



# North Carolina Medicaid Bulletin

*Published as an Informational Service to  
Medicaid Providers by the  
Division of Medical Assistance and  
EDS, Fiscal Agent for the N.C. Medicaid Program*

Number 9

September 2004

## In This Issue . . .

### All Providers:

- ◆ Change in Billing Requirements for Anesthesia Codes 01961, 01968, and 01969 ..... 7
- ◆ Clinical Coverage Policies ..... 2
- ◆ Clinical Policy and Programs..... 2
- ◆ EDS Address List..... 3
- ◆ Medicare Crossovers..... 4
- ◆ Medicare Crossover Reference Request Form ..... 5
- ◆ The New NCMMIS Commitment to North Carolina Providers..... 4

### Anesthesia Providers:

- ◆ Adjustments to Anesthesia Claims ..... 6

### Area Mental Health Programs:

- ◆ Medicaid Determination of Eligibility for New CAP-MR/DD Recipients ..... 9
- ◆ Submission of MR-2 for Level of Care Determination ..... 10

### CAP-MR/DD Providers:

- ◆ Medicaid Determination of Eligibility for New CAP-MR/DD Recipients ..... 9
- ◆ Submission of MR-2 for Level of Care Determination..... 10

### Community Alternatives Program Providers:

- ◆ Reimbursement Rate Increase for Community Alternatives Program Services ..... 8

### Dental Providers:

- ◆ 2002 American Dental Association Claim Form ..... 10
- ◆ ADA Claim Form Example ..... 11
- ◆ Dental Seminar Schedule ..... 12
- ◆ Directions to the Dental Seminars ..... 13

### Dialysis Treatment Facility Providers:

- ◆ Erythropoietin (EPO) Billing Instructions ..... 14

### Health Departments Dental Clinics:

- ◆ 2002 American Dental Association Claim Form ..... 10
- ◆ ADA Claim Form Example ..... 11
- ◆ Dental Seminar Schedule ..... 12
- ◆ Directions to the Dental Seminars ..... 13

### Hospice Providers:

- ◆ Hospice Nursing Facility Room and Board Billing Guidelines ..... 7

### Local Management Entities:

- ◆ Medicaid Determination of Eligibility for New CAP-MR/DD Recipients ..... 9
- ◆ Submission of MR-2 for Level of Care Determination..... 10

### Personal Care Providers (excluding Adult Care Homes):

- ◆ Reimbursement Rate Increase for Personal Care Services ..... 8

### Pharmacists:

- ◆ Removal of ADHD Drugs and Rebetrone from the Prior Authorization Drug List ..... 15
- ◆ Synagis Coverage for 2004-2005..... 15
- ◆ Technical Correction to General Policy for Over the Counter Medications ..... 14

### Physicians:

- ◆ Synagis Coverage for 2004-2005..... 15

### Prescribers:

- ◆ Removal of ADHD Drugs and Rebetrone from the Prior Authorization Drug List ..... 15
- ◆ Technical Correction to General Policy for Over the Counter Medications ..... 14

**Providers are responsible for informing their billing agency of information in this bulletin.**

**CPT codes, descriptors, and other data only are copyright 2003  
American Medical Association. All rights reserved. Applicable FARS/DFARS apply.**

## Attention: All Providers

### Clinical Coverage Policies

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

- 1A-7 – Neonatal and Pediatric Critical and Intensive Care Services
- 1A-8 – Hyperbaric Oxygenation Therapy
- 1A-10 – Panniculectomy
- 1A-11 – Extra Corporeal Shockwave Lithotripsy
- 1A-15 – Surgery for Clinically Severe Obesity
- 1A-18 – Screening Laser Glaucoma Test
- A2 – Over the Counter Medications

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

**Gina Rutherford, Clinical Policy and Programs Section**  
**DMA, 919-857-4020**

## Attention: All Providers

### Clinical Policy and Programs

The Division of Medical Assistance (DMA) has changed the name of the Medical Policy Section to the Clinical Policy and Programs Section. This new title more accurately reflects the various clinical specialties within DMA's program policy area.

