Number 9 *September 2005*

North Carolina Medicaid Bulletin

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

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

Attention: All Providers of Enhanced Benefit Mental Health/Substance Abuse Services

Notice for upcoming seminar in September

PLEASE NOTE: The agenda for the upcoming seminar in September has been modified. Only the following services are going to be discussed in this seminar:

Community Supports-Adult (Individual and Group)
Community Supports-Child (Individual and Group)
Mobile Crisis Management
Diagnostic Assessment
Intensive In-Home
Multisystemic Therapy (MST)
Community Support Teams (adult) (CST)
Assertive Community Treatment Team (ACTT)
Psychosocial Rehabilitation
Partial Hospital

The remaining enhanced benefit services will be covered at a seminar in early 2006. Please reference the September 2005 Special Bulletin – Providers of Enhanced Benefit Mental Health/Substance Abuse Services for additional information pertaining to the services mentioned above. Please watch for additional details in future Medicaid Bulletins.

Behavioral Health Services
DMA, 919-855-4290

Attention: All Providers

Clinical Coverage Policy Update

All of the Division of Medical Assistance's clinical coverage policies have been updated to include new or revised language pertaining to the federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirement. The clinical coverage policies are available on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm

The following policies are also now available on DMA's website:

3A – Home Health Services
9 – Outpatient Pharmacy Program

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

Attention: All Providers

Compliance Date for Health Insurance Portability Accountability Act (HIPAA) Electronic Transactions

Effective October 1, the N.C. Medicaid program will cease acceptance of non-HIPAA compliant transaction formats. Providers currently filing on non-HIPAA compliant formats need to make the necessary changes to ensure compliance. The following article includes information regarding the Health Insurance Portability and Accountability Act (HIPAA), the importance of compliance and recommendations to become compliant.

HIPAA legislation requires the standardized transmission of electronic information. Covered entities were required to comply with these standards by October 16, 2003. Covered entities are defined in HIPAA as:

1. Health plans.
2. Health care clearinghouses or vendors.
3. Health care providers who transmit any health information in electronic format in connection with a transaction covered in the HIPAA Transaction Rule. These terms are defined in detail in 45 CFR 160.103.

The N.C. Medicaid program, as a covered entity, satisfied the HIPAA compliance date by implementing the American National Standard Institute (ANSI) Accredited Standards Committee (ASC) X12N standards, Version 4010A1 on October 13, 2003, for the following transactions:

- Health Care Claim (Professional, Institutional, Dental) - 837 Transaction
- Health Care Claim Payment/Advice - 835 Transaction
- Health Care Claim Status Request and Response - 276/277 Transaction
- Benefit Enrollment and Maintenance - 834 Transaction

- Payroll Deducted and Other Group Premium Payment for Insurance Products - 820 Transaction
- Eligibility Benefit Inquiry and Response - 270/271 Transaction
- Health Care Services Review-Request for Review and Response - 278 Transaction

The N.C. Medicaid program also implemented the National Council for Prescription Drug Programs (NCPDP), Versions 1.1 Batch and 5.1 Point-of-Sale, in accordance to HIPAA legislation, as the standard for all retail pharmacy transactions.

Although the compliance date mandated by HIPAA was October 16, 2003, CMS allowed payers, including the N.C. Medicaid program, to continue accepting non-compliant formats to minimize financial hardship for the associates with whom they exchange transactions. The N.C. Medicaid program has been accepting both compliant and non-compliant transactions since October 13, 2003. October 1, 2005 marks the date the N.C. Medicaid program will cease accepting transactions on non-compliant electronic formats.

Currently, there are no billing policy changes related to this date. Should changes to billing policy become necessary, they will be communicated in future bulletin articles.

Compliance Options

Providers currently submitting claims via non HIPAA-compliant formats have several options for meeting the compliance date indicated above. These options are briefly detailed below:

1. Vendor - Providers may purchase HIPAA compliant software, from a vendor, which allows the creation of HIPAA compliant transactions. Providers who exercise this option will be required to have a Trading Partner Agreement on file, and are required to complete transaction testing before submitting transactions in production to N.C. Medicaid.

2. Clearinghouse - Providers may contract for the services of a clearinghouse. A clearinghouse acts as a middle-man between the provider and payer. Providers submit claims to the clearinghouse; in turn, the clearinghouse forwards the transactions to payers for adjudication. Under this option, the Trading Partner Agreement exists between the clearinghouse and the fiscal agent for N.C. Medicaid program since the clearinghouse is the actual entity submitting transactions to N.C. Medicaid on behalf of the provider.

3. In-House - Providers with technical staff or services may create their own transactions based on the standard electronic formats. As with the vendor solution, providers are required to have a Trading Partner Agreement on file and test with N.C. Medicaid before transactions can be filed in production.

4. NCECSWeb - Providers may file claims directly to N.C. Medicaid using NCECSWeb. NCECSWeb replaces all previous versions of N.C. Medicaid created claims filing software such as NECS and NCECS. NCECSWeb is a claims filing tool only and is only compatible with N.C. Medicaid. NCECSWeb complies with the data content standards required by HIPAA.

Providers are encouraged to begin the transition to one of these HIPAA-compliant formats immediately to ensure ample time to test and address compliance errors, if necessary. Regardless of the option selected, all providers who wish to file claims electronically will be required to have an Electronic Claims Submission Agreement on file for their provider number.

Providers should ensure that vendors, clearinghouses, and other associates with whom they conduct business are HIPAA-compliant. Providers must also be aware that HIPAA is federal legislation and impacts more than N.C. Medicaid. It may be necessary for providers to make changes in claims filing practices with all associated health plans.

