September 2007 Medicaid Bulletin

Visit DMA on the Web at: http://www.ncdhhs.gov/dma

In This Issue*.....*Page#

Attention: All Providers

False Claims Act Education

Effective January 1, 2007, Section 6023 of the Deficit Reduction Act (DRA) of 2005 requires providers receiving annual Medicaid payments of $5 million or more to educate employees, contractors, and agents about Federal and State fraud and false claims laws and the whistleblower protections available under those laws.

Beginning September 2007 and annually thereafter, the North Carolina Division of Medical Assistance (DMA) will notify providers that they received a minimum of $5 million dollars in Medicaid payments during the last federal fiscal year and that they must submit a Letter of Attestation to show that they are in compliance with the DRA. This minimum amount may have been paid to one North Carolina Medicaid provider number or to multiple provider numbers associated with the same tax identification number. Each Medicaid provider who receives a notification letter must download a copy of the Letter of Attestation from the DMA Web site and print, sign, and mail it to EDS within 30 days of the date of notification Downloadable Letter of Attestation forms and a complete list of Medicaid provider numbers identified as having received the minimum amount of Medicaid payments can be found on our website at http://www.ncdhhs.gov/dma/fca/falseclaimsact.html.

Compliance with Section 6023 of the DRA is a condition of receiving Medicaid payments. Medicaid payments will be denied for providers that do not submit a signed Letter of Attestation within 30 days of the date of notification. Providers may resubmit claims once the signed Letter is received.

Beginning November 1, 2007, provider enrollment application packets submitted to DMA must include the signed Letter of Attestation. An enrollment application packet is considered received by DMA when it is current, complete, original, and signed.

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

Attention: All Providers

Importance of One to One Enumeration

N.C. Medicaid strongly recommends that providers obtain an NPI for each Medicaid Provider Number in use today. Providers should mirror their Medicaid enrollment when enumerating. The only exception is for sole proprietors, who are only able to obtain one individual (Type I) NPI. When NPI is implemented, claims will continue to process through the current MMIS system. Therefore, N.C. Medicaid has designed a mapping solution to crosswalk the NPI to the Medicaid Provider Number used today. Ideally, each NPI will only crosswalk to one Medicaid Provider Number, otherwise known as a "one to one" match. If the NPI crosswalks to multiple Medicaid Provider Numbers, the NPI will have a "one to many" match. If a "one to many" match occurs, the mapping solution will attempt to determine the appropriate Medicaid Provider Number by taking the claim through a series of steps. Information such as Zip + 4 and taxonomy will play important roles in determining the appropriate Medicaid Provider Number. If the mapping solution cannot narrow down to one Medicaid Provider Number, impacted claims may require additional research in order to process, and payment could be delayed.

To request additional NPIs, providers should complete an application by visiting the NPPES website: https://nppes.cms.hhs.gov. If you request additional NPIs, please be sure to report them to us as soon as possible. DMA forms and directions for reporting an NPI are located at http://www.dhhs.state.nc.us/dma/NPI.htm

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

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

Attention: All Providers

Basic Medicaid Seminar Registration

Basic Medicaid seminars will be held in October 2007. Registration information, a list of dates, and site locations for the seminars are listed below.

Seminars will begin at 9:00a.m. and will end at 12:00 p.m. Providers are encouraged to arrive by 8:45a.m. to complete registration. Lunch will not be provided at the seminars. **Because meeting room temperatures vary, dressing in layers is strongly advised.**

Due to limited seating, registration is limited to two staff members per office. Pre-registration is required. Unregistered providers are welcome to attend if space is available. Providers may register for the seminars by completing and submitting the registration form online at http://www.ncdhhs.gov/dma/prov.htm, under "Seminar Information." Please indicate on the registration form which session you plan to attend.

The Basic Medicaid Billing Guide on the DMA Web site will be used as the primary training document for the seminar. Please review and print the current information and bring it to the seminar. The Basic Medicaid Billing Guide can be found at http://www.ncdhhs.gov/dma/medbillcaguide.htm.

Hickory, NC **October 24, 2007** **Gateway Center** **909 US Highway 70 SW**	**Winston-Salem, NC** **October 25, 2007** **Holiday Inn Select** **5790 University Parkway**
Wilmington, NC **October 30, 2007** **Coastline Convention Center** **501 Nutt St.**	**Raleigh, NC** **October 31, 2007** **Velvet Cloak Inn** **1505 Hillsborough St.**

Directions to the Basic Medicaid Seminars:

Hickory, NC – Gateway Center
From I-40
Exit 123B off of I-40 to 321 North (half a mile) take Exit 44. Park Inn Hickory hotel is on the right hand side.

Winston-Salem, NC – Holiday Inn Select
From I-40
Take I-40 to NC HWY 52 North, 8 miles to exit 115B, University Parkway South, hotel is on the right.