The mission of the Clinical Policy and Programs Section is to structure benefits available to Medicaid clients in a manner that promotes access to medically necessary and cost effective care. This section is responsible for:

- Behavioral Health Services
- Clinical Policy Development
- Community Alternatives Program Services
- Dental Services
- Facility and Community Care Services
- Pharmacy and Ancillary Services
- Practitioner and Clinic Services

Along with the new title comes a change in the section's leadership. Marcia Rao joins DMA as the Assistant Director for Clinical Policy and Programs. Ms. Rao brings with her a wealth of knowledge and experience as she has worked in broad areas of medical policy for the Medicaid program in the State of New York for more than twenty years. She has worked in systems design, overseen the State Plan, and developed and implemented many programs, including waivers. She has particular interest in community care and in children's needs.

**Gina Rutherford, Clinical Policy and Programs**  
**DMA, 919-857-4020**

## Attention: All Providers

## EDS Address List

This is a reminder of the addresses to use when mailing correspondence or claims to EDS.

<b>Adjustments/Medicaid Resolution Inquiries</b> EDS PO Box 300009 Raleigh, NC 27622	<b>ADA Claims</b> EDS PO Box 300011 Raleigh, NC 27622
<b>CMS-1500 Claims</b> EDS PO Box 30968 Raleigh, NC 27622	<b>Drug Rebates</b> EDS PO Box 300002 Raleigh, NC 27622
<b>General Correspondence</b> (Name of EDS Employee) EDS PO Box 300009 Raleigh, NC 27622	<b>Hysterectomy Statements</b> EDS PO Box 300012 Raleigh, NC 27622
<b>Medicare Crossovers (Part A Only)</b> EDS PO Box 300011 Raleigh, NC 27622	<b>Medicare/Medicaid Part B Only</b> EDS P.O. Box 30968 Raleigh, NC 27622
<b>Nursing Facility Claims-Medicare/Medicaid Part B Only</b> Attn: Nursing Facility Claims EDS P.O. Box 300009 Raleigh, NC 27622	<b>Pharmacy Claims</b> EDS PO Box 300001 Raleigh, NC 27622
<b>Prior Approval Requests</b> EDS PO Box 31188 Raleigh, NC 27622	<b>Returned Checks</b> EDS PO Box 300011 Raleigh, NC 27622
<b>Sterilization Consent Forms</b> EDS PO Box 300012 Raleigh, NC 27622	<b>UB-92 Claims</b> EDS PO Box 300010 Raleigh, NC 27622
When sending Certified mail, UPS or Federal Express, send to: EDS (Name of EDS Employee or Department) 4905 Waters Edge Drive Raleigh, NC 27606	

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

**Attention: All Providers****T**he New NCMMIS Commitment to North Carolina Providers

On July 1, 2004, Carmen Hooker Odom, Secretary of the Department of Health and Human Services, created the Office of Medicaid Management Information System (MMIS) Services to ensure a successful transition to the new NCLeads system. The Office of MMIS Services reports directly to the Office of the Secretary and will work with Affiliated Computer Services (ACS) State Healthcare LLC on the implementation of the new NCLeads system. Staff from the Division of Medical Assistance; the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; and the Division of Public Health as well as the Division of Facility Services have been reassigned to the Office of MMIS Services to assist with the transition.

The Office of MMIS Services Provider Relations Team is developing a website for providers to access information about the new NCLeads system and for updates about the transition to the new system. Providers will be notified through the general Medicaid bulletin when the website is available.

Providers may contact the Provider Relations Team with questions or comments by calling 919-855-3112 or by e-mail at [ncmmis.provider@ncmail.net](mailto:ncmmis.provider@ncmail.net).

**Tom Liverman, Provider Relations  
Office of MMIS Services  
919-855-3112**

**Attention: All Providers****M**edicare Crossovers

On September 6, 2004, the N.C. Medicaid program will return to processing all crossover claims billed on a CMS-1500 form or as an 837 professional transaction as direct crossovers from Medicare.

In anticipation of this change, providers should verify that their Medicare provider numbers are cross-referenced to their Medicaid provider numbers. Providers can verify this by contacting EDS Provider Services at 1-800-688-6696 or 919-851-8888.

If your Medicaid and Medicare provider numbers are not cross-referenced, please complete and submit the following form by fax or mail to EDS at the address indicated on the form. Additional information on crossover claims will be published in upcoming general Medicaid bulletins.

Refer to the August 2004 Special Bulletin V, *Medicare Part B Billing* on DMA's website at <http://www.dhhs.state.nc.us/dma/bulletin.htm> for additional information.

