September 2008 Medicaid Bulletin

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

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

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Attention: All Providers

Change in Banks for EDS

DMA has approved EDS to change banks from Wachovia to the Bank of America. This will have no impact to your receipt of check or electronic funds transfer (EFT) payment; however, the EFT transaction description on your bank statement or bank EFT notice will reflect Bank of America in place of Wachovia. Providers may expect to see this change in September 2008.

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

Attention: All Providers

Clinical Coverage Policies

The following new or amended clinical coverage policies are now available on DMA's website at http://www.ncdhhs.gov/dma/mp/mpindex.htm:

General Coverage Policy A2, Over-the-Counter Medications
1A-20, Sleep Studies and Polysomnography Services
10B, Independent Practitioners

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

Ordering Copies of Remittance and Status Reports

There is no charge for copies of Remittance and Status Reports (RAs) for the previous 10 checkwrite periods. If the request is for a copy of an RA for the current checkwrite, please wait 10 business days before submitting your request to EDS Provider Services.

For RAs that are more than 10 checkwrites old, there is a charge of 35 cents per page.

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

Attention: All Providers

CPT Procedure Codes 92978 and 92979 (Intravascular Ultrasounds) and Diagnosis List

Clinical Coverage Policy 1R-4, *Electrocardiography, Echocardiography, and Intravascular Ultrasound*, was effective on March 1, 2008. CPT procedure codes 92978 (intravascular ultrasound, initial vessel) and 92979 (intravascular ultrasound, each additional vessel) are to be billed with a diagnosis from the approved list in Attachment A of the policy. ICD-9-CM diagnosis code 998.0 (postoperative shock) is included in the approved list but was not included in the system update, which caused some claims to deny.

Changes have been made in the claims payment system to correct the problem. Providers who received claim detail denials related to EOB 0082 (service is not consistent with/or not covered for this diagnosis/or description does not match diagnosis) for CPT procedure code 92978 or 92979 for dates of service March 1, 2008, and after, may resubmit the denied charges as a new claim (not as an adjustment request) for processing.

Refer to Clinical Coverage Policy 1R-4, *Electrocardiography, Echocardiography, and Intravascular Ultrasound*, on DMA's website at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

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

Attention: All Providers

CPT Procedure Codes 93000, 93005, and 93010 (Electrocardiograms) and Denials

Clinical Coverage Policy 1R-4, *Electrocardiography, Echocardiography, and Intravascular Ultrasound*, was effective March 1, 2008. The unit limitation for CPT procedure codes 93000 (electrocardiogram, routine ECG with at least 12 leads; with interpretation and report), 93005 (electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report), and 93010 (electrocardiogram, routine ECG with at least 12 leads, interpretation and report only) was increased on March 1, 2008, to four units per day. After the increase, systems issues occurred that may have caused some detail lines on claims to be denied with EOB 5201 (diagnostic procedure allowed one per day unless billed with appropriate modifiers) or EOB 5202 (repeat diagnostic procedure allowed twice per day).

Changes have been made to the claims payment system to correct the problem. Providers who received claim detail denials related to EOB 5201 or 5202 for CPT procedure codes 93000, 93005, or 93010 may resubmit the denied charges as a new claim (not as an adjustment request) for processing.

When billing for more than one unit of CPT procedure code 93000, 93005, or 93010 on the same day of service, providers should bill all units for a single code as one detail on the claim.

Refer to Clinical Coverage Policy 1R-4, *Electrocardiography, Echocardiography, and Intravascular Ultrasound*, on DMA's website at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

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

Attention: All Providers

False Claims Act Education Compliance for Federal Fiscal Year 2007

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.

Each year DMA will notify those providers who received a minimum of $5 million in Medicaid payments during the last federal fiscal year (October 1 through September 30) with a reminder that they must submit a Letter of Attestation to Medicaid in compliance with the DRA. (A complete list of providers who meet this requirement is available on DMA's website at http://www.ncdhhs.gov/dma/fca/falseclaimsact.html.) This minimum amount may have been paid to one N.C. Medicaid provider number or to multiple Medicaid provider numbers associated with the same tax identification number. A separate notification will be mailed for each Medicaid provider number.

Providers must complete and submit a copy of the Letter of Attestation form within 30 days of the date of notification. Upon completion, submit the Letter to EDS by fax or by mail:

EDS
Attn: PVS-False Claims Act
P.O. Box 300012
Raleigh NC 27622

Fax: Attn: PVS-False Claims Act at 919-851-4014

Compliance with Section 6023 of the DRA is a condition of receiving Medicaid payments. Medicaid payments will be denied for providers who 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 submitted to and received by EDS.