Wilmington, NC – Coastal Convention Center
From I-40 East / Raleigh Durham Area
Follow Interstate 40 East to Wilmington. As you approach Wilmington, turn right onto MLK Parkway/74 West/Downtown. Continue on route to downtown and it will become 3rd Street. Follow 3rd Street for five blocks until you reach Red Cross Street. Turn right onto Red Cross Street and follow for two blocks. Turn right onto Nutt Street. Second drive way on left is the entrance to the convention center.

Raleigh, NC – Velvet Cloak Inn
From I-40 East
Take exit 289 which becomes Wade Ave. At the third traffic light make a left onto Faircloth Street. At first traffic light make a left onto Hillsborough Street. The Velvet Cloak Inn is approximately two miles on the right.
From I-40 West
Merge with beltline I-440 – stay left. Take exit 298-B (South Saunders Street and Downtown). Turn right at the bottom of the exit. Stay right and head into downtown Raleigh. (Note: South Saunders Street will turn into McDowell Street). Turn left onto Edenton Street. Turn left onto Salisbury Street. Turn right onto Hillsborough Street. The Velvet Cloak Inn is one mile on the left.

Basic Medicaid Workshops
October 2007 Seminar Registration Form
(No Fee)

Provider Name_____
Medicaid Provider Number_____NPI Number_____
Mailing Address_____
City, Zip Code_____County_____
Contact Person_____E-mail_____
Telephone Number(____)_____Fax Number_____
1 or **2** person(s) will attend the seminar at _____on_____
(circle one) (location) (date)

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

Attention: All Providers

Breast Imaging Policy Update for Screening Mammography

Clinical Coverage Policy 1K-1, Breast Imaging Procedures, was effective with date of service June 1, 2007. Due to early system changes, providers may have received incorrect denials for the following screening mammography procedures:

77057	Screening mammography; bilateral
G0202	Screening mammography, producing direct digital image, bilateral, all views
RC 403	Screening mammography, bilateral

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity. The diagnosis criteria are as follows:

Annual Screening Mammography Ages 40 Years and Older Primary Diagnosis Allowed	
ICD-9-CM Code	**Description**
V76.10	Breast screening, unspecified
V76.11	Screening mammogram for high-risk patient
V76.12	Other screening mammogram

Screening Mammography Ages 35 through 39 Years (Baseline Once in Five Years) Primary Diagnosis Allowed	
ICD-9-CM Code	**Description**
V76.10	Breast screening, unspecified
V76.12	Other screening mammogram

Annual Screening Mammography Ages 20 through 39 Years Primary Diagnosis Allowed (Secondary Diagnosis Required—see below)	
ICD-9-CM Code	**Description**
V76.11	Screening mammogram for high-risk patient

Annual Screening Mammography Ages 20 through 39 Years Secondary Diagnosis Required	
ICD-9-CM Code	**Description**
V10.3	Personal history of malignant neoplasm of the breast
V15.89	Other specified personal history presenting hazards to health
V16.3	Family history of malignant neoplasm of the breast
V76.19	Special screening for malignant neoplasms in the breast

Recent claims payment system changes have been made to clarify the policy. Providers may resubmit new claims (not adjustments) for processing if:

1. Claims were submitted according to the diagnosis/age guidelines documented in this article; and
2. Claim denials were received related to EOB 82 (service is not consistent with or not covered for this diagnosis or description does not match diagnosis) for screening mammography codes 77057, G0202, or RC403; and
3. The denials have occurred since the policy was posted June 1, 2007.

The policy is posted on the Division of Medical Assistance Web site at http://www.ncdhhs.gov/dma/mp/mpindex.htm .

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

Attention: All Providers

Clinical Coverage Policies

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

1A-20, Sleep Studies and Polysomnography Services
1K-1, Breast Imaging Procedures

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

Citizenship and Identity Documentation

Recently the Centers for Medicare and Medicaid Services (CMS) issued its final rule regarding documents or proof needed to establish citizenship and identity for U.S. citizens. County departments of social services must ensure that the appropriate citizenship and identity is verified on all applicants before Medicaid coverage begins.

The following are acceptable proofs of citizenship that were introduced by the new rule.

- Early school records showing a U.S. place of birth
- Religious records recorded in the U.S. within 3 months of birth, provided that the records show that the birth occurred in the U.S. and contain either the date of the birth or the individual's age at the time the record was made
- Written affidavit attesting to citizenship or naturalization (may be used only when no other acceptable proof is available)

The following are acceptable proofs of identity that were introduced by the new rule.

- For children under 16 only—school, clinic, doctor and hospital records
- For newborns and children under 16 only—if no other acceptable documentation is available, an affidavit may be used unless an affidavit was used to prove citizenship
- For disabled individuals in residential care facilities only—if no other acceptable documentation is available, the facility director or administrator may attest to the identity of the disabled individual
- When no other category of identity proof is available, the individual may submit three or more corroborating documents, such as marriage certificates, divorce decrees, or school diplomas, which taken together reasonably corroborate the identity of the individual.