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

**Medicare Crossover Reference Request**

Provider Name: \_\_\_\_\_  
 Contact Person (required): \_\_\_\_\_ Telephone (required): \_\_\_\_\_

Select the appropriate *Medicare Carrier/Intermediary/DMERC* from the following listing, the *Action to be taken*, and your *Medicare* and *Medicaid* provider numbers. **If this section is not completed, the form will not be processed.** These are the only carriers for which EDS can currently cross-reference provider numbers.

<b>Medicare Part A Intermediaries</b>	
<input type="checkbox"/> Riverbend GBA Medicare Part A (Tennessee) <a href="http://www.riverbendgba.com">http://www.riverbendgba.com</a> <input type="checkbox"/> Palmetto GBA Medicare Part A. Effective November 1, 2001, Palmetto GBA assumed the role of North Carolina Part A intermediary from Blue Cross/Blue Shield of NC. (North Carolina) <a href="http://www.palmettogba.com">http://www.palmettogba.com</a> <input type="checkbox"/> Trailblazer Medicare Part A (Colorado, New Mexico and Texas) <a href="http://www.the-medicare.com">http://www.the-medicare.com</a> <input type="checkbox"/> United Government Services Medicare Part A (Wisconsin) <a href="http://www.ugsmedicare.com">http://www.ugsmedicare.com</a>	<input type="checkbox"/> Palmetto Medicare Part A (South Carolina) <a href="http://www.palmettogba.com">http://www.palmettogba.com</a> * <input type="checkbox"/> AdminaStar Medicare Part A (Illinois, Indiana, Ohio, and Kentucky) <a href="http://www.adminastar.com">http://www.adminastar.com</a> * <input type="checkbox"/> Carefirst of Maryland Medicare Part A (Maryland) <a href="http://www.marylandmedicare.com/pages/mdmedicare/mdmedicaremain1.htm">http://www.marylandmedicare.com/pages/mdmedicare/mdmedicaremain1.htm</a> * <input type="checkbox"/> Veritus Medicare Part A (Pennsylvania) <a href="http://www.veritusmedicare.com">http://www.veritusmedicare.com</a> * <input type="checkbox"/> First Coast Service Options Medicare Part A, subsidiary of BCBS of Florida (Florida) <a href="http://www.floridamedicare.com">http://www.floridamedicare.com</a> *
<p style="text-align: center;"><b>Medicare Part B Carrier</b></p> <input type="checkbox"/> CIGNA Medicare Part B (Tennessee, North Carolina, and Idaho) <a href="http://www.cignamedicare.com">http://www.cignamedicare.com</a> <input type="checkbox"/> AdminaStar Medicare Part B (Indiana and Kentucky) <a href="http://www.adminastar.com">http://www.adminastar.com</a> * <input type="checkbox"/> Palmetto Medicare Part B (South Carolina) <a href="http://www.palmettogba.com">http://www.palmettogba.com</a> *	<p style="text-align: center;"><b>Medicare Regional DMERC</b></p> Palmetto Region C DMERC (Alabama, Arkansas, Colorado, Florida, Georgia, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas and the Virgin Islands); <a href="http://www.palmettogba.com">http://www.palmettogba.com</a>

\*Trading Partners currently in testing phase.

**Action to be taken:**

**Addition** - This is used to add a new provider number (Medicare or Medicaid) to the crossover file.  
 Medicare Provider number: \_\_\_\_\_ Medicaid Provider number: \_\_\_\_\_

**Change** - This is used to change an existing provider number (Medicare or Medicaid) on the crossover file.

Medicare Provider number: \_\_\_\_\_ Medicaid Provider number: \_\_\_\_\_

**Mail completed form to:**

P.O. Box 300009  
 Raleigh, NC 27622  
 FAX: 1-919-851-4014  
 1-800-688-6696

## Attention: Anesthesia Providers

### Adjustments to Anesthesia Claims

Anesthesia modifiers QK, QX, QY, QZ, and AA were implemented for all anesthesia claims processed on or after May 16, 2004. These modifiers allow better definition of services rendered by the certified registered nurse anesthetist (CRNA) and anesthesiologist and allows proper payment when anesthesia services are rendered by the CRNA and medically directed by the anesthesiologist. One of these modifiers is required on all claims filed for anesthesia service. This includes claims filed for anesthesia for obstetrical services and for anesthesia services that are reimbursed based on the fee schedule instead of time units.