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

Attention: All Providers

ICD-9-CM Diagnosis Codes that Are Not Subject to the Annual Visit Limitation

The Adobe Acrobat version of the list of ICD-9-CM diagnosis codes that are not subject to the annual visit limitation (on DMA's website at http://www.ncdhhs.gov/dma/AnnualVisitLimit.htm) has been corrected. The original version did not correctly display all of the ICD-9-CM codes that are included on the list.

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

Attention: All Providers

Implementation of N.C. Medicaid's Uniform Screening Program for PASARR Only

All individuals admitted to a nursing facility must be screened before admission and annually thereafter, according to federal regulations. This is called the Pre-admission Screening and Annual Resident Review (PASARR). The PASARR-only screening segment of the automated Uniform Screening Program (USP) is scheduled to be implemented on September 12, 2008.

Providers who currently submit the PASARR Level I Screening Form via fax or ProviderLink are strongly advised to go to http://www.ncmust.com for ongoing information regarding online registration, training, and test requirements.

Please visit http://www.ncmust.com frequently for specific information regarding implementation of the automated PASARR-only screen.

Access to the PASARR component of the MUST will require each provider administrator and user to create a user account with North Carolina Identity Management (NCID) and then use that account to register their organization and/or themselves within the PASARR component. Providers are strongly advised to register an NCID account prior to the September implementation. Instructions for creating an NCID account are available at http://www.ncmust.com.

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

Attention: All Providers

Independent Practitioner Program Seminars

Independent Practitioner Program seminars are scheduled for November 2008. The seminars will be held at locations throughout the state. Seminars are intended to educate providers on the basics of Medicaid billing.

The seminar sites and dates will be announced in the October 2008 general bulletin (http://www.ncdhhs.gov/dma/bulletin.htm). Pre-registration will be required. Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

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

Attention: All Providers

Medicaid Credit Balance Reporting.

All providers participating in the Medicaid program are required to submit to DMA's Third Party Recovery Section a quarterly **Credit Balance Report** indicating balances due to Medicaid. Providers must report any **outstanding** credits owed to Medicaid that have not been reported previously on a Medicaid Credit Balance Report. However, hospital and nursing facility providers are required to submit a report every calendar quarter even if there are no credit balances. The report must be submitted no later than 30 days following the end of the calendar quarter (March 31, June 30, September 30, and December 31).

The Medicaid Credit Balance Report is used to monitor and recover credit balances owed to the Medicaid program. A credit balance results from an improper or excess payment made to a provider. For example, refunds must be made to Medicaid if a provider is paid twice for the same service (e.g., by Medicaid and a medical insurance policy, by Medicare and Medicaid, or by Medicaid and a liability insurance policy), if the patient liability was not reported in the billing process, or if computer or billing errors occur.

For the purpose of completing the report, a Medicaid credit balance is the amount determined to be refundable to the Medicaid program. When a provider receives an improper or excess payment for a claim, it is reflected in the provider's accounting records (patient accounts receivable) as a "credit." However, credit balances include money due to Medicaid regardless of its classification in a provider's accounting records. If a provider maintains a credit balance account for a stipulated period (e.g., 90 days) and then transfers the account or writes it off to a holding account, this does not relieve the provider of liability to the Medicaid program. The provider is responsible for identifying and repaying all money owed the Medicaid program.

The Medicaid Credit Balance Report requires specific information on each credit balance on a claim-by-claim basis. The reporting form provides space for 15 claims but may be reproduced as many times as necessary to accommodate all the credit balances being reported. Specific instructions for completing the report are on the reverse side of the reporting form.

Submitting the Medicaid Credit Balance Report does not result in the credit balances automatically being reimbursed to the Medicaid program. A check is the preferred form of satisfying the credit balances; the check must be made payable to EDS and sent to EDS with the required documentation for a refund. If an adjustment is to be made to satisfy the credit balance, an adjustment form must be completed and submitted to EDS with all the supporting documentation for processing.

Submit **Medicaid Credit Balance Report Form** to:	Submit **refund checks** to:	Submit **Medicaid Claim Adjustment Request Form** to:
Third Party Recovery Section Division of Medical Assistance 2508 Mail Service Center Raleigh NC 27699-2508	EDS Refunds P.O. Box 300011 Raleigh NC 27622-3011	EDS Adjustment Unit P.O. Box 300009 Raleigh NC 27622-3009

Submit **only** the completed Medicaid Credit Balance Report to DMA. **Do not** send refund checks or adjustment forms to DMA. **Do not** send the Credit Balance Report to EDS. Failure to submit a Medicaid Credit Balance Report will result in the withholding of Medicaid payment until the report is received.