Additional Information

Implementation guides for the ASC X12N and NCPDP (Pharmacy) transactions listed in this bulletin article have been established as the standard for HIPAA compliance.

The implementation guides for ASC X12N transactions are available at http://www.wpc-edi.com. The NCPDP implementation guide is available at http://www.ncpdp.org. The guides offer a detailed layout for standard transaction formats. In addition, to ensure a seamless transition from non-compliant electronic formats to HIPAA standard formats, companion guides have been published. These guides provide the specifics requirements necessary to successfully exchange transactions electronically with the N.C. Medicaid program in ASC X12 and NCPDP standard formats.

The information contained in the guides is for billing providers, their technical staff, clearinghouses or vendors. N.C. Medicaid companion guides are available at: http://www.dhhs.state.nc.us/dma/hipaa/compguides.htm.

Please visit the website on a regular basis to see if changes have been made to the companion guides that may impact your electronic transaction exchange with EDS.

Additional helpful information regarding HIPAA legislation can be found at:

- Centers for Medicare and Medicaid Services' HIPAA page: http://www.cms.hhs.gov/hipaa
- Workgroup for Electronic Data Interchange (WEDI) - HIPAA page: http://www.wedi.org
- June 2003, Special Bulletin II, HIPAA Update http://www.dhhs.state.nc.us/dma/bulletin/0603specbull.htm

For questions or a list of vendors and clearinghouses, please contact EDS Electronic Commerce Services at 1-800-688-6696, or 919-851-8888, option 1.

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

Attention: All Providers

Compression Garments

Effective with date of service August 1, all compression garments will be covered through the Orthotic and Prosthetic program. Refer to Clinical Coverage Policy #5B, *Orthotic and Prosthetic Devices* on the Division of Medical Assistance web site at www.dhhs.state.nc.us/dma/mp/mpindex.htm.

Compression garments are no longer covered when obtained through a physician's office. Clinical Coverage Policy 1A-1, *Compression Garments*, was end-dated on August 1, 2005 to reflect this change.

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

Attention: All Providers

OB/GYN Medicaid Billing Seminar

OB/GYN Medicaid Billing seminars are scheduled for October 2005. Seminars are intended for providers who provide OB/GYN services. Topics to be discussed include but are not limited to, Baby Love, obstetrics, gynecology, billing instructions and denial resolution.

The seminars are scheduled at the locations listed below. **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 OB/GYN Medicaid billing seminars by completing and submitting the registration form available on the next page or by registering online at http://www.dhhs.state .nc.us/dma/prov.htm. Please indicate the session you plan to attend on the registration form. **There will be two sessions, one for hospital providers and one for physician's providers. The session for hospitals will begin at 9:00 a.m. and end at 12:00 p.m. The session for physicians will begin at 1:00 p.m. and end at 4:00 p.m.** Providers are encouraged to arrive by 8:45 a.m. for the first session to complete registration and 12:45 for the second session. Refreshments will not be provided.

Please print the PDF version of the October 2005 OB/GYN Special Medicaid Billing Guide which will be available October 1, 2005 on DMA's website at http://www.dhhs.state.nc.us/dma/prov.htm, and bring it to the seminar.

The seminar will also reference the Basic Medicaid billing guidelines, so please bring a copy of the ***Basic Medicaid Billing Guide*** to the seminar. This billing guide can be found on DMA's website at http://www.dhhs.state.nc.us/dma/medbillcaguide.htm

Tuesday, October 11, 2005 Catawba Valley Technical College 2550 US Highway 70 Southeast Hickory, NC	**Wednesday, October 12, 2005** Ramada Inn Conference Center 212 W. Woodlawn Rd. Charlotte, NC
Wednesday, October 19, 2005 Greenville Hilton 207 SW Greenville Blvd Greenville, NC	**Friday, October 28, 2005** Jane S. McKimmon Center 1101 Gorman Street Raleigh, NC

Directions to the OB/GYN Medicaid Billing Seminars

Catawba Valley Technical College, Auditorium – Hickory, North Carolina

Take I-40 to exit 125. Travel approximately ½ mile to Highway 70. Travel east on Highway 70. The college is located approximately 1½ miles on the right. Ample parking is available in the rear lower parking areas. The entrance to the auditorium is between Student Services and the Maintenance Center. Follow sidewalk (toward satellite dish) and turn right to auditorium entrance.

Ramada Inn Conference Center-Charlotte, North Carolina

I-77 to Exit 6A Woodlawn Road. Hotel will be on the left

Greenville Hilton – Greenville, North Carolina

Take US 64 east to US 264 east. Follow 264 east to Greenville. Once you enter Greenville, turn right on Allen Road. After traveling approximately 2 miles, Allen Road becomes Greenville Boulevard/Alternate 264. Follow Greenville Boulevard for approximately 2½ miles. The Hilton Greenville is located on the right.

Jane S. McKimmon Center – Raleigh, North Carolina

Traveling East on I-40

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

Traveling West on I-40

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

(cut and return the registration form only)

OB/GYN Medicaid Seminars
Seminar Registration
(No Fee)

Provider Name _____ Provider Number _____
Address _____
City, Zip Code _____ County _____
Contact Person _____ E-mail Address _____
Telephone Number (____) _____ Fax Number (____)_____

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

Session: _____ AM (Hospital) _____ PM (Physicians)

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

Attention: All Providers

Obstetric Anesthesia Code Limitation Change

Effective with date of service October 1, the maximum unit limitation for the following Obstetric anesthesia codes that are billed with units of time will be 180 units per date of service.