Overpayments of anesthesia services for dually eligible recipients were made due to Medicare processing with the medical direction modifiers that were not recognized by Medicaid. These overpayments will be resolved with the processing of these adjustments.

N.C. Medicaid will begin initiating adjustments of anesthesia claims that were either denied or paid incorrectly at 100 percent of the allowed amount for the service.

#### **Adjustments for claims submitted under the following scenario will be initiated immediately and will occur on-going for future claim submissions:**

If a claim was submitted by both the anesthesiologist and the CRNA and the first claim was processed and paid at 100 percent and the second claim was submitted with either modifier QX, QY or QK, denoting medical direction, but has not yet been processed:

- The first claim (paid at 100 percent) will be recouped with an EOB instructing the provider to rebill services using a medical direction modifier.
- The second claim will be processed and paid at 50 percent of the allowed amount for the service.

#### **Adjustments for claims submitted under the following scenario will be initiated in the future. (Providers will be notified through the general Medicaid bulletin prior to the reprocessing of these claims):**

1. If a claim was submitted by either the anesthesiologist or the CRNA for the same service and both claims have been processed, and if the first claim was paid and the second claim was denied:
  - The paid claim will be adjusted and repaid at 50 percent of the total allowed amount for the service.
  - The denied claim will be reprocessed and paid at 50 percent of the allowed amount for the service.
2. If a claim was submitted by both the anesthesiologist and the CRNA for the same service and both claims were processed and paid at 100 percent of the total allowed amount, both claims will be adjusted and repaid at 50 percent of the allowed amount for the service.

Providers will not be required to file adjustments or refund overpayments. Recoupments will be done when the claims are reprocessed.

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

## Attention: All Providers

### Change in Billing Requirements for Anesthesia Codes 01961, 01968, and 01969

Effective with date of service September 1, 2004, providers billing for the following anesthesia codes must now bill with unit of time. For Medicaid billing, one minute = one unit. The time plus base units will be used in calculating the reimbursement.

- 01961, Anesthesia for cesarean delivery only
- 01968, Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia
- 01969, Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia

For additional information on billing for anesthesia services using anesthesia modifiers, refer to the April 2004 general Medicaid bulletin.

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

## Attention: Hospice Providers

### Hospice Nursing Facility Room and Board Billing Guidelines

Hospice providers currently bill Hospice Nursing Facility Room and Board according to the level of care determined by the FL-2 approval. If the level of care is Intermediate (ICF), the Hospice providers bill using RC658. If the level of care is Skilled (SNF), the Hospice providers bills using RC659. If a claim is billed using a revenue code that does not match the level of care on the FL-2, the claim will deny with EOB 2229 "There is not an approved FL-2 for the billed Nursing Facility level of care for the date of service".

Effective with date of service June 1, 2004 all prior approvals will be granted at one level of care, Nursing Facility (NF) level of care. This action is being taken to comply with the change in level of care for nursing facilities from two levels to one level of care. (Refer to the August 2004 general Medicaid bulletin on DMA's website at <http://www.dhhs.state.nc.us/dma/bulletin.htm> for more information). Hospice claims for the facility charge approved at the new NF level of care must be billed using RC659. If the level of care was approved prior to June 1, 2004 at the ICF level of care, the provider should continue using RC658 as long as the ICF approval is valid. If the level of care was approved prior to June 1, 2004 at the SNF level of care, providers will continue to bill using RC659. Hospice providers should bill accordingly to avoid receiving a denial with EOB 2229.

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

## Attention: Community Alternatives Program Providers

### Reimbursement Rate Increase for Community Alternatives Program Services

Effective with date of service August 16, 2004, the Medicaid maximum reimbursement rate for the following Community Alternatives Program (CAP) services has been increased. This is an interim rate increase that will be effective through December 2004. Results from a pending audit of PCS providers may result in a subsequent rate change. Providers will be notified of any further rate changes in future general Medicaid bulletins.

