Number 9 *September 2006*

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

Basic Medicaid Billing Seminar Schedule

Basic Medicaid Billing seminars are scheduled for October 2006. Seminars are intended for providers who are new to the NC Medicaid program. Topics to be discussed will include, but are not limited to, provider enrollment requirements, billing instructions, eligibility issues, and managed care. Persons inexperienced in billing NC Medicaid are encouraged to attend.

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 Basic Medicaid Billing seminars by completing and submitting the registration form 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. Seminars will begin at 9 a.m. and end at 12 p.m. Providers are encouraged to arrive by 8:45 a.m. to complete registration.

Providers must print the PDF version of the October 2006 Basic Medicaid Billing Guide from DMA's website at http://www.dhhs.state.nc.us/dma/medbillcaguide.htm and bring it to the seminar.

The registration form for the seminars is on the next page of this bulletin.

Tuesday, October 3, 2006 City Hotel & Bistro Greenville Blvd. Greenville, North Carolina	**Thursday, October 5, 2006** Jane S. McKimmon Center 1101 Gorman Street Raleigh, North Carolina
Tuesday, October 17, 2006 Blue Ridge Community College Bo Thomas Auditorium College Drive Flat Rock, North Carolina	**Tuesday, October 24, 2006** Holiday Inn Conference Center 530 Jake Alexander Blvd S. Salisbury, North Carolina

Directions to the Basic Medicaid Seminars

City Hotel & Bistro – Greenville
From Raleigh: Take 264 East to Wilson, N.C., and then to Greenville. Coming into Greenville city limits, turn right at the 2nd stoplight onto 264 Alternate (also called Allen Road). The hotel is 5 miles from the turn, on the right.

From New Bern: Take 17 North to Vanceboro, N.C. In Vanceboro, take 43 East to Greenville. At the 3rd stoplight coming into Greenville (Plaza Mall is on your left), turn left onto Greenville Boulevard. The hotel is approximately 2 miles on the left.

From North/South of North Carolina: Take Interstate 95 to Wilson, N.C. In Wilson, take 264 East to Greenville. Coming into Greenville city limits, turn right at the 2nd stoplight onto 264 Alternate (also called Allen Road). The hotel is 5 miles from the turn, on the right.

Jane S. McKimmon Center – Raleigh
Traveling East on I-40: Take Exit 295 and turn left onto Gorman Street. Travel approximately 2.5 miles. 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 2.5 miles. The McKimmon Center is located on the right at the corner of Gorman Street and Western Boulevard.

Blue Ridge Community College, Bo Thomas Auditorium – Flat Rock
Take I-40 to Asheville. Travel east on I-26 to Exit 53, Upward Road. Turn right at the end of the ramp. At the second light (about 0.5 mile), turn right onto South Allen Drive. Drive about 0.4 mile to the Blue Ridge Community College sign, and turn left onto College Drive. The first building on right is the Sink Building. Bo Thomas Auditorium is on the left side of the Sink Building.

Holiday Inn Conference Center – Salisbury
Traveling South on I-85: Take Exit 75. Turn right onto Jake Alexander Boulevard. Travel approximately 0.5 mile. The Holiday Inn is located on the right.

Traveling North in I-85: Take Exit 75. Turn left onto Jake Alexander Boulevard. Travel approximately 0.5 mile. The Holiday Inn is located on the right.

Basic Medicaid Seminars
Seminar Registration
(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)

Attention: All Providers

Clinical Coverage Policies

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

3 H-1 Home Infusion Therapies
3 H-2 Home Tocolytic Infusion Therapies
5A Durable Medical Equipment
5B Orthotic and Prosthetics
8C Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers
8D-1 Psychiatric Residential Treatment Facilities for Children under the Age of 21
8D-2 Residential Treatment Facilities

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

Family Planning Waiver Eligible Recipients

Effective October 1, 2005, the North Carolina "Be Smart" Family Planning Waiver was implemented. Eligible recipients for the Family Planning Waiver are:

- Women age 19 through 55
- Men age 19 through 60
- US citizens or documented immigrants
- North Carolina residents who:
  - Have income at or below 185% of the federal poverty level
  - Are not incarcerated, pregnant or permanently sterilized
  - **Do not receive Medicare**

Recipients eligible to receive Family Planning Waiver services are not eligible for Medicaid under any other Medicaid program. The department of social services (DSS) determines all recipient eligibility for the Family Planning Waiver. Local departments of social services should be contacted for questions regarding recipient eligibility.