Code	Description
01960	Anesthesia for vaginal delivery only
01961	Anesthesia for cesarean delivery only
01962	Anesthesia for urgent hysterectomy following delivery
01968	Anesthesia for cesarean delivery following neuraxial labor analgesia /anesthesia
01969	Anesthesia for cesarean hysterectomy following neuraxial labor analgesia /anesthesia

Units billed exceeding 180 will be cut back and payment will be made only for 180 units. An adjustment with medical records to support the need for additional units must be submitted for consideration of additional payment. Documentation must always support all units billed and services rendered.

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

Attention: All Providers

Transcranial Doppler Studies (CPT Codes 93886 – 93893) Covered ICD-9-CM Diagnosis Codes

Effective September 1, the list of ICD-9-CM codes covered by N.C. Medicaid for transcranial doppler study procedures 93886 through 93893 were changed or updated according to the 2005 edition of the ICD-9-CM diagnosis codes.

The changes to the diagnosis list for CPT codes 93886 through 93893 are:

- Diagnoses 434.00 through 434.91 were updated to include the 5th digit
- Diagnoses 742 through 742.9 were deleted

The following table lists the new covered ICD-9-CM diagnosis list:

From	Thru		From	Thru		From	Thru		From	Thru		From	Thru
282.5	282.5		282.60	282.69		348.8	348.8		430	430		433.00	433.01
433.10	433.11		433.20	433.21		434.00	434.91		435	435.9		436	436
437	437.9		447.1	447.1		747.81	747.81						

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

Attention: Case Management Service Providers

Federal Requirements for All Case Management Programs

All providers who bill fee-for-service for case management should review the federal requirements for case management programs to assess their level of alignment. The requirements for case management services as governed by Sections1902 (a) (23); 1905(a) (19); and 1915(g) of the Social Security Act have been summarized in this article to assist in this self-assessment. Because of the anticipated federal and state scrutiny of case management services, this self-assessment gives providers the opportunity to identify problem areas that need to be brought into alignment as soon as possible.

Providers with questions about these requirements and how they pertain to their case management program may contact the Division of Medical Assistance at the numbers listed below.

Program	Contact Name	Contact Phone Number
Case Management for Children and Adults At-Risk from Abuse, Neglect, or Exploitation	For Children - Behavioral Health Services For Adults - Facility and Community-Based Services	919-855-4290 919-855-4340
Child Service Coordination	Practitioner and Clinic Services	919-855-4260
Community Alternatives Program – Choice	Facility and Community-Based Services	919-855-4340
Community Alternatives Program for Children	Facility and Community-Based Services	919-855-4340
Community Alternatives Program for Disabled Adults	Facility and Community-Based Services	919-855-4340
Community Alternatives Program for Individuals with Aids	Facility and Community-Based Services	919-855-4340
HIV Case Management	Facility and Community-Based Services	919-855-4340
Maternity Care Coordination	Practitioner and Clinic Services	919-855-4260
Targeted Case Management for Individuals with Mental Retardation or Developmental Disabilities	Behavioral Health Services	919-855-4290

Service Components

Case management is defined as activities performed to assist recipients in coordinating access to needed medical, social, and educational services as well as other appropriate services. All case management programs are composed of the following components:

- **Assessment** activities focus on identifying the recipient's need for medical, education, social and other services. This includes:
  1. obtaining client history;
  2. identifying the recipient's needs, completing related documentation;
  3. gathering information from other sources such as family member, medical providers, and educators.
- **Care Planning** uses the information collected through the assessment to develop goals and to identify a course of action to respond to the assessed medical, social and educational needs of the recipient.
- **Referral and Linkage** includes activities that help the recipient to link with the providers of the medical, social, and educational needs identified in the assessment and care planning stages by making referrals to the providers and scheduling appointments with the providers. Additionally, this

component includes documentation of contacts with other agencies and programs and the actions that are taken to ensure non-duplication of payment.

- **Monitoring/Follow-up** includes activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addressing the needs of the recipients. Monitoring/follow-up activities are used to:
  1. evaluate services to determine that they are being furnished in accordance with the recipient's care plan;
  2. evaluate the care plan to ensure that it continues to address the recipient's needs; and
  3. re-evaluate and adjust the goals of the care plan as needed as a result of a change in the needs or the status of the recipient.

Medicaid does not reimburse for case management services when case management is also being provided as an integral part of another Medicaid covered service.

Payment for case management services may not duplicate payments made to public agencies or private entities under other program authorities for this same purpose **except** when the services are provided:

1. for prenatal care;
2. for preventive pediatric care, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services;
3. under a plan for an individual for whom child support enforcement is being carried out;
4. through a waiver program, unless case management is a component of the waiver program; or
5. through a recipient's Individualized Education Program (IEP).

Medicaid does not reimburse for case management services when a third party payer is liable for payment. The case management provider must appropriately identify and bill all liable third parties.

Non-covered Components

Outreach activities to contact potential recipients of a case management program do not constitute case management services. Therefore, outreach activities cannot be billed as a case management service.

Medicaid does not reimburse the case management provider for any service (medical, education, social, or transportation) other than what meets the definition of case management services. Medicaid only covers the referral and coordination activities associated with identifying the recipient's needs and assisting the recipient to obtain the appropriate care to address the needs identified in the recipient's care plan.

Discharge planning is required as a condition for payment of hospital, nursing facility, and ICF/MR services. Therefore, discharge planning cannot be billed separately as a case management service.

Coordination of Care

Because case management activities are an integral part of the home and community based services covered by Medicaid through programs such as home health, private duty nursing, personal care services, etc., case management providers are responsible for coordinating their activities to ensure non-duplication of payment.

Case management services provided to a recipient who is also receiving benefits through a Title IV-B and Title IV-E foster care program must be coordinated to ensure that the services billed to Medicaid meet the definition of case management and are not directly connected to the delivery of foster care benefits and services.