In addition, the rule clarifies the status of newborn children of women who have applied for, have been determined eligible for, and are receiving Medicaid on the date of the child's birth. The citizenship and identity of such newborns are not required to be documented so long as the mother remains eligible and the child remains in the mother's household, regardless of the mother's immigration status.

William Appel
DMA, 919-855-4005

Attention: All Providers

Contacting EDS – Automated Attendant Telephone Line Instructions

The Automated Attendant Telephone Line (1-800-688-6696 or 919-851-8888) has been revised to include more options for providers when calling EDS as of August 24, 2007. Calls made from a touch-tone telephone can be routed to the appropriate units by an automated attendant as follows:

	Overview of group	**Option**
Electronic Commerce (ECS)	ECS analysts provide over-the-phone technical support for NCECS-WEB Software, POS transactions, and Eligibility Verification issues	Press 1
Prior Approval	Prior approval (PA) may be required for some services, products, or procedures to verify medical necessity.	Press 2
Provider Services	Provider Services educate provider on Division Medical Assistance' policies procedures. In addition, EDS Provider Services offer response and resolution to provider inquiries both verbal and written. Note: EDS Provider Services does not given out claims status. Please contact the	Press 3
IPRS	The Integrated Payment and Reporting System (IPRS) analysts provide support all claims submitted by the Area programs/LME's. The claims are only for the state fund resources. IPRS only supports calls directly from Area programs/LME's .	Press 4
PASSAR	Completes Preadmission Screen ing and Annual Resident Review (PASARR).	Press 7

Medicaid recipients are instructed to press 6 which will direct recipients to call the Care Line Information and Referral Service at 1-800-662-7030.

EDS, 1-800-688-6696 or 919-851-8000

Attention: All Providers

Correction to Sleep Studies and Polysomnography Services Policy

The diagnosis list in Attachment A of the Sleep Studies and Polysomnography Services Policy listed on the Web site at http://www.dhhs.state.nc.us/dma/physician/1A20.pdf incorrectly lists 799.0, Asphyxia. According to the International Classification of Diseases, Ninth Edition (ICD-9-CM) 2007 Edition, 799.0 requires a fifth digit. The policy has been updated to read 799.01, Asphyxia, and 799.02, Hypoxemia.

EDS, 1-800-688-6696 or 919-851-8000

Attention: All Providers

Coverage for CPT codes 59015, 76945, 76820 and 76821

Four procedures were added to the Fetal Surveillance Policy effective with date of service April 01, 2007. These procedures are:

Code	Description
59015	Chorionic villus sampling, any method
76945	Ultrasonic guidance for chorionic villus sampling, imaging supervision and interpretation
76820	Doppler velocimetry, umbilical artery
76821	Doppler velocimetry, middle cerebral artery (MCA)

Providers who received claim denials for the above codes since April 01, 2007 as non-covered procedures may resubmit new claims (not adjustments) for processing.

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

Attention: All Providers

CPT Code 77003 Denials

Effective with date of service January 1, 2007, CPT code 77003 (fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures, including neurolytic agent destruction) must include a **26 modifier** (professional component) when billed with CPT codes 62310, 62311, 62318 and 62319. Claims payment system changes have been made to correct the problem. Providers who received claim denials related to EOB 4237 or 4238 for CPT code 77003 may resubmit new claims (not adjustments) for processing.

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

Attention: All Providers

North Carolina Definition of "New Patient"

Effective with date of service June 1, 2007, Medicaid defines a new patient as one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years.

This definition does not apply to behavioral health providers or to dental providers.

Practitioner and Clinical Services
DMA, 855-4320

Attention: All Providers

Policy and Procedures for Prescribing Synagis for 2007–2008 Respiratory Syncytial Virus Season

On October 15, 2007, N.C. Medicaid will begin coverage of Synagis prescriptions for respiratory syncytial virus (RSV). This year, Synagis prescriptions will not require prior approval. However, health care and pharmacy providers are expected to ensure the appropriate usage of Synagis. The clinical criteria utilized in this policy are consistent with currently published American Academy of Pediatrics Red Book guidelines (on the Web at http://aapredbook.aappublications.org/cgi/content/full/2006/1/3.107—subscription required; or in *Red Book: 2006 Report of the Committee on Infectious Diseases, 27th Edition)*.
Please ensure that either

- the conditions exist and are accurate, and are verified by completion and submission of the Synagis for RSV Prophylaxis Form ("in-criteria form") at http://www.ncdhhs.gov/dma/Forms/SynagisCriteriaForm.pdf; or
- the patient does not fit the published criteria, but the Request for Medical Review for Synagis Outside of Criteria Form at http://www.ncdhhs.gov/dma/Forms/SynagisMedicalReview.pdf has been completed and submitted.

Note: Processing delays can occur if the patient does not have a Medicaid identification number or the form is not complete.