A copy of the Medicaid Credit Balance Report form follows this article. Both the Medicaid Claim Adjustment Request form and the Medicaid Credit Balance Report form are also available on DMA's website at http://www.ncdhhs.gov/dma/formsprov/html.

Third Party Recovery Section
DMA, 919-647-8100

Instructions for Completing Medicaid Credit Balance Report

Complete the "Medicaid Credit Balance Report" as follows:

- **Full name of facility as it appears on the Medicaid Records**
- **The facility's Medicaid provider number**. If **the facility has more than one provider number, use a separate sheet for each number. DO NOT MIX**
- **Circle the date quarter end**
- **Enter year**
- The name and telephone number of the person completing the report. This is needed in the event DMA has any questions regarding some item in the report

Complete the date fields for each Medicaid balance by providing the following information:

Column 1 – The last name and first name of the Medicaid recipient (e.g., Doe, Jane)

Column 2 – The individual Medicaid identification (MID) number

Column 3 – The month, day, and year of beginning service (e.g., 12/05/03)

Column 4 – The month, day, and year of ending service (e.g., 12/10/03)

Column 5 – The R/A date of Medicaid payment (not your posting date)

Column 6 – The Medicaid ICN (claim) number

Column 7 – The amount of the credit balance (not the amount your facility billed or the amount Medicaid paid)

Column 8 – The reason for the credit balance by entering: "81" if it is a result of a Medicare payment; "83" if it is the result of a health insurance payment; "84" if it is the result of a casualty insurance/attorney payment or "00" if it is for another reason. Please explain "00" credit balances on the back of the form.

After this report is completed, total column 7 and mail to **Third Party Recovery, DMA, 2508 Mail Service Center, Raleigh, NC 27699-2508.**

MEDICAID CREDIT BALANCE REPORT

PROVIDER NAME:_____ CONTACT PERSON: _____
PROVIDER NUMBER: _____ TELEPHONE NUMBER: _____
QUARTER ENDING: (Circle one) 3/31 6/30 9/30 12/31 YEAR: _____

(1) RECIPIENT'S NAME	(2) MEDICAID NUMBER	(3) FROM DATE OF SERVICE	(4) TO DATE OF SERVICE	(5) DATE MEDICAID PAID	(6) MEDICAID ICN	(7) AMOUNT OF CREDIT BALANCE	(8) REASON FOR CREDIT BALANCE
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							

Circle one: Refund Adjustment

Return form to: **Third Party Recovery**
DMA
2508 Mail Service Center
Raleigh, NC 27699-2508

Revised 10/07

Attention: All Providers

Registration for Basic Medicaid Seminars

Basic Medicaid seminars are scheduled for October 2008. Registration information, a list of dates, and site locations for the seminars are listed below.

Seminars will begin at 9:00 a.m. and will end at 12:00 noon. Providers are encouraged to arrive by 8:45 a.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. Providers may also complete the Seminar Registration Form on the following page and fax it to the number listed on the form. Please indicate on the registration form the session that you plan to attend.

The *Basic Medicaid Billing Guide* will be used as the primary training document for the seminar. Please review and print the **October 2008** version and bring it to the seminar. The October 2008 *Basic Medicaid Billing Guide* is available on DMA's website at http://www.ncdhhs.gov/dma/medbillcaguide.htm.

EDS will discuss and review basic N.C. Medicaid topics while providing an overall understanding of the N.C. Medicaid Program. New and established billers are encouraged to attend these training sessions.

Morganton **October 23, 2008** Western Piedmont Community College Moore Hall 1001 Burkemont Ave. Morganton NC 28655 828-438-6000	**Williamston** **October 30, 2008** Martin Community College Auditorium 1161 Kehukee Park Rd. Williamston NC 27892 252-792-1521	**Raleigh** **November 4, 2008** Wake Technical Community College 9101 Fayetteville Rd. Raleigh NC 27603 919-866-5500

Directions to the Basic Medicaid Seminars:

MORGANTON

Western Piedmont Community College

I-40 West

From Hickory, take Exit #103 and turn right onto Burkemont Avenue. Cross the bridge over I-40. Western Piedmont Community College is on the right.

I-40 East

From Asheville, take Exit #103 and turn left onto Burkemont Avenue. Cross the bridge over I-40. Western Piedmont Community College is on the right.