Providers should contact EDS with billing questions.

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

Attention: All Providers

Medicare Part D

Beginning January 1, 2006, if a Medicaid recipient is entitled to Medicare Part A or B, federal law states that Medicaid CANNOT pay for this recipient's prescription drugs. This federal law also applies even when a recipient has not enrolled with a Medicare Part D prescription drug plan or the Medicare Part D prescription drug plan does not become effective until a future month. The pharmacy can submit a point of sale claim to Wellpoint, which is Medicare's transitional or temporary Part D prescription drug plan.

Wellpoint's phone number is 1-800-662-0210. If a pharmacy is having problems filing with Wellpoint, they can contact Medicare's pharmacy consultants: Dr. Denise Stanley at 404-562-7366 or Dr. Carla Jones at 404-562-7228.

Please refer to the December 2005 General Medicaid Bulletin article titled, Medicaid Coverage Information for the Excluded Drug Classes under Medicare Part D. This bulletin article gives a list of drug classes that are currently excluded under the Medicare Part D drug plans, which Medicaid may consider for payment.

For a list of drug classes that are currently excluded under the Medicare Part D drug plans, which Medicaid may consider for payment. Please refer to the December 2005 General Medicaid Bulletin article titled, Medicaid Coverage Information for the Excluded Drug Classes under Medicare Part D.

If a pharmacy receives a denial to bill Medicare, and the Medicaid recipient is no longer entitled to Medicare Part A or B or the Medicaid recipient's Medicare is not effective until a future month, the pharmacy can call the DMA Claims Analysis Unit, at 919-855-4045 to have the recipient's Medicaid file corrected.

Medicare Pharmacy Eligibility
1-866-835-7595

Attention: All Providers

National Provider Identifier (NPI) Informational Seminar Schedule

National Provider Identifier (NPI) seminars are scheduled for October 2006. Seminars are intended for providers who are interested in obtaining a general overview of NPI and learning about DMA's implementation approach and plans for gathering NPIs.

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 NPI seminars by completing and submitting the registration form 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. Seminars will begin at 1:30 p.m. and end at 3:30 p.m. Providers are encouraged to arrive by 1:15 p.m. to complete registration. Providers are not required to bring any published material to this seminar.

Tuesday, October 3, 2006 City Hotel & Bistro Greenville Blvd. Greenville, North Carolina	**Thursday, October 5, 2006** Jane S. McKimmon Center 1101 Gorman Street Raleigh, North Carolina
Tuesday, October 17, 2006 Blue Ridge Community College Bo Thomas Auditorium College Drive Flat Rock, North Carolina	**Tuesday, October 24, 2006** Holiday Inn Conference Center 530 Jake Alexander Blvd S. Salisbury, North Carolina

Directions to the NPI Seminars

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From Raleigh: Take 264 East to Wilson, N.C., and then to Greenville. Coming into Greenville city limits, turn right at the 2nd stoplight onto 264 Alternate (also called Allen Road). The hotel is 5 miles from the turn, on the right.

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NPI Seminars
Seminar Registration
(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)

Attention: All Providers

Sincalide, 5 micrograms (HCPCS code J2805)—Billing Guidelines

Effective with date of service January 1, 2006, the diagnostic agent Sincalide is covered by the N.C. Medicaid program when billed with HCPCS procedure code J2805.