<b>Procedure Code</b>	<b>Description</b>	<b>Reimbursement Rate</b>
S5125	CAP/C Personal Care	\$3.55/15 min unit
S5125	CAP/AIDS In-Home Aide II-Personal Care	3.55/15 min unit
S5125	CAP/AIDS In-Home Aide III-Personal Care	3.55/15 min unit
S5125	CAP/DA In-Home Aide II-Personal Care	3.55/15 min unit
S5125	CAP/DA In-Home Aide III-Personal Care	3.55/15 min unit
S5125	CAP-MR/DD Personal Care	3.55/15 min unit
S5120	CAP-MR/DD In-Home Aide Level I	3.55/15 min unit
S5150	CAP/C Respite Care In-Home	3.55/15 min unit
S5150	CAP/AIDS Respite Care In-Home, Aide Level	3.55/15 min unit
S5150	CAP/DA Respite Care-In Home	3.55/15 min unit
S5150	CAP-MR/DD Respite Care Community Based	3.55/15 min unit

**Robyn Slate, Rate Setting  
DMA, 919-857-4015**

## Attention: Personal Care Providers (excluding Adult Care Homes)

### Reimbursement Rate Increase for Personal Care Services

Effective with date of service August 16, 2004, the Medicaid maximum reimbursement rate for In-Home Personal Care Services (PCS) is \$3.55 per 15-minute unit (\$14.20/hour). This is an interim rate increase that will be effective through December 2004. Results from a pending audit of PCS providers may result in a subsequent rate change. Providers will be notified of any further rate changes in future general Medicaid bulletins.

**Robyn Slate, Rate Setting  
DMA, 919-857-4015**



## Attention: Area Mental Health Programs, CAP-MR/DD Providers, and Local Management Entities

### Medicaid Determination of Eligibility for New CAP-MR/DD Recipients

When determining eligibility for potential CAP-MR/DD coverage for a person who is applying for Medicaid, the lead agency or provider must follow the county department of social services (DSS) time standards for processing applications. For Medicaid recipients applying for CAP-MR/DD, the lead agency or provider must follow the guidelines in the *CAP-MR/DD Manual* found at <http://www.dhhs.state.nc.us/mhddsas>.

According to the Code of Federal Regulations, 42CFR435.911, Timely Determination of Eligibility for Medicaid for DSS, the “agency must establish time standards for determining eligibility.” These standards may not exceed “a) Ninety days for applicants who apply for Medicaid on the basis of disability; and b) Forty-five days for all other applicants.”

As indicated on page 5-10, section 5.4 of the *CAP-MR/DD Manual*: “For a person to get CAP-MR/DD benefits and for provider agencies, including the lead agency, to get paid, activities must be coordinated with the DSS Medicaid staff. Promptly processing the Plan of Care to get an approval from the local lead agency as quickly as possible is important for the person as well as DSS. DSS has strict time limits to act on application. If the Plan is not approved within the time limit, DSS may have to deny the Medicaid application. This means a person may have to reapply for Medicaid. Getting the Plan approved within the designated DSS and CAP-MR/DD timeframes benefits the person.” The manual further states on page 8-2, section 8.2.1a: “For new Medicaid applicants, the Plan of Care approval date must be coordinated with the DSS Medicaid Office so the plan is approved within the time standards required for Medicaid applicants.” Contact the county DSS to determine which application processing time standard applies.

If there is no approved plan of care by the end of the 45-day/90-day timeframe, DSS will process the application as a regular non-CAP-MR/DD case applying regular Medicaid eligibility rules. If this creates a denial before the approved plan of care is received by DSS, the process must start over with the application for Medicaid.

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

**Attention: Area Mental Health Programs, CAP-MR/DD Providers,  
and Local Management Entities**

**S**ubmission of MR-2 for Level of Care Determination

Session Law 437 1.2 (c) repealed G.S. 122C-3 (34) and (35) regarding Single Portal Services in area mental health programs. Therefore, it is no longer a Medicaid requirement to have the Single Portal Coordinator sign the MR-2 for ICF-MR level of care before it is submitted to EDS. However, the physician's signature and the signature of the case manager are still required on the MR2.

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

**Attention: Dental Providers and Health Departments Dental Clinics**

**2**002 American Dental Association (ADA) Claim Form

The Division of Medical Assistance (DMA) and EDS currently are updating the Medicaid claims processing system to accept the 2002 ADA claim form. The planned implementation date for the new form is October 1, 2004. Once the system has been updated, providers will be given a three-month transition period to begin using the 2002 claim form. During the three-month transition period, both the 1999 and 2002 ADA forms will be accepted. After the transition period, claims filed using the 1999 ADA form will be returned to the provider. Please refer to upcoming general Medicaid bulletins for notification of the official implementation date.