Note: During the RSV season, **no more than five monthly doses of Synagis can be obtained for each recipient** by using these forms. The number of doses should be adjusted if an infant received the first dose prior to a hospital discharge.

Submitting the Synagis for RSV Prophylaxis Form

Infants born on or after October 15, 2005, meet the medical criteria for Synagis if they have one or more of the following conditions:

Diagnosis	Comments
Chronic lung disease of prematurity (bronchopulmonary dysplasia)	The infant has chronic lung disease (bronchopulmonary dysplasia) and has needed treatment (supplemental oxygen, bronchodilator, diuretic, or corticosteroid) in the six months before the start of the season.
Hemodynamically significant congenital heart disease	Infants less than 12 months of age who are most likely to benefit include those receiving medication to control congestive heart failure, moderate to severe pulmonary hypertension, or cyanotic heart disease. Infants NOT at increased risk from respiratory syncytial virus who generally should NOT receive immunoprophylaxis include those with hemodynamically insignificant heart disease

	such as secundum atrial/septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, patent ductus arteriosus, lesions adequately corrected by surgery unless the infant continues on medication for congestive heart failure, and mild cardiomyopathy where the infant is not receiving medical therapy.
Cystic fibrosis	The infant has cystic fibrosis and either requires chronic oxygen or has been diagnosed with nutritional failure.
Severe congenital immunodeficiency	Severe combined immunodeficiency disease or severe acquired immunodeficiency syndrome.

Other infants may meet the medical criteria for Synagis as follows:

Infant Is Born at an Estimated Gestational Age of	**AND Meets These Other Criteria**
Less than or equal to 28 weeks	Date of birth on or after October 15, 2006
29 weeks through 32 weeks	Date of birth on or after April 15, 2007
32 weeks and 1 day through 35 weeks and 0 days	Date of birth on or after April 15, 2007, AND two or more of the following risk factors: --Has school-age siblings --Attends day care --Has severe neuromuscular disease --Is exposed to prolonged wood-burning heaters as the primary source of heat for the family (tobacco smoke is NOT a risk factor because it can be controlled by the family) --Has congenital abnormalities of the airways

When it has been verified that one or more of the above conditions exist and are accurate, submit the Synagis for RSV Prophylaxis form by doing the following:

- Prescriber signs and submits to the pharmacy distributor of choice (not to DMA).
- Pharmacy distributor must maintain the form on site.
- Every week, pharmacy distributor must send DMA copies of the forms submitted that week.
  - Mail to N.C. Division of Medical Assistance, Pharmacy Program, 1985 Umstead Drive, 2501 Mail Service Center, Raleigh, N.C. 27699-2501
  - Or submit high-volume Synagis claims on a diskette; please call Charlene Sampson at (919) 855-4306 to coordinate this process.

Submitting the Request for Medical Review Form
When a patient does not explicitly meet the guidelines but the provider still wishes to prescribe Synagis, submit the Request for Medical Review Form by doing the following:

- Prescriber completes the form, including the medical necessity justification, signs it, and faxes it to DMA at (919) 715-1255. This is the only form that prescribers should fax to DMA.
- The request will be reviewed and either approved or denied. Notification of the result will be sent to prescribers.
- Pharmacy distributor maintains a copy of the approval letter on site.

Medicaid will allow Synagis claims processing to begin on October 10, 2007, to allow sufficient time for pharmacies to provide Synagis by October 15, 2007. Payment of Synagis claims prior to October 10, 2007, and after March 31, 2008, will not be allowed. Pharmacy providers should always indicate an accurate days' supply when submitting claims to N.C. Medicaid. Physicians and pharmacy providers are subject to audits of Synagis records by DMA Program Integrity.

Pharmacy and Ancillary Services
DMA, 919-855-4300

Attention: All Providers

Updated EOB Code Crosswalk to HIPAA Standard Codes

The list of standard national codes used on the Electronic Remittance Advice (ERA) has been cross-walked to EOB codes as an informational aid to adjudicated claims listed on the Remittance and Status Report (RA). An updated version of the list is available on the Division of Medical Assistance's Web site at http://www.dhhs.state.nc.us/dma/prov.htm.

With the implementation of standards for electronic transactions mandated by the Health Insurance Portability and Accountability Act (HIPAA), providers now have the option to receive an ERA in addition to the paper version of the RA.

The EOB codes that providers currently receive on a paper RA are not used on the ERA. Because the EOB codes on the paper RA provide a greater level of detail on claim denials, all providers will continue to receive the paper version of the RA, even if they choose to receive the ERA transaction. The crosswalk is current as of the date of publication. Providers will be notified of changes to the crosswalk through the general Medicaid bulletin.

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

Attention: CAP/DA Lead Agencies

Automated Quality and Utilization Improvement Program Quarterly Training Seminar

The Carolinas Center for Medical Excellence (CCME; www.thecarolinascenter.org) announces continued quarterly training for new users of the Automated Quarterly and Utilization Improvement Program (AQUIP) in CAP/DA lead agencies.