Billing Guidelines:

- HCPCS code J2805 must be billed with CPT code 78223 (Hepatobiliary ductal system imaging, including gallbladder, with or without pharmacologic intervention, with or without quantitative measurement of gallbladder function) by the same billing provider for the same date of service.
- HCPCS code J2805 must also be billed with A9510 (Technetium TC-99M disofenin, per vial) **OR** A9537 (Technetium TC-99M mebrofenin, diagnostic, per study dose, up to 15 millicuries), by the same billing provider for the same date of service.
- It is not necessary to send an invoice for J2805; however, it is necessary to send an invoice for A9510 and A9537 with the claim. Invoices must indicate the name of the recipient, the recipient's Medicaid identification number (MID), the name of the agent, the dosage administered, and the cost per dose.
- Claims submitted without appropriate codes listed on the claim will be denied.
- It is recommended that all of these related codes that are billed by the same provider be billed on the same claim.

Providers must bill the usual and customary charge. One Medicaid unit of J2805 equals 5 micrograms. The maximum reimbursement rate per unit of J2805 is $44.48.

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

Attention: All Providers

Billing Forms

The National Uniform Billing Committee (NUBC) and National Uniform Claim Committee (NUCC) have issued revised professional and institutional paper claim formats. The NUCC has stated an effective date of 10/01/2006 for the revised CMS 1500 (8/05) paper claim. North Carolina Medicaid will publish an implementation timeline for both the revised CMS 1500 and UB 04 paper claim formats in future provider bulletins. NC Medicaid will not be able to process claims on the new CMS 1500 (8/05) paper format on 10/1/2006. Any claims received on this claim format will be returned unprocessed to the provider.

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

Attention: All Providers

Updated Provider Type/Provider Specialty for Family Planning Waiver Services

Effective with date of service October 1, 2005, the CPT codes listed below have been updated to allow the following providers to bill when performing Family Planning Waiver services:

Procedure	CPT Code	Modifier	Providers
Annual Examination	99385 99386 99395 99396	FP	Health Departments Nurse Practitioner Nurse Midwife Planned Parenthood Physicians
Sterilization	58670 58671	FP	Nurse Practitioners Physicians
Contraceptive Procedure	57170	FP	Health Departments Planned Parenthood Nurse Practitioners Nurse Midwives Physicians

If you are currently enrolled as a North Carolina Medicaid provider and your licensure and accreditation allows you provide family planning services, then you are eligible to provide Family Planning Waiver services. Family Planning Waiver services must be billed with the FP modifier appended to the claim.

Claims that were previously denied for EOB 79, "This service is not payable to your provider type or specialty in accordance with Medicaid guidelines" for the procedure codes listed above may now be resubmitted as a new claim. The new claim must have an exact match of recipient MID number, provider number, from date of service, and total billed.

Providers should contact EDS with any billing questions.

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

Attention: CAP/DA Lead Agencies and AQUIP Users

Quarterly Automated Quality and Utilization Improvement Program Training Seminar

The third quarterly Automated Quality and Utilization Improvement Program (AQUIP) training seminar for new AQUIP users in CAP/DA lead agencies is scheduled for September 26, 2006, at the Hilton Greenville.

Attendance at this meeting is of the utmost importance for new AQUIP users. CAP/DA lead agency contacts have been informed via e-mail of any identified new AQUIP users in their counties who should attend this session. Any current AQUIP users who would like to attend the session may do so if space permits.

The AQUIP seminar is scheduled to begin at 9:30 a.m. (registration 9:00 to 9:30 a.m.) and end at 3:30 p.m. The session will focus on how to maneuver a new CAP/DA client from the waiting list through the termination process while accurately completing the Client Information Sheet, Data Set Assessment, and Plan of Care. System overview and use will also be addressed.

Pre-registration is required. Contact your CAP/DA lead agency to verify if your name is on the required attendance list. You may register for the seminar online, beginning September 1, 2006, by going to https://www2.mrnc.org/aquip and clicking on Registrations. You will receive a computer-generated confirmation number, which you should bring to the seminar.

Lunch will be on your own.

Driving Directions

Hilton Greenville - Greenville
From Raleigh/Durham: Take US 64 East to US 264 East to Greenville. Turn right onto Allen Rd. in Greenville. Go approximately 2 miles. Allen Rd. turns into Greenville Blvd/Alternate 264. Follow Greenville Blvd. for 2.5 miles to the Hilton Greenville, which is located on the right.