Documentation

The case management provider must maintain case records that indicate all contacts with and on behalf of the recipient. The case record must also, at a minimum, document the:

1. recipient's name and Medicaid identification number;
2. name of the provider agency and the case manager assigned to the recipient;
3. place of service delivery;

4. date of service; and
5. nature, duration and/or units of service.

For audit purposes, services for which there is no such documentation will be deemed as not having been provided.

Additional information about specific case management programs will be provided at a future date.

Clinical Policy and Programs
919-855-4260

Attention: Case Management Service Providers and Local Management Entities

Level of Care Prior Approval for Intermediate Care Facilities for the Mentally Retarded (ICF/MR)

Effective September 1, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and the Division of Medical Assistance (DMA) implemented a new prior approval process for individuals applying for intermediate care facility for the mentally retarded(ICF/MR). The Murdoch Center is providing a clinical team to perform the review and determination part of the approval process. (This function was previously performed by DMA's fiscal agent, Electronic Data Systems or EDS.)

Prior approval for services provided to individuals who meet the criteria for intermediate level of care is required when:

1. there is an admission to an intermediate care facility for individuals with mental retardation (ICF/MR);
2. an individual seeks to apply for services through the Community Alternatives Program for Individuals with Mental Retardation or Developmental Disabilities (CAP/MR-DD);
3. the utilization review committee recommends a change in the level of care;
4. an individual residing in an ICF/MR who was previously paying for services privately or through a third party carrier seeks Medicaid assistance;
5. a resident is discharged from an ICF/MR to a lower level of care or to his/her own home, and then later re-applies for ICF/MR level of care; and
6. a Medicaid recipient's benefits are terminated for 90 days or more before reinstatement, even though the individual remains in the same facility.

Medicaid-eligible individuals with mental retardation are referred to a case manager for services and supports by their Local Management Entity (LME). The LME uses an access, screening, and triage process to identify individuals who appear to meet the intermediate level of care criteria, which are referenced in the CAP-MR/DD manual.

If the LME determines that the individual appears to meets the criteria, the LME refers the individual to a case management provider for a diagnostic assessment and for targeted case management services. Case management services are pre-authorized for a 30-day period to allow for the diagnostic assessment.

If an individual, the guardian or a family member contacts the case manager directly, it is the case manager's responsibility to notify the LME and ensure that prior authorization is received for the diagnostic assessment and for targeted case management services.

Once the preliminary level of care has been determined, the case management provider must request approval for services. Requests are made using the MR2 form. The form must be completed and signed by a physician or a clinical psychologist licensed in the State of North Carolina, and by the case manager or the LME. The request must be accompanied by a psychological evaluation and an adaptive behavior assessment. For children, the evaluation and assessment must have been completed within the last year. For adults, the evaluation and assessment must have been completed within the last three years. It is the responsibility of the case management provider to coordinate any additional assessments that might be needed (speech, physical therapy, occupational therapy, etc.).

Requests may be submitted to the Murdoch Center by fax. However, the original MR2 and documentation must be received by the Murdoch Center within 10 working days of the fax or phone approval. If the Murdoch Center does not receive the original MR2 within this time frame, the prior authorization will be voided.

The clinical team from the Murdoch Center reviews the MR2 request and documentation and makes a decision within five business days. The LME is notified by phone or fax of the decision, and if the individual meets the criteria for intermediate level of care, a prior authorization number is issued. The effective date of the MR2 is the date of the initial approval. This approval in and of itself does not entitle anyone to Wavier Services. If the request was initially submitted by fax, the effective date is the date the fax was received by the Murdoch Center. If the individual does not meet the ICF/MR level of care criteria an Appeal Request Form will be provided with the denial letter.

The fax number and address for the Murdoch Center are:

Murdoch Center
Specialized Services
PO Box 3000
Butner, NC 27509

Fax: 919-575-1083

Attention: Francis Averett/Jeffrey Holden
919-575-1070

Behavioral Health Services
DMA, 919-855-4290

Attention: Home Health Agencies, Private Duty Nursing Providers, and Community Alternatives Program Case Managers

HCPCS Code Additions for Medical Supplies

The following medical supply codes are being added to the home health fee schedule, effective with dates of service August 1. The code additions resulted from a review of items billed using the miscellaneous supply code T1999. Providers are reminded to limit the use of T1999 to billing for supplies that meet the criteria for home health medical supplies but with no applicable HCPCS code on the Home Health Fee Schedule. The brand names used in the description of the codes are only intended as examples of items similar in purpose and function.

