit 5B for Charlotte Street. Exit right onto Charlotte Street. At the 4th traffic light, turn left onto Biltmore Avenue. Proceed through three traffic lights. At the 4th light, turn right into the Mission Hospitals emergency entrance. Take the first right and then another immediate right into the parking deck.

FAYETTEVILLE
Holiday Inn Bordeaux
Take I-95 to Exit 56 to US 301 to the traffic light at Owen Drive. Turn west* onto Owen Drive and continue for 2.3 miles to the Holiday Inn.
*If you are driving south on US 301 (from I-95 South), this is a right turn. If you are driving north on US 301 (from I-95 North), this is a left turn.

GREENSBORO
Clarion Hotel Airport
Traveling on I-40 West/I-85 South: Take I-40 West/I-85 South to Exit 131 (I-40 West/Business I-85 South). Follow I-40 Business West through Greensboro to Exit 213 (Guilford College Road).

Traveling North on I-85: Take I-85 North to Exit 120B (PTI Airport/I-40 West/Winston Salem). Avoid Exit 214 (Wendover Boulevard to Guilford College Road. Follow to the second Exit 212B, I-40 East and take Exit 213, Guilford College Road.

Traveling from the Piedmont Triad International Airport: Turn right onto Bryan Boulevard. Take the second exit to I-40 (towards Winston Salem). Take Exit 1 (Greensboro/421 South). Stay in the left-hand lane to avoid going west on I-40. Take Exit 213 (Guilford College Road).

Traveling North on Highway 220/1-73: Take Exit 81 (PTI Airport/ 421 North). Stay in the left-hand lane of the exit to avoid going east on I-40. Take Exit 213 (Guilford College Road).

LENOIR
J.E. Broyhill Civic Center
Traveling East on I-40:   Take I-40 West to Exit 105 for Highway 18 North. Follow Highway 18 through Morganton. In Lenoir, turn left onto Southwest Boulevard. Follow Southwest Boulevard for approximately 5.5 miles. Take the northbound exit to Lenoir. The Civic Center is located just ahead on the right past Walters Auto Dealership.

Traveling West on I-40:   Take I-40 East to Exit 123B for Highway 321 North. Follow Highway 321 for approximately 15 miles. The Civic Center is located on the right just past Walters Auto Dealership.

RALEIGH
Hilton North Raleigh
Traveling East on I-40:   Take I-40 to I-440 North (inner beltline). Follow I-440 North to Exit 10 for Wake Forest Road. At the bottom of exit ramp turn left. The hotel is located on the left approximately 0.5 mile from the exit ramp.

Traveling West on I-40:   Take I-40 to I-440 South (outer beltline). Follow I-440 South to Exit 10 for Wake Forest Road. At the bottom of exit ramp turn right. The hotel is located on the left approximately 0.5 mile from the exit ramp.

The Royal Banquet and Convention Center
Traveling East on I-40:   Take I-40 East towards Raleigh. Take Exit 289 for Wade Avenue. Pass the exits for Edwards Mill Road and Blue Ridge Road, then merge right onto I-440 S/US 1 South toward I-40 East/Hillsborough Street/Sanford (the Outer Beltline). Take Exit 3 for NC 54/Hillsborough Street. Turn left at the bottom of the exit ramp onto Hillsborough Street. Turn right at the 3rd stoplight at Meredith College and Playmakers (the turn is located in front of Quizno's and Ben & Jerry's). Go to the end of the parking lot and turn left to park BEHIND the building or in the covered parking area.

Traveling West on I-40:   Take I-40 West towards Raleigh. Take Exit 293 for I-440/US 1/US 64/Raleigh/Wake Forest. The exit will split into two lanes. Stay in the right-hand lane to merge onto I-440/Inner Beltline/Raleigh. Take Exit 3 for NC 54/Hillsborough Street. Turn left at the bottom of the exit ramp onto Hillsborough Street. Turn right at the 3rd traffic light at Meredith College and Playmakers (the turn is located in front of Quizno's and Ben & Jerry's). Go to the end of the parking lot and turn left to park BEHIND the building or in the covered parking area.

SALISBURY
Holiday Inn Salisbury
Traveling South on I-85:   Take I-85 to Exit 75. At the end of the exit ramp, turn right onto Jake Alexander Boulevard. Travel approximately 0.5 mile. The Holiday Inn is located on the right.

Traveling North on I-85:   Take I-85 to Exit 75. At the end of the exit ramp, turn left onto Jake Alexander Boulevard. Travel approximately 0.5 mile. The Holiday Inn is located on the right.

WILLIAMSTON
Martin Community College
Building 2 Auditorium
Traveling East on US 64:   Take US 64 West to the intersection at McDonald's in Williamston. Turn left on the US 13/US 17 Bypass. The name will change to Old Highway 64 Bypass. Continue approximately 2.3 miles and turn left on Kehukee Park Road. The college is located on the right approximately 0.5 mile from the intersection.

Traveling West on US 64: Take US 64 East to Exit 512 (Prison Camp Road). (Look for the sign just before Exit 512 for Senator Bob Martin Agricultural Center and Martin Community College.) Turn right on Prison Camp Road. Drive for approximately 0.5 mile and turn left on Kehukee Park Road. The college is located on the right approximately 0.5 mile from the intersection.

Traveling North on US 13/US 17: Take US 13/US 17 South to Williamston. Continue to follow US 13/US 17 until it becomes Old Highway 64 Bypass. Continue driving for approximately 2.5 miles. Turn left on Kehukee Park Road. The college is located on the right approximately 0.5 mile from the intersection.

WILMINGTON
Holiday Inn Wilmington
Traveling East on I-40: Take exit 8 (Market Street). Turn left at the light. The hotel is located on the left, 0.5 mile from the intersection.

Traveling South on US 17: Follow US-17 South into Wilmington. The hotel is located on the left 0.5 mile from the intersection of US 17 and I-40.

Traveling North on US 17/East on NC 74/76: Follow US 17 North into Wilmington. The hotel is located on the right approximately 4 miles after entering Wilmington.

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

Basic Medicaid Seminars
September 2009 Seminar Registration Form
(No Fee)

Provider Name _____

Medicaid Provider Number _____ NPI Number _____

Mailing Address _____

City, Zip Code _____ County _____

Contact Person _____ E-mail _____

Telephone Number (_____) _____ Fax Number _____

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

Please fax completed form to: 919-851-4014
Please mail completed form to:
EDS Provider Services
P.O. Box 300009
Raleigh, NC 27622

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

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

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

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

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

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

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

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

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

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

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

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

Proposed Clinical Coverage Policies

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

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

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

2009 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
August	8/6/09	8/11/09
	8/13/09	8/16/09
	8/20/09	8/27/09
September	9/3/09	9/9/09
	9/10/09	9/15/09
	9/17/09	9/24/09

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

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

Melissa Robinson
Executive Director
EDS, an HP Company