Attention: CAP-MR/DD Providers, Local Management Entities, Targeted Case Managers for CAP-MR/DD

Home and Community Billing Reminder

As described in the February 2006 general Medicaid bulletin (pp. 9 and 10), CAP/MR-DD providers billing day supports (code T2021 for individual and T2021 HQ for group) must be providing services in a licensed day setting effective September 1, 2006. Day supports providers may no longer bill services using the home and community codes of H2015 (individual) and H2015 HQ (group) after August 31, 2006.

Also effective September 1, 2006, home and community supports providers, billing Medicaid for the **community** component only on the same day of service as residential supports levels 1 through 4, may bill only up to 4 hours (16 units). The six hours allowed a day up until August 31, 2006, was an allowance made so day supports providers using these codes (H2015 and H2015 HQ) could bill for their six-hour-a-day programs. This service will now be billed using Day Supports.

If you have any questions, please contact:

Behavioral Health Section
DMA, 919-855-4290

Attention: Enhanced Benefit Mental Health Services and Enhanced Benefit Substance Abuse Services

Clarification on Diagnosis Code Editing for the Enhanced Benefit Services

Providers must bill the ICD-9-CM diagnosis code to the highest level of specificity that supports medical necessity.

Diagnosis code editing is applicable for each service, with the exceptions of H2011 and T1023. Diagnosis editing will require providers to bill the applicable diagnosis in one of the four fields in block 21 on the CMS-1500 claim form.

HCPCS Service Codes—Subject to Diagnosis Editing			Diagnosis Codes
H0035	H0040	H2022	V11.0 through V11.9
H0036 HA	H2012 HA	H2033	V40.0 through V40.9
H0036 HB	H2015 HT	S9484	290.0 through 298.9
H0036 HQ	H2017		300 through 316.9
H0010	H0014	H2036	V11.3
H0012 HB	H0015		303.0 through 305.0
H0013	H2035		305.2 through 305.9
H0020			304.0 through 304.9 305.5 305.6 305.9

Please check the diagnosis codes when submitting the claim to ensure that you 1) do not use a decimal in the diagnosis code (for example, 305.2 would be reported as 3052) and 2) do not add an additional (5th) digit when none is required.

Behavioral Health Services
DMA, 919-855-4291

Attention: Family Planning Waiver Providers

Reminder Regarding the FP Modifier

Effective with date of service October 1, 2005, N.C. Medicaid requires that the FP modifier be appended to all CPT/HCPCS codes bill on Family Planning Waiver claims, along with the appropriate and ICD-9-CM diagnosis.

Providers should contact EDS with any billing questions.

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

Attention: Health Choice Providers

State Health Plan Statement for the North Carolina Hospital Association

The State Health Plan has recently established the corrected calculation for institutional inpatient claims, in compliance with the statute requiring the equivalent of 115% of Medicaid for dates of service from January 1 to June 30, 2006, and the equivalent of 100% of Medicaid for dates of service from July 1, 2006 forward, for North Carolina Health Choice members. Now that the updated algorithm has been established, you should expect to see a letter from the State Health Plan confirming recoup or repayment amounts for your institution**.**

Becky W. Murray,
NC State Health Plan, 919 881-2300

Attention: Home Infusion Therapy Providers

Medicaid Coverage of Home Tocolytic Infusion Therapy

Effective with date of service September 1, 2006, Medicaid will begin coverage of subcutaneous home tocolytic infusion therapy under the Home Infusion Therapy (HIT) program. Tocolytic therapy utilizes a low-dose subcutaneous infusion of a tocolytic agent as a means to prevent preterm labor in pregnant women. All services will require prior approval through the Carolinas Center for Medical Excellence, CCME (formerly Medical Review of N.C.), prior to the beginning of service. There are special provisions made for therapy ordered by the physician to begin on an emergency basis.

Each recipient's condition must be individually evaluated by the physician providing treatment. The recipient must have all of the following conditions to be appropriate for the service.