HCPCS CODE	Description	Unit	Maximum Allowable
A4212	NON-CORING NEEDLE OR STYLET WITH OR WITHOUT CATHETER *(HUBER NEEDLE)*	each	10.00
A4352	INTERMITTENT URINARY CATHETER; COUDE (CURVED) TIP, WITH OR WITHOUT COATING (TEFLON, SILICONE, SILICONE ELASTOMERIC, OR HYDROPHILIC, ETC.), EACH	each	5.94
A4353	INTERMITTENT URINARY CATHETERS WITH INSERTION SUPPLIES	each	7.00
A4365	ADHESIVE REMOVER WIPES	Box 50	11.32
A4372	OSTOMY SKIN BARRIER, SOLID 4X4 OR EQUIVALENT, STANDARD WEAR, WITH BUILT-IN CONVEXITY, EACH	each	4.18
A4373	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE OR ACCORDION), STANDARD WEAR, WITH BUILT-IN CONVEXITY, ANY SIZE, EACH	each	6.28
A4375	OSTOMY POUCH, DRAINABLE, WITH FACEPLATE ATTACHED, PLASTIC, EACH	each	17.18
A4377	OSTOMY POUCH, DRAINABLE, FOR USE ON FACEPLATE, PLASTIC, EACH	each	4.29
A4379	OSTOMY POUCH, URINARY, WITH FACEPLATE ATTACHED, PLASTIC, EACH	each	15.02
A4381	OSTOMY POUCH, URINARY, FOR USE ON FACEPLATE, PLASTIC, EACH	each	4.61
A4385	OSTOMY SKIN BARRIER, SOLID 4X4 OR EQUIVALENT, EXTENDED WEAR, WITHOUT BUILT-IN CONVEXITY, EACH	each	6.49
A4390	OSTOMY POUCH, DRAINABLE, WITH EXTENDED WEAR BARRIER ATTACHED, WITH BUILT-IN CONVEXITY (1 PIECE), EACH	each	9.61
A4398	OSTOMY IRRIGATION SUPPLY; BAG, EACH	each	13.81
A4400	OSTOMY IRRIGATION SET	each	41.54
A4416	OSTOMY POUCH CLOSED /BARRIER /FILTER (ONE PIECE)	each	2.75
A4417	OSTOMY POUCH/BARRIER/BUILT IN CONVEXCITY/FILTER (ONE PIECE)	each	3.72
A4418	OSTOMY POUCH CLOSED WITHOUT BARRIER WITH FILTER (ONE PIECE)	each	1.81
A4419	OSTOMY POUCH for BARRIER WITH FLANGE/FILTER (TWO PIECE	each	1.74
A4423	OSTOMY POUCH, CLOSED FOR USE ON BARRIER WITH LOCKING FLANGE and FILTER (TWO PIECE)	each	1.86
A4424	OSTOMY POUCH, DRAINABLE, WITH BARRIER ATTACHED WITH FILTER (ONE PIECE)	each	4.75
A4425	OSTOMY POUCH, DRAINABLE, FOR USE ON BARRIER WITH NON-LOCKING FLANGE (TWO PIECE SYSTEM)	each	3.58
A4426	OSTOMY POUCH, DRAINABLE, FOR USE ON BARRIER WITH LOCKING FLANGE (TWO PIECE SYSTEM)	each	2.70

HCPCS CODE	Description	Unit	Maximum Allowable
A4427	OSTOMY POUCH, DRAINABLE, *FOR USE ON* BARRIER WITH LOCKING FLANGE WITH FILTER(TWO PIECE SYSTEM)	each	2.78
A4428	OSTOMY POUCH, URINARY, WITH EXTENDED WEAR BARRIER ATTACHED, WITH FAUCET TYPE TAP WITH VALVE (ONE PIECE)	each	6.51
A4429	OSTOMY POUCH, URINARY, *WITH* BARRIER ATTACHED, WITH BUILT IN CONVEXITY FAUCET TYPE TAP WITH VALVE (ONE PIECE)	each	8.25
A4431	OSTOMY POUCH, URINARY, *WITH* BARRIER ATTACHEDFAUCET TYPE TAP WITH VALVE(ONE PIECE)	each	6.22
A4433	OSTOMY POUCH, URINARY FOR USE ON BARRIER WITH LOCKING FLANGEFAUCET TYPE TAP WITH VALVE(TWO PIECE)	each	3.34
A4462	ABDOMINAL DRESSING HOLDER / BINDER,	each	3.29
A4628	OROPHARYNGEAL SUCTION CATH	each	3.56
A6200	COMPOSITE DRESSING, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING	each	9.50
A6201	COMPOSITE DRESSING, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING	each	20.80
A6203	COMPOSITE DRESSING, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	each	3.35
A6204	COMPOSITE DRESSING, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	each	6.23
A6206	CONTACT LAYER, 16 SQ. IN. OR LESS, EACH DRESSING	each	14.30
A6207	CONTACT LAYER, MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH DRESSING	each	7.34
A6209	FOAM DRG LESS THAN OR EQUAL TO 16 SQ IN WITHOUT BORDER	each	7.48
A6210	FOAM DRG MORE THAN 16 SQ IN BUT LESS THAN OR EQUAL TO 48 SQ IN WITHOUT BORDER	each	19.92
A6212	FOAM DRG LESS THAN OR EQUAL TO 16 SQ IN WITH/BORDE	each	9.70
A6213	FOAM DRG MORE THAN 16 BUT LESS THAN OR EQUAL TO 48 SQ IN W/BORDER	each	20.00
A6215	FOAM DRESSING WOUND FILLER	per Gm	11.50
A6219	GAUZE, NON-IMPREGNATED, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	each	0.95
A6220	GAUZE, NON-IMPREGNATED, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	each	2.58