Claim forms can be ordered directly from the ADA. Listed below are the web address, toll-free telephone number, and contact address for the ADA.

<http://www.ada.org/ada/prod/catalog/index.asp>

1-800-947-4746

American Dental Association  
Attn: Salable Materials Office  
211 E. Chicago Avenue  
Chicago, IL 60611

The claim form is available as a single or two-part form. The single form must be used when submitting claims for payment. The two-part form must be used when requesting prior approval. The original is returned to the provider and serves as the prior approval/claim copy. The second page is retained by EDS.

**Dr. Ron Venezie, Dental Director  
DMA, 919-857-4033**



## Attention: Dental Providers and Health Departments Dental Clinics

### Dental Seminar Schedule

Seminars for dental providers are scheduled for September 2004. This seminar will focus on upcoming changes to the clinical coverage policy for dental services and will include guidelines for completing the ADA claim form, changes in covered procedure codes, the most common denials for dental claims, and other general Medicaid issues. Medicaid billing personnel, supervisors, and office managers are encouraged to attend.

The seminars will begin at 10:00 a.m. and end at 1:00 p.m. Providers are encouraged to arrive by 9:45 a.m. to complete registration. Lunch will not be provided at the seminars. 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 by completing and submitting the registration form on page 13 or by registering online at <http://www.dhhs.state.nc.us/dma/provsem.htm>. Please indicate on the registration form the session you plan to attend.

Special Bulletin V, *Dental Services Coverage Policy and Billing Guidelines*, available on DMA's website at <http://www.dhhs.state.nc.us/dma/bulletin.htm>, will be used as the primary training document for the seminar. Please print the special bulletin and bring it to the seminar.

Because the seminar also will briefly address the general Medicaid billing guidelines, providers may wish to bring a copy of the *General Medicaid Billing/Carolina ACCESS Policies and Procedures Guide* (<http://www.dhhs.state.nc.us/dma/medbillcaguide.htm>) to the seminar.

**Wednesday, September 8, 2004**

Jane S. McKimmon Center  
1101 Gorman Street  
Raleigh, NC

**Thursday, September 23, 2004**

Park Inn Gateway Conference Center  
909 Highway 70 SW  
Hickory, NC

**Tuesday, September 28, 2004**

Coast Line Convention Center  
501 Nutt Street  
Wilmington, NC

**Thursday, September 30, 2004**

Holiday Inn Conference Center  
530 Jake Alexander Blvd., S  
Salisbury, NC

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

# Directions to the Dental Seminars

## **Jane S. McKimmon Center – Raleigh**

### Traveling East on I-40

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

### Traveling West on I-40

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

## **Park Inn Gateway Conference Center – Hickory**

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

## **Coast Line Convention Center – Wilmington**

Take I-40 east to Wilmington. Take the Highway 17 exit. Turn left onto Market Street. Travel approximately 4 or 5 miles to Water Street. Turn right onto Water Street. The Coast Line Inn is located one block from the Hilton on Nutt Street behind the Railroad Museum.

## **Holiday Inn Conference Center – Salisbury**

### Traveling South on I-85

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

### Traveling North on I-85

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

(cut and return the registration form only)

-----  
**Dental Seminar Registration Form**  
**(No Fee)**

Provider Name \_\_\_\_\_ Provider Number \_\_\_\_\_

Address \_\_\_\_\_

City, Zip Code \_\_\_\_\_ County \_\_\_\_\_

Contact Person \_\_\_\_\_ E-mail Address \_\_\_\_\_

Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

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

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

## Attention: Dialysis Treatment Facility Providers

### Erythropoietin (EPO) Billing Instructions

Effective with date of service October 1, 2004, claims submitted for erythropoietin (Epogen) must include ICD-9-CM diagnosis code 585 as the primary diagnosis and one of the additional diagnosis codes listed below to be considered for EPO reimbursement. If the primary diagnosis code and an appropriate additional diagnosis code are not listed on the claim, it will deny with EOB 082, "Service is not consistent with/or not covered for this diagnosis/or description does not match diagnosis."

The following information is required on the claim when billing for Epogen:

- ICD-9-CM diagnosis code 585, Chronic renal failure, must be entered on the claim as the primary diagnosis for end-stage renal disease.