1. The recipient must be between 24 and 34 weeks gestation.
2. The recipient must be experiencing preterm labor and must meet all of the following conditions:
   a. contractions occurring at a frequency of 4 in 20 minutes or 8 in 60 minutes, plus progressive changes in the cervix;
   b. cervical dilation of greater than 1 cm;
   c. cervical effacement of 80% or greater; and
   d. failure of previous attempts at oral tocolytic therapy, requiring continued infusion of the drug to stop further progression of preterm labor.
3. The recipient must have the ability to independently operate the infusion pump, care for the infusion site, and maintain the infusion therapy after receiving training.
4. The recipient must have the ability to communicate by telephone with either a nurse trained in tocolytic infusion therapy management or with an obstetrician.
5. The home environment must be suitable for the administration of the infusion and must include direct telephone access for communication with the infusion therapy provider.

Reimbursement for home tocolytic therapy is based on a per diem rate for each day the service is provided. The following services are included in the per diem rate::

1. initial registered nurse (RN) assessment of maternal/fetal environmental and psychosocial factors;
2. assessment of recipient's ability to recognize and detect signs and symptoms of preterm labor, correctly operate monitoring and infusion devices, and comply with self-care protocols and treatment regimen as defined in the plan of care;
3. assessments conducted by an RN with high-risk obstetrical experience;
4. additional RN assessments as ordered by the physician;
5. additional components as ordered by the physician, including, but not limited to, blood pressure and pulse monitoring, assessment, weight analysis, and dietary assessment;
6. initial nurse education of the recipient regarding preterm labor, pregnancy, care plan objectives, data collection activities and devices, and infusion pumps to be used;
7. ongoing reinforcement of recipient regarding preterm labor and management with subcutaneous tocolytic therapy;

8. recipient education materials related to preterm labor, tocolytics, and subcutaneous infusion therapy;
9. use of infusion pump and uterine monitoring device;
10. use of contraction monitor;
11. ;tocolytic medication and related supplies, preparation and delivery
12. telephonic nursing and pharmacy support 24 hours a day, 7 days a week, in accordance with all applicable laws, rules, and regulations, agency policy, and the staff qualifications listed in Section 6.2 of Clinical Coverage Policy 3H-2, Home Tocolytic Infusion Therapy;
13. routine clinical status reporting to the physician;
14. daily and "as needed" data transmission to the patient service center; and
15. routine and "as needed" contraction and vital sign data collected by the recipient, based upon changes in recipient status, symptom management, and physician plan of treatment.

The billing code for subcutaneous home tocolytic therapy is S9349 (home infusion therapy, tocolytic infusion therapy). The modifier UA must be used with the code to receive payment for the service and to indicate "all inclusive rate." Additional information on providing this service can be found in the Home Tocolytic Therapy Policy (3H-2) in the Medicaid Clinical Coverage Policies and Provider Manuals policy section on the DMA Web site, http://www.dhhs.state.nc.us/dma/mp/mpindex.htm.

Clinical Policy/Facility and Community Care
DMA, 919-855-4380

Attention: Hospitals

Acute Admission versus Behavioral Health Admission

If a hospital submits an acute hospital admission with a behavioral health diagnosis, the claim will deny with EOB 213 (No Prior Approval on File. Contact Value Options at 1-888-510-1150 for confirmation). If the recipient was in a medical bed and it was **truly NOT** a behavioral health admission, hospital providers must submit the denied claim directly to the Division of Medical Assistance. Providers should submit a copy of the claim with the history and physical along with the discharge summary. **Only claims that have denied for EOB 213 should be submitted to DMA.**

Claims and attachments should be mailed to

Division of Medical Assistance
Clinical Policy and Programs, Behavioral Health Section
2501 Mail Service Center
Raleigh NC 27699-2501

Providers may elect to send the above information electronically via ProviderLink. For questions or information regarding ProviderLink, please call 919-465-1855 or visit their Web site at www.providerlink.com.

The medical records attached will reviewed and if the admission is determined to have been a behavioral admission for which prior approval should have been obtained from ValueOptions, a non-certification letter (with a provider appeal form describing the appeals process enclosed) will be mailed to the facility.

If the admission is determined to have been a medical admission, an override of the denial will be sent to EDS for claims payment.