HCPCS CODE	Description	Unit	Maximum Allowable
A6236	HYDROCOLLIOD DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING.	each	27.25
A6237	HYDROCOLLIOD DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING.	each	7.91
A6238	HYDROCOLLIOD DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING.	each	22.79
A6242	HYDROGEL DRESING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING	each	6.07
A6243	HYDROGEL DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 SQ. IN BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING	each	12.31
A6245	HYDROGEL DRESING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	each	7.27
A6246	HYDROGEL DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 SQ. IN BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	each	9.92
A6248	HYDROGEL DRESSING, WOUND FILLER, GEL, PER FLUID OUNCE		16.24
A6253	SPECIALTY ABSORPTIVE DRESSINGS, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING	each	6.34
A6259	TRANSPARENT FILM, MORE THAN 48 SQ. IN., EACH DRESSING	each	10.94
A6453	SELF-ADHERENT BANDAGE, ELASTIC, NON-KNITTED/NONWOVEN WIDTH LESS THAN 3", PER YD (*DYNAFLEX ELASTIC BANDAGE, COBAN)*	per yd	0.61
A6454	SELF-ADHERENT BANDAGE, ELASTIC, NON-KNITTED/NONWOVEN WIDTH GREATER OR EQUAL TO 3"AND LESS THAN 5 IN., PER YD (*DYNAFLEX ELASTIC BANDAGE, COBAN)*	per yd	0.77
A6455	SELF-ADHERENT BANDAGE, ELASTIC, NON-KNITTED/NONWOVEN WIDTH GREATER OR EQUAL TO 5", PER YD. (*DYNAFLEX ELASTIC BANDAGE, COBAN)*	per yd	1.39
A7527	TRACHEOSTOMY/LARYNGECTOMY TUBE/PLUG	each	3.58
A9999	MISCELLANEOUS DME SUPPLY NOT OTHERWISE SPECIFIED. *(PROFORE, DYNAFLEX, ETC. LAYERED COHESIVE KIT)*	each	27.22
B9998	NOC FOR ENTERAL SUPPLIES (*MIC-KEY TUBE*, LOW PROFILE GASTROSTOMY)	each	152.46
T5999	SUPPLY, NOT OTHERWISE CLASSIFIED (VENIPUNCTURE KIT)	each	2.34

Providers are reminded to use their usual and customary rates when billing for Medicaid medical supplies

Providers are reminded to use their usual and customary rates when billing for Medicaid medical supplies

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

Attention: Community Development Service Agency, Head Start/Local Education Agencies, Home Health Providers, Independent Practitioner Providers, Local Health Departments, Local Management Entities, Outpatient Hospital Clinics, and Physicians.

Clarification of First Treatment for Outpatient Specialized Therapies

This information is a follow up to the article in the July 2005 bulletin on Outpatient Specialized Therapies. If a recipient is under five years of age and has had a CDSA evaluation or a CDSA-approved evaluation and has an Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP), the time for required prior approval for continued services will change to six months after the initial physician's order. The date of the physician's order is known as the first treatment date (FTD). **Once a recipient reaches their fifth birthday, the 6-month exemption ends and prior approval is required even if the six months is not over.** When a claim is submitted and it has prior approval as well as an FTD the claim will use the PA units first and the **FTD will be ignored**. The FTD will not be identified from the claim as long as PA is available. The **FTD will also be ignored if the claim denies for any reason**. That is why it is important that the same first treatment date be entered on each claim submitted during the 6-month period. If a date of service on the claim is prior to the first treatment date, the claim is subject to prior approval. Providers who bill on the CMS-1500 must enter the first treatment date in block 15. Providers who bill on the UB-92 must use the occurrence form locators 32, 33, 34, or 35. Enter a "28" in the occurrence code field and then enter the first treatment date in the corresponding "date" field. Once a first treatment date is entered on a claim, per discipline, and the six months have been exhausted, there can not be another first treatment date or six unmanaged visits.

If there is no first treatment date on the claim, prior approval will be required. If a recipient starts on a six unmanaged visit track within a particular discipline then they are not able to change to a 6-month track within that same discipline.

Systematic Reprocessing

Specialized therapy claims that have been paid or denied incorrectly will be systematically identified and adjusted. In an effort to eliminate the adjusting of claims already identified for systematic processing, all specialized therapy adjustments and replacement claims submitted by providers will be denied until the system adjustments have been completed. If you have submitted an adjustment request or replacement claim for a specialized therapy service that has been identified for systematic adjustment it will be denied with **EOB 2046** that states: "Adj request denied. Adj/replacement claims for specialized therapy services will be adjusted systematically".

Time frames for system generated adjustments will be during the month of September. When you receive your R/A, please review the adjusted specialized therapy claims to determine if your initial adjustment request has been addressed. If so, no further action is required. Once the systematic adjustments have been completed, the denials of manual adjustments will no longer be in effect.

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

Attention: Dialysis Facilities, Outpatient Hospitals, and Physicians

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

This article contains corrections to the August 2005 bulletin titled "Epogen for End-Stage Renal Disease - Changes to Billing Guidelines." The corrections are in bold letters.

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

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

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

- ICD-9-CM diagnosis code 585, chronic renal failure, must be entered on the claim (UB-92) as the primary diagnosis,
  along with
- One of the following additional diagnosis codes:
  - 285.8, Other specified anemia;
  - 285.9, Anemia, unspecified; and
  - 285.21, Anemia in end-stage renal disease.
- Bill one unit for each 1000 units of EPO administered.
- EPO must be billed with either RC 634 or RC 635 (placed in form locator 42).
- RC634 and RC635 must be billed with Q4055 (placed in form locator 43) for EPO.
- Bill RC634 if EPO administered is **less than** 10,000 units.
- Bill RC635 if EPO administered is **equal to or greater than** 10,000 units.
- Enter the service date in form locator 45.
- Enter the number of units administered in form locator 46. For example, **for 10,000 units record 10 units.**
- Enter the total charge in form locator 47.
- All EPO charges for the same date of service must be billed as one detail on the claim. If EPO charges are billed on two or more details on the claim for the same date of service, each of the details will deny.
- Value code 49 (for HCT) or 48 (for HGB) must be billed to represent the HCT or HGB blood level at the beginning of the billing period (the date of service on the claim). Place the number "49" and the HCT value in form locator 39a. Place the number "48" and the HGB value in form locator 40a.
- Value code 68 must be billed to represent the total amount of EPO given during the billing period. Place the number "68" and the value for the total amount of EPO given during the billing period in form locator 41a. **Record the total units for value code 68: For example, 10,000 units of Epogen should be indicated by 10000.**
- Billing must be done on a calendar month basis. Do not bill for dates of service spanning more than one calendar month: Bill on two separate claims.