The third quarterly training session this year will be held on September 25, 2007, at the Park Inn Gateway Conference Center in Hickory. 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 users in their counties who should attend this session. We recommend that all attendees read and become familiar with the AQUIP User Manual, which can be accessed by going to the AQUIP Web site (https://www2.mrnc.org/aquip) and clicking on Downloads, prior to the training session. Current users who would like to attend the session may do so if space permits. However, the information presented will be designed for new users.

The seminar is scheduled to begin at 9:00 a.m. and end at 3:00 p.m. The session will focus on understanding Resource Utilization Group (RUG) scores, accurately completing the three parts of the AQUIP tool (client information sheet, data set assessment, and plan of care), and resolving common data entry errors. The session will end with an overview of Health Check/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for Medicaid-eligible recipients under 21.

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 4, 2007, by going to https://www2.mrnc.org/aquip and clicking on Training Sessions. You will receive a computer-generated confirmation number, which you should bring to the seminar. Check-in will be from 8:30 until 9:00 a.m. on the day of the seminar; lunch will be on your own. Because meeting room temperatures vary, dressing in layers is recommended.

CCME, 1-800-682-2650

Attention: Home Infusion Therapy Providers

2007 Rate Update and New HCPCS Code

Effective with date of service September 1, 2007, rates for home infusion therapy (HIT) providers have been changed in accordance with the State Plan. All HIT providers had the opportunity to participate in a survey conducted by the actuary to update materials usage, delivery information, and preparation and monitoring time for setting per diem rates for infusion therapies. In addition, a new procedure code–modifier combination has been added, S9329 with modifier SJ, to establish a payment for Chemotherapy Infusion Therapy as a tertiary treatment.

Please refer to the published fee schedule for all current rates on the DMA Web site at http://www.ncdhhs.gov/dma/fee/fee.htm. Providers are reminded to bill their usual and customary rates when submitting claims to N.C. Medicaid.

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

Attention: Pediatric Primary Healthcare Providers

Childhood Obesity Focused Care Study

The North Carolina Division of Medical Assistance (DMA) will be conducting a Childhood Obesity Focused Care Study beginning in October 2007. The goal of this study is to obtain baseline data regarding overweight and obesity screening, counseling, follow-up, and referral practices in primary care settings of Medicaid-eligible children in North Carolina.

Practices randomly chosen for this study will be contacted starting in early October. Medical record abstraction should be completed by December 2007 and results of the study will be posted under Publications on the DMA Web site (www.ncdhhs.gov/dma) in late spring or early summer 2008. (Results from all practices will be presented in aggregate and will not identify individual provider data.)

For additional information or questions regarding this study, please contact Nubya Shabazz at Nubya.Shabazz@ncmail.net or 919-855-4137.

Nubya Shabazz
DMA, 855-4137

Attention: Pharmacists

Devices Are Not Covered in the Outpatient Pharmacy Program

This is a reminder that any product the Food and Drug Administration (FDA) approves as a device will not be covered in the outpatient pharmacy program. It was recently discovered that Atopiclair Cream (NDC 13453-0100-11) meets this definition and has been removed from the North Carolina pharmacy drug file.

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

Attention: Pharmacists

Emergency Supplies of Medications under Focused Risk Management

A Medicaid recipient who has opted in to a pharmacy is permitted up to a 4-day emergency supply of medication for times when he or she is not able to get to the pharmacy to obtain medication. The pharmacy provider will be paid for the drug cost only, and the recipient will be responsible for the co-payment. A "3" in the Level of Service field (418-DI) indicates that the transaction is an emergency supply.

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

Attention: Pharmacists

Medication Therapy Management Is Now Focused Risk Management (FORM)

The program known as Medication Therapy Management (MTM) has been changed to Focused Risk Management (FORM) effective August 1, 2007. Details on this change are listed in the July 2007 Outpatient Pharmacy Program Special Bulletin, which is posted on DMA's Web site at www.ncdhhs.gov/dma.

The FORM process is initiated when the pharmacist tries to submit the 12th prescription at the point-of-sale (POS) during the claims adjudication process. A denial message will appear stating "maximum 11 prescriptions allowed per month". At this point the pharmacist must call EDS to have the recipient opt-in to their pharmacy of choice. DMA has instructed EDS not to accept opt-ins from pharmacy providers prior to the recipient's 12th prescription.

The professional services fee that automatically paid on the first checkwrite of each month will no longer occur after the July payment (for June). Beginning in August, providers performing July FORM reviews for the third calendar quarter (July, August, and September) will need to document the date of service for the July review and submit the professional services fee at the POS as detailed in the July 2007 Outpatient Pharmacy Program Special Bulletin.