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

Attention: Optical Providers

New CPT Code and Billing Procedures for Dispensing Newly Fit Contact Lenses

Effective with date of service July 31, 2006, DMA end-dated state-created codes V0320 and V0330. The replacement CPT code 92310, *prescription of optical and physical characteristics of and fitting of contact lenses, with medical supervision of adaptation,* is covered by the N. C. Medicaid program effective with date of service August 1, 2006. As a replacement code, CPT code 92310 includes the same services (K-readings, fittings measurements, training, dispensing, etc.) covered under the state-created V-codes. Claims submitted with end-dated codes will deny.

New Billing Procedure

Effective with date of service August 1, 2006, DMA implemented the following new billing procedure:

- Bill one (1.0) unit for dispensing two contact lenses and one half (0.5) unit for dispensing one contact lens. Claims approved for one contact lens must be billed as one half (0.5) unit to prevent denial.

- Do **not** follow CPT guidelines regarding modifier 52 when billing for one eye.

- CPT code 92310 must be billed with HCPCS codes V2510 (contact lens, gas permeable) or V2520 (contact lens, hydrophilic) for the same date of service with the same billing provider. Claims that are submitted without the secondary code will deny. Denied claims may be corrected and resubmitted as a new claim.

- The rate for new code 92310 is $160.74 for dispensing two contact lenses and $80.37 for dispensing one contact lens.

NOTE: Dispensing fees for visual aids should **not** be billed until the recipient has received the visual aids and the dispensing service has been completed. Documentation should reflect services provided.

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

Attention: Physicians, Nurse Practitioners, Nurse Midwives and Health Departments

CPT Procedure Code 90761

Effective with date of service January 1, 2006, CPT procedure codes 90765, 90774, 96409, and 96413 have been added to the list of primary codes that can be billed with "add-on" procedure code 90761, "*intravenous infusion, hydration; each additional hour, up to 8 hours (List separately in addition to code for primary procedure).*" (CPT procedure code 90760 may also be used as a primary code.)

Claims that were submitted for reimbursement of CPT procedure code 90761 listed with 90765, 90774, 96409, or 96413 and were denied may now be resubmitted for payment as a new claim. The claim must be filed exactly as it was originally submitted and must be resubmitted within 18 months from the date of denial. Claims submitted more than 18 months after denial will not be paid.

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

Attention: All Providers

National Provider Identifier (NPI) Collection Form

Effective September 15, 2006, the National Provider Identifier (NPI) Form will be available on the Division of Medical Assistance's (DMA) web site at http://www.dhhs.state.nc.us/dma/npi.htm.

The North Carolina Medicaid Program will begin collecting the NPI numbers from currently enrolled Medicaid providers. The form can be returned by fax or mail to the address listed on the form. Providers must also include with the NPI form a copy of the notification letter from the National Plan and Provider Enumeration System (NPPES). Please provide this information to DMA no later than March 31, 2007.

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

Provider Services
DMA, 919-855-4050

NCLeads Update

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

Provider Relations
Office of MMIS Services
919-647-8315

Proposed Clinical Coverage Policies

In accordance with Session Law 2005-276, proposed new or amended Medicaid clinical coverage policies are available for review and comment on DMA's website at http://www.ncdhhs.gov/dma/prov.htm. To submit a comment related to a policy, refer to the instructions on the website. Providers without Internet access can submit written comments to the address listed below.

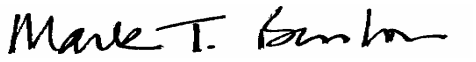
Gina Rutherford
Division of Medical Assistance
Clinical Policy Section
2501 Mail Service Center
Raleigh, NC 27699-2501

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

2006 Checkwrite Schedule

September (e)	09/01/06	09/06/06
	09/08/06	09/12/06
	09/15/06	09/19/06
	09/22/06	09/28/06
October (f)	10/06/06	10/10/06
	10/13/06	10/17/06
	10/20/06	10/26/06
November	11/03/06	11/07/06
	11/08/06	11/12/06
	11/15/06	11/21/06

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



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

Cheryll Collier
Executive Director
EDS