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

1. Claim #1 is for dates of service 1-1-2005 thru 1-15-2005 (billing period). EPO 20,000 units were given during this time period and are billed as a total of 20 units on various details of the claim. Value code 68 on the claim would **show 20000** units.

2. Claim #2 is for dates of service 1-16-2005 thru 1-31-2005 (billing period). EPO 15,000 units were administered during that time. The claim is billed with a total of 15 units of EPO on various details of the claim. Value code 68 for this claim would **show 15000** units.

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

Outpatient Hospitals

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

- Bill on the UB-92 claim form.
- ICD-9-CM diagnosis code 585, chronic renal failure, must be entered on the claim (UB-92) as the primary diagnosis
  along with
- One of the following additional diagnosis codes:
  - 285.8, Other specified anemia;
  - 285.9, Anemia, unspecified; and
  - 285.21, Anemia in end-stage renal disease
- Bill one unit for each 1000 units of EPO administered.
- EPO must be billed with either RC 634 or RC 635 (placed in form locator 42).
- RC634 and RC 635 must be billed with Q4055 (placed in form locator 43) for EPO.
- Bill RC634 if EPO is **less than** 10,000 units.
- Bill RC635 if EPO is **equal to or greater than** 10,000 units.
- Enter the service date in form locator 45.
- Enter the number of units in form locator 46. **For example, for 10,000 units, record 10 units.**
- Enter the service date in form locator 47.
- All EPO charges for the same date of service must be billed as one detail on the claim. If EPO charges are billed on two or more details on the claim for the same date of service, each of the details will deny.
- Value code 49 (for HCT) or 48 (for HGB) must be billed to represent the HCT or HGB blood level at the beginning of the billing period (the date of service on the claim). Place the number "49" and the HCT value in form locator 39a. Place the number "48" and the HGB value in form locator 40a.
- Value code 68 must be billed to represent the total amount of EPO given during the billing period. Place the number "68" and the value for the total amount of EPO given during the billing period in form locator 41a. **Record the total units for value code 68: For example, 10,000 units of Epogen should be indicated by 10000.**
- Billing must be done on a calendar-month basis. Do not bill for dates of service spanning more than one calendar month: Bill on two separate claims.

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

1. Claim #1 is for dates of service 1-1-2005 thru 1-15-2005 (billing period). EPO 20,000 units were given during this time period and are billed as a total of 20 units on various details of the claim. Value code 68 on the claim would **show 20000** units.

2. Claim #2 is for dates of service 1-16-2005 thru 1-31-2005 (billing period). EPO 15,000 units were administered during that time. The claim is billed with a total of 15 units of EPO on various details of the claim. Value code 68 for this claim would **show 15000** units.

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

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

- ICD-9-CM diagnosis code 585, chronic renal failure, must be entered on the claim (UB-92) as the primary diagnosis

along with

- One of the following additional diagnosis codes:
  - 285.8, Other specified anemia;
  - 285.9, Anemia, unspecified; and
  - 285.21, Anemia in end-stage renal disease.
- Bill HCPCS code Q4055 for EPO; enter the number of units given in block 24-G on the CMS-1500 claim form.

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

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

Attention: Durable Medical Equipment Providers

Code Conversion for Blood Glucose Monitor with Special Features

In order to comply with the Centers for Medicare and Medicaid Services (CMS) HCPCS coding changes, HCPCS code E0609, blood glucose monitor with special features, was converted to code E2100, blood glucose monitor with integrated voice synthesizer. The change is effective with date of service September 1, 2005.

Prior approval is required. The coverage criteria for code E2100 remains the same as that established for code E0609. The lifetime expectancy remains three years. The maximum allowable rates for code E2100 have been established as follows: $634.31 for new purchase, $475.75 for used purchase, and $63.43 for rental. Providers must bill their usual and customary rate. Refer to Clinical Coverage Policy #5A, Durable Medical Equipment, on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm for detailed coverage and billing information.

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

Attention: Durable Medical Equipment Providers

Correction to July 2005 Code Conversions for Power Wheelchair Electronics, Wheelchair Components, and Enteral Nutrition Products

HCPCS code E2325, "power wheelchair accessory, sip and puff interface, non-proportional, including all related electronics, mechanical stop switch, and manual swingaway mounting hardware", was erroneously omitted from the conversion chart for code K0108/W4151, specialty controls with hardware, in the July 2005 Bulletin article. The code became effective with date of service July 1. Code E2325 requires prior approval. The lifetime expectancy of the accessory is 2 years for recipients ages birth through 20 years and four years for recipients ages 21 and older. The maximum reimbursement rates are as follows: $1,346.83 for new purchase, $1,010.13 for used purchase, and $134.70 for monthly rental.

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

Attention: Hospital Outpatient Departments, Local Management Entities, Mental Health Practitioners who are employed in Physicians Offices/Clinics, and School Based Health Centers

Correction to Billing Information for Dually Eligible Medicare/Medicaid Recipients Printed in the August 2005 General Medicaid Bulletin

If you are a master's level psychologist/ (LPA), a Licensed Professional Counselor/(LPC), Licensed Marriage and Family Therapist/(LMFT), Certified Clinical Supervisor/ (CCS) or a Certified Clinical Addictions Specialist/(CCAS) and are seeing Medicare recipients, you must bill "incident to" a physician, a PhD, CNS or Psychiatric Nurse Practitioner whenever you treat Medicare/Medicaid recipients. LCSW was incorrectly included in the above list in the August 2005 General Medicaid Bulletin article.