The following fields are required for billing the professional services fee:

Field #	Field Name	Required/ Optional/ Not Used	Field Type	Max Length	North Carolina Medicaid Specifications
455-EM	Prescription/Service Reference Number Qualifer	Required	A/N	1	1=Prescription (Rx) Billing **2=Service Billing (e.g., Pharmacy management fee claims)**
477-BE	Professional Service Fee Submitted	Optional*	N	8	Follow rules of the Implementation Guide ***Note this field is required for Pharmacy Management Fee claims**
426-DQ	Usual and Customary Charge	Required	N	8	Follow rules of the Implementation Guide
430-DU	Gross Amount Due	Required	N	8	Follow rules of the Implementation Guide

When submitting the professional services fee, the Professional Service Fee Submitted, Usual and Customary Charge, and Gross Amount Due fields must all be the same and no greater than the allowed quarterly fee of $30.00. If the fee claim is submitted with a value less than $30.00, it will be accepted. If a previously submitted claim for a fee needs to be corrected, the previous claim must be reversed prior to submitting the new claim.

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

Attention: Pharmacists

Oxycontin Reimbursement

The Division of Medical Assistance is aware that generic versions of the medication Oxycontin have limited availability. Since the federal upper limit (FUL) price will remain on the pharmacy drug file until the new average manufacturer's price (AMP)-based FULs are implemented, it is acceptable to dispense the brand name Oxycontin and indicate DAW 1 on the claim transaction. This will override the FUL price and allow the claim to continue to process at the appropriate reimbursement rate.

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

Attention: Pharmacists

Program Integrity Monitoring of Focused Risk Management Program

Program Integrity will perform audits to ensure adherence to the Focused Risk Management (FORM) policy. Details on this policy are listed in the July 2007 Outpatient Pharmacy Program Special Bulletin, which is posted on DMA's Web site at www.ncdhhs.gov/dma. Failure to perform the review as required by DMA policy, or failure to have documentation of the review on file at the time of audit, will result in the recoupment of the FORM fee payment as well as the payments for all claims that exceed the limit of 11 prescriptions per month. The signed documentation of the reviews must be kept on file in the pharmacy and readily retrievable for review by Program Integrity. If the primary care physician refuses to sign the FORM review, then the pharmacist must document the refusal on the review form. The name of the primary care physician who refused to sign and the reason for the refusal must be stated and dated. DMA will allow up to one month from the date of initial impartation to the primary care physician for the appropriate documentation for circumstances in which the physician refuses to sign the review form. Recoupment for not documenting quarterly reviews will not affect providers when recipients have opted in to their pharmacy for 2 months or less.

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

Attention: Physicians, Anesthesiologists, Certified Registered Nurse Anesthetists and Hospitals

Obstetric Add-Ons

Effective with date of service January 20, 2006, Obstetric add-on codes 01968 and 01969 may be billed by the same or a different provider when billed within 48 hours of the primary procedure code 01967.

Providers who received claim denials for 01968 or 01969 related to EOB 3011 may resubmit new claims (not adjustments) for processing.

Reminder: Providers must bill Medicaid their usual and customary charge.

EDS, 1-800-688-6696 or 919-851-8000

Attention: CMS-1500 and UB Outpatient Dialysis Providers billing for drugs in the Prescription Drug Program

National Drug Codes Required on Claims as of December 2007

Effective with dates of service on and after **December 28, 2007,** the North Carolina Division of Medical Assistance (DMA) will require all drugs administered by physicians in offices, clinics, or outpatient dialysis facilities to include the National Drug Code (NDC) on the claim submitted.

> Claims will continue to be priced using the submitted HCPCS procedure code. Please note that the billed HCPCS procedure code must also be valid and covered by N.C. Medicaid. If the HCPCS procedure code is not accompanied by the NDC, the detail will be denied.

This change is in compliance with the Centers for Medicare and Medicaid Services (CMS) requirements related to the Deficit Reduction Act of 2005 (details at http://www.cms.hhs.gov/MedicaidGenInfo/08_DRASection.asp).

An NDC is a unique identifier assigned to each drug or biologic product approved by the Food and Drug Administration (FDA). The NDC is found on the package and/or vial of medication in a 10-digit format. For additional information regarding NDCs, refer to the NDC Directory at www.fda.gov/cder/ndc.

All providers affected by this change **must** implement a process to record and maintain the NDC(s) of the drug(s) administered to the recipient as well as the quantity of the drug(s) given.

NDC seminars are scheduled for November 2007. Future issues of the North Carolina general Medicaid bulletin will have details about seminar sites and dates. More detailed information on the NDC program will in an upcoming Special Bulletin.

Proper billing of an NDC requires an 11-digit number in a 5-4-2 format. A 10-digit NDC must be converted to an 11-digit NDC. Converting NDCs from a 10-digit to an 11-digit format requires a strategically placed zero. The following table shows common 10-digit NDC formats indicated on packaging and the associated conversion to an 11-digit format. The asterisk (*)represents the proper placement of the additional zero.