AND

- One of the following additional diagnosis codes:
  - ◆ 285.8, Other specified anemia
  - ◆ 285.9, Anemia, unspecified
  - ◆ 285.21, Anemia in end stage renal disease
- Epogen must be billed with revenue code 634 and an appropriate procedure code.
- All Epogen charges for the same date of service must be billed as one detail on the claim. If Epogen charges are billed on two or more details on the claim for the same date of service, each of the details will deny with EOB 1198 "Service billed multiple times. If on this claim, combine units on single detail and resubmit new claim. If paid on previous claim, combine units and file an adjustment."

The requirements related to hematocrit values remain unchanged. Refer to the January 1999 general Medicaid bulletin for additional information.

The procedure codes for billing Epogen will change from Q9920 through Q9940 to Q4055, Injection, epoetin alfa, 1000 units. Billing instructions and the effective date of the change will be published in a future general Medicaid bulletin when the system is ready to receive claims.

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

## Attention: Pharmacists and Prescribers

### Technical Correction to General Policy for Over the Counter Medications

A technical correction to clarify how over the counter medications are dispensed was made to Section 1.0 of General Coverage Policy #A2, *Over the Counter Medications*. The updated policy is now available on DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm>.

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

## Attention: Pharmacists and Physicians

### Synagis Coverage for 2004-2005

For the Synagis season 2004-2005, Synagis will no longer require prior authorization. However, physicians are required to complete a Synagis for RSV Prophylaxis criteria (1, 2 or 3) form for coverage. These forms will be available on the Division of Medical Assistance's website at <http://www.dhhs.state.nc.us/dma/forms.html> by September 15, 2004.

Completed forms should be sent to the physician's pharmacy provider of choice for processing. If clinical criteria 1, 2 or 3 applies, then the pharmacy provider reviews the form to ensure that it has been completed in full and verifies the recipient's Medicaid eligibility. The pharmacy provider ships the Synagis to the physician's office.

In the event that a recipient does not meet the clinical criteria for coverage, the physician can request an exemption by completing a N.C. Medicaid Request for Medical Review for Synagis Outside of Criteria form and submitting it to the pharmacy provider. The pharmacy provider forwards the form to DMA for clinical review. If the request for coverage is denied, the physician may appeal to DMA.

Physicians and pharmacy providers are subject to audits of Synagis records by the DMA Program Integrity Unit. All Synagis criteria forms and requests for coverage outside of criteria must be sent by the pharmacy provider on a weekly basis to DMA for review.

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

## Attention: Pharmacists and Prescribers

### Removal of ADHD Drugs and Rebetron from the Prior Authorization Drug List

Effective August 5, 2004, the following drugs will no longer require prior authorization from Medicaid:

Amphetamine Mixtures (Adderall, Adderall XR)  
Dextroamphetamine (generics, Dexedrine, Dextrostat)  
Methamphetamine (Desoxyn)  
Methylphenidate (generics, Ritalin, Methylin, Concerta)  
Methylphenidate sustained-release (generics, Ritalin SR, Ritalin LA, Methylin ER, Metadate ER, Metadate CD), Ritalin LA 20mg, 30mg, 40mg  
Pemoline (generics, Cylert, PemADD)  
Focalin (Dexmethylphenidate HCL)  
Rebetron (Interferon Alfa-2b and Ribavirin combination pack)

**Sharman Leinwand, RPh, MPH Pharmacy Program  
DMA, 919-857-4020**

---

## Proposed Clinical Coverage Policies

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

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

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

---

## Holiday Observance

The Division of Medical Assistance and EDS will be closed on Monday, September 6, 2004 in observance of Labor Day.

---

## Checkwrite Schedule

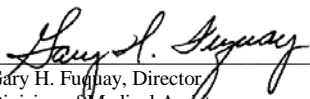
September 8, 2004	October 5, 2004	November 2, 2004
September 14, 2004	October 12, 2004	November 9, 2004
September 23, 2004	October 19, 2004	November 16, 2004
		November 24, 2004

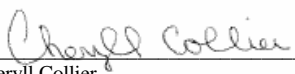
## Electronic Cut-Off Schedule

September 3, 2004	October 1, 2004	October 29, 2004
September 10, 2004	October 8, 2004	November 5, 2004
September 17, 2004	October 15, 2004	November 12, 2004
		November 19, 2004

*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.*

---

  
Gary H. Fughay, Director  
Division of Medical Assistance  
Department of Health and Human Services

  
Cheryl Collier  
Executive Director  
EDS

---