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

Behavioral Health Section
919-855-4290

Attention: Nurse Practitioners and Physicians

Abarelix, 10 mg (Plenaxis) J0128 – Revised Billing Guidelines

Effective with date of service September 1, the N.C. Medicaid program has redefined the billing guidelines for Plenaxis from the original article in the January 2005 general Medicaid bulletin. Plenaxis can **only** be used as a palliative treatment in patients with advanced symptomatic prostate cancer in whom gonadotropin-releasing hormone (GnRH) therapy is not appropriate and who decline surgical castration and who present with one of the following:
(a) risk of neurological compromise due to metastases;
(b) ureteral or bladder outlet obstruction due to local encroachment or metastatic disease; or
(c) severe bone pain from skeletal metastases persisting on narcotic analgesia.

Additionally, in accordance with the Food and Drug Administration (FDA) labeling requirements, to ensure that Plenaxis is used only in patients for whom the drug is indicated, and in light of concern regarding its safety risks, prescribing physicians are required to be enrolled in the post-marketing risk management program that the drug manufacturer has established.

In a recent National Coverage Decision (NDC), the Centers for Medicare and Medicaid Services (CMS) determined that the evidence is not adequate to conclude that Plenaxis is reasonable and necessary for indications other than those specified above. Therefore, all other uses are non-covered.

The FDA's recommended dosing schedule for Plenaxis is 100 mg administered intramuscularly on day 1, 15, 29, and every four weeks thereafter. Treatment failure can be detected by measuring serum testosterone concentrations just prior to Plenaxis administration beginning on day 29 and every eight weeks thereafter.

The ICD-9-CM diagnosis codes required when billing for Plenaxis are:
V58.1 – admission or encounter for chemotherapy;
and
185 – Malignant Neoplasm of Prostate.

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

Attention: Nurse Practitioners and Physicians

Paclitaxel Protein-bound Particles for Injectable Suspension, 1mg. (Abraxane, J9999) – Billing Guidelines

Effective with date of service February 1, the N.C. Medicaid program covers Abraxane, 1 mg. (paclitaxel protein-bound particles) for use in the Physician's Drug Program. The FDA-approved indication for Abraxane is the treatment of breast cancer after failure of combination chemotherapy for metastatic disease or relapse within six months of adjuvant chemotherapy. Prior therapy should have included an anthracycline unless clinically contraindicated. The recommended dosing schedule is 260 mg/m2 administered intravenously over 30 minutes every three weeks.

An ICD-9-CM diagnosis in the range of **174.0-175.9** is required when billing for Abraxane.

Providers must bill J9999, the unclassified drug code for antineoplastic agents, with an invoice attached to the CMS-1500 claim form. **An invoice must be submitted with each claim.** The paper invoice must indicate the recipient's name and Medicaid identification number, the name of the medication, the dosage given, the National Drug Code (NDC) number from the vial(s) used, the number of vials used, and the cost per dose. Providers must indicate the number of units given in block 24G on the CMS-1500 claim form. For Medicaid billing, one unit of coverage is 1 mg. The maximum reimbursement rate per unit is $8.32. Providers must bill their usual and customary charge. Add this drug to the list of injectable drugs published in the November 2004 general Medicaid bulletin.

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

Attention: Nursing Facility Providers

Nursing Facility Changes in Ownership

The North Carolina Medicaid State Plan was amended effective October 1, 2003 to include a requirement requirement that for nursing facility change of ownership, the new owner assumes all Medicaid liabilities, sanctions and penalties regardless of when the ownership took place. The Division of Medical Assistance will not approve nursing facility agreements that exclude this requirement. Refer to the Attachment 4.19-D .0102 (f) (2) on DMA's website at http://www.dhhs.state.nc.us/dma/plan/sptoc.htm for additional information.

DMA, Provider Services
919-855-4050

Attention: Pharmacy Providers

Medicare Part D: Implications for North Carolina's Pharmacists and Senior Citizens a Continuing Education Program for Pharmacists and Pharmacy Technicians

This fall, the North Carolina Association of Pharmacists (NCAP), North Carolina Senior Care, and the UNC-CH School of Pharmacy are co-sponsoring Medicare Part D continuing education programs for pharmacists and pharmacy technicians. There will be 10 programs across the state between September 15, 2005, and October 18. Most programs will be held in AHEC facilities, with one conducted on Sunday evening, October 16, 2005, at the NCAP Annual Convention (Sheraton Imperial Hotel, Durham). The UNC-CH School of Pharmacy is serving as the ACPE accredited provider for continuing education credit.

The goal of this program is to describe the intent of Medicare Part D and the prescription drug benefit. North Carolina pharmacists who are Medicare experts will discuss the role of the pharmacist and how this historical reform will affect pharmacy as a profession.

Please visit www.ncpharmacists.org/calendar.cfm to view the brochure and register for the Medicare Part D program in your area.

Medicare Part D
919-855-4000

NCLeads Update

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

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

Proposed Clinical Coverage Policies

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

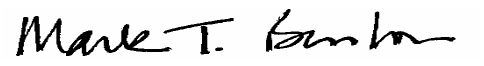
Gina Rutherford
Division of Medical Assistance
Clinical Policy Section
2501 Mail Service Center
Raleigh, NC 27699-2501

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

2005 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
September	9/02/2005	9/07/2005
	9/09/2005	9/13/2005
	9/16/2005	9/20/2005
	9/23/2005	9/29/2005
October	10/07/2005	10/11/2005
	10/14/2005	10/18/2005
	10/21/2005	10/27/2005
November	11/04/2005	11/08/2005
	11/11/2005	11/15/2005
	11/18/2005	11/23/2005

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



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

Cheryll Collier
Executive Director
EDS