10-Digit Format on Package	10-Digit Format Example	11-Digit Format	11-Digit Format Example	Actual 10-Digit NDC Example	11-Digit Conversion of Example
4-4-2	9999-9999-99	5-4-2	*9999-9999-99	0002-7597-01 Zyprexa 10-mg vial	00002-7597-01
5-3-2	99999-999-99	5-4-2	99999-*999-99	50242-040-62 Xolair 150-mg vial	50242-0040-62
5-4-1	99999-9999-9	5-4-2	99999-9999-*9	60574-4112-1 Synagis 50-mg vial	60574-4112-01

Note that hyphens indicated in the chart are used solely to illustrate the various formatting examples for NDCs. Do not use hyphens when entering the actual data on the claim.

The Automated Voice Response System (AVRS) is currently used to validate allowed 11-digit NDCs within the N.C. Medicaid program. To access the AVRS, dial (800) 723-4337 and select option 3. For detailed instructions on how to use the AVRS, click on the following link: http://www.ncdhhs.gov/dma/bulletin/pdfbulletin/0701SpecBulletin.pdf.

Billing software programs need to be modified to include the required NDC-related fields. A provider may bill multiple NDCs for a HCPCS procedure code when applicable. N.C. Medicaid will allow up to 10 NDCs per HCPCS procedure code. If more than 3 NDCs are billed with one HCPCS procedure code, the claim must be billed electronically. Please refer to the HIPAA Implementation Guides (Washington Publishing, http://www.wpc-edi.com/) for information regarding the placement of NDC information on an 837 transaction.

On CMS-1500 and UB claim forms, the HCPCS procedure code that is currently billed to N.C. Medicaid must include the following data elements:

- National Drug Code (NDC)
- Quantity of each submitted NDC
- N4 qualifier (applies only to CMS-1500 paper submissions)

Paper CMS-1500

Prior to NPI Implementation Example (with Medicaid provider number):

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 N400026064871 UN2						N400026064872		UN3						1D	890XXXX
01	01	08	01	01	08	11		J1563			500 00	20	N	NPI	0123456789

Paper UB

The required field for reporting NDCs on the paper UB is currently under review by the Division of Medical Assistance. Please reference the upcoming NDC Special Bulletin for further information on this topic.

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

Attention: Physicians and Nurse Practitioners

Histrelin Acetate (Supprelin LA, J3490) Billing Guidelines

Effective with date of service July 1, 2007, the N.C. Medicaid program covers histrelin acetate subcutaneous implants (Supprelin LA) for use in the Physician's Drug Program. Supprelin LA is indicated for the treatment of central precocious puberty (CPP). Supprelin LA is not recommended for children less than 2 years of age, and treatment should be discontinued at the appropriate age for the onset of puberty (approximately 11 years for females and 12 years for males).

Each 50-mg kit contains one implant, which releases about 65 mcg of histrelin acetate per day over 12 months, and an insertion tool.

Supprelin LA is administered as one 50-mg subcutaneous implant every 12 months, with removal of the implant no later than 12 months after implantation.

For Medicaid Billing:

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

259.1	Precocious sexual development and puberty, not elsewhere classified
255.2	Adrenogenital disorders
256.0	Hyperestrogenism
256.1	Other ovarian hyperfunction
257.0	Testicular hyperfunction

- Providers must bill Supprelin LA with HCPCS procedure code J3490 (unclassified drugs), with the original invoice or copy of the original invoice attached to the CMS-1500 claim form. **An invoice must be submitted with each claim.** The paper invoice must include the recipient's name and Medicaid identification number, the name of the medication, the dosage given, the National Drug Code (NDC) number from the implant used, and the cost per dose.
- Providers must indicate the number of units given in block 24G on the CMS-1500 claim form.
- Providers must bill their usual and customary charges.
- Providers must not bill for Supprelin LA more than once in 12 months for each recipient.

One unit of coverage is one 50-mg implant kit. The maximum reimbursement rate per unit is $15,750.00.

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

Attention: Physicians and Nurse Practitioners

Protein C Concentrate (Human) (Ceprotin, J3590) Billing Guidelines

Effective with date of service July 1, 2007, the N.C. Medicaid program covers Ceprotin [Protein C Concentrate (Human)] for use in the Physician's Drug Program. Ceprotin is indicated for patients with severe congenital Protein C deficiency for the prevention and treatment of venous thrombosis (blood clot in the vein), and purpura fulminans (blood spots, bruising, and discoloring to skin as a result of clotting of small blood vessels in the skin). Ceprotin is indicated as a replacement therapy for pediatric and adult patients. Since there are fewer than 20 known cases of severe congenital Protein C deficiency in the United States, the FDA has granted Ceprotin orphan drug status.

Ceprotin is distributed in 500- and 1,000-IU vials and is administered as an intravenous infusion. Frequency, duration, and dose should be individualized based on the patient's severity of Protein C deficiency, age, clinical condition, and level of Protein C. General dosing information for acute and long-term prophylaxis is given below.

- Acute episode/short-term prophylaxis: 100–120 IU/kg (initial dose) followed by three doses of 60–80 IU/kg every 6 hours, adjusted to maintain a target peak Protein C activity of 100%. After the acute episode is resolved, the same dose should be used to maintain a Protein C activity level of about 25% for the remainder of the treatment period.
- Maintenance dose for short-term prophylaxis: 45–60 IU/kg given every 6 or 12 hours
- Long-term prophylaxis: 45–60 IU/kg every 12 hours

For Medicaid Billing:

- The ICD-9-CM diagnosis code required for billing Ceprotin is 289.81, Primary hypercoagulable state.
- Providers must bill Ceprotin with HCPCS procedure code J3590 (unclassified biologics), with the original invoice or copy of the original invoice attached to the CMS-1500 claim form. **An invoice must be submitted with each claim.** The paper invoice must include 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 vial(s) used, and the cost per dose.
- Providers must indicate the number of units given in block 24G on the CMS-1500 claim form.
- Providers must bill their usual and customary charges.

One unit of coverage is one IU. The maximum reimbursement rate per unit is $1.30.

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

Attention: Physicians and Nurse Practitioners

Temsirolimus (Torisel, J3490) Billing Guidelines

Effective with date of service July 1, 2007, the N.C. Medicaid program covers temsirolimus (Torisel) for use in the Physician's Drug Program. Torisel is indicated for advanced renal cell carcinoma. Temsirolimus and its active metabolite, sirolimus, are targeted inhibitors of mammalian target of rapamycin (mTOR) kinase activity, inhibiting growth of tumor cells.

Each single-use kit contains two vials. One vial contains 25 mg/ml of Torisel, and the second contains the diluent. After dilution, the Torisel is further diluted with 250 ml of 0.9% sodium chloride injection.

The recommended dose of Torisel is 25 mg via intravenous infusion administered over 30 to 60 minutes, once a week. Antihistamine pretreatment is recommended.

For Medicaid Billing:

- The ICD-9-CM diagnosis codes required for billing Torisel are 189.0, malignant neoplasm of kidney, except pelvis; **AND** V58.1, admission or encounter for chemotherapy.
- Providers must bill Torisel with HCPCS procedure code J3490 (unclassified drugs), with the original invoice or copy of the original invoice attached to the CMS-1500 claim form. **An invoice must be submitted with each claim.** The paper invoice must include the recipient's name and Medicaid identification number, the name of the medication, the dosage given, the National Drug Code (NDC) number from the kit(s) used, the number of kit(s) used, and the cost per dose.
- Providers must indicate the number of units given in block 24G on the CMS-1500 claim form.
- Providers must bill their usual and customary charges.

One unit of coverage is one kit (25 mg of Torisel). The maximum reimbursement rate per unit is $1,296.77.

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

Attention: Rural Health Clinics and Federally Qualified Health Centers

Family Planning Waiver Denials for Evaluation and Management CPT Procedure Codes

Since the beginning of the Family Planning Waiver in North Carolina, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) have experienced claim denials for evaluation and management (E/M) services provided to waiver recipients. This issue has been addressed and is now corrected.

RHCs and FQHCs may now refile new day claims for the CPT E/M codes for dates of service October 2005 through June 2007 that were incorrectly denied with EOB 36: "UB claim form: Revenue code invalid this bill type, other claims place of service missing/invalid for this procedure. Correct bill type or POS and resubmit as a new claim."

RHCs and FQHCs are reminded that this refiling is only for claims that have denied for the Medicaid Family Planning Waiver clients (MAFD-N). For recipients eligible under other program categories, family planning visits are core services.

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

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 Web site at http://www.ncdhhs.gov/dma/prov.htm. To submit a comment related to a policy, refer to the instructions on the Web site. Providers without Internet access can submit written comments to the address listed below.

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

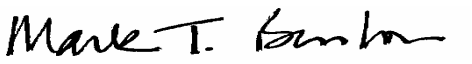
The initial comment period for each proposed policy is 45 days. An additional 15-day comment period will follow if a proposed policy is revised as a result of the initial comment period.

2007 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
September	08/30/07	09/05/07
	09/06/07	09/11/07
	09/13/07	09/18/07
	09/20/07	09/27/07
October	10/04/07	10/09/07
	10/11/07	10/16/07
	10/18/07	10/23/07
	10/25/07	10/31/07
November	11/01/07	11/06/07
	11/08/07	11/14/07
	11/15/07	11/21/07
December	11/29/07	12/04/07
	12/06/07	12/11/07
	12/13/07	12/20/07

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.

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



Mark T. Benton, Director
Division of Medical Assistance
Department of Health and Human Services

Cheryll Collier
Executive Director
EDS