Hwy. 18 from Lenoir

Turn left onto South Sterling Street. Turn right at Burger King onto West Fleming Drive. At the N.C. School for the Deaf, turn left onto Burkemont Avenue. Western Piedmont Community College is on the left at the second traffic light.

Hwy. 64 from Rutherfordton
Driving into Morganton, cross over I-40. Western Piedmont Community College is on the right, 1 block beyond I-40.

WILLIAMSTON

Martin Community College

Traveling East on US 64
Take US 64 West to the intersection at McDonald's in Williamston. Turn left on the Highway 13/17 Bypass. The name will change to Old Highway 64 Bypass. Continue approximately 2.3 miles and turn left on Kehukee Park Road. The college is located on the right approximately ½ mile from the intersection.

Traveling West on US 64
Take US 64 East to exit 512 (Prison Camp Road). (Look for the sign just before exit 512 for Senator Bob Martin Agricultural Center and Martin Community College.) Turn right on Prison Camp Road. Drive for approximately ½ mile and turn left on Kehukee Park Road. The college is located on the right approximately ½ mile from the intersection.

Traveling North on US 13/US 17
Take US 13/US 17 South to Williamston. Continue to follow US 13/US 17 until it becomes Old Highway 64 Bypass. Continue driving for approximately 2½ miles. Turn left on Kehukee Park Road. The college is located on the right approximately ½ mile from the intersection.

RALEIGH

Wake Technical Community College

Take I-440 to US 401 South/S. Saunders Street (exit 298). Stay to the right to continue on US 401 South/Fayetteville Road. Continue to travel on US 401 South/Fayetteville Street towards Fuquay-Varina. The college is located on the left approximately 1.0 mile from the intersection with NC 1010. Turn left onto Chandler Ridge Circle. Visitor parking is on the left.

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

Basic Medicaid Workshops
October 2008 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

Sleep Study and Polysomnography Denials

Clinical Coverage Policy 1A-20, *Sleep Studies and Polysomnography Services,* has been amended to include three new ICD-9-CM diagnosis codes appropriate for billing. These codes are added to the table in Attachment A, letter B, and include the following:

Diagnosis Code	Description
327.23	Obstructive sleep apnea
327.51	Periodic limb movement disorder
786.09	Dyspnea and respiratory abnormality, other

If you received claim denials for dates of service on or after June 15, 2006, you may resubmit new claims for processing if the claim:

- was billed with one of the following sleep study/polysomnography CPT procedure codes: 95805, 95807, 95808, 95810, or 95811; and
- contains one of the following ICD-9-CM diagnosis codes: 327.23, 327.51, or 786.09; and
- was denied with EOB 82 (service is not consistent with/or not covered for diagnosis/or description does not match diagnosis).

The policy has been further amended (Section 4.2, letter c) to define snoring as an indication of medical necessity for a sleep study or polysomnography procedure only when an underlying physiology exists, such as those listed under Section 3.2.6 of the policy. Section 3.2.6 now states that for snoring to be considered as an indication for a sleep study or polysomnography, at least one of the following conditions must be met:

a. Disturbed sleep patterns
b. Excessive daytime sleepiness
c. Unexplained awake hypercapnia
d. Apneic breathing
e. Cognitive problems
f. Excessive fatigue

Refer to Clinical Coverage Policy 1A-20, *Sleep Studies and Polysomnography Services,* on DMA's website at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

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

Attention: All Providers

Suspension of Medicaid Benefits for Incarcerated Recipients and Recipients in Institutions for Mental Diseases

Effective September 1, 2008, if a Medicaid recipient age 21 through 64 enters an Institution for Mental Disease (IMD) or a Medicaid recipient of any age becomes incarcerated, his benefits will be suspended through the end of his current Medicaid certification period.

For an incarcerated recipient, Medicaid only covers medical services received during an inpatient hospital stay. When the recipient is released from incarceration, he should report his release to the Medicaid caseworker at the county department of social services (DSS). If the certification period has not expired, the Medicaid case may be reactivated. An eligibility redetermination will be completed at the end of the certification period. If the recipient is still incarcerated, he is ineligible.

For a recipient in an IMD, age 21 through 64, Medicaid does not cover any services during the suspension period. When the recipient is released from the IMD he should report his release to the Medicaid caseworker at the county DSS. If the certification period has not expired, the Medicaid case may be reactivated. An eligibility redetermination will be completed at the end of the certification period. If the recipient is still in the IMD, he is ineligible.

The only exception to the suspension of benefits is for a recipient who turns age 21 while residing in an IMD. A recipient who is in an IMD when he turns age 21 can receive Medicaid payment for IMD services, if medically necessary, through the month of his 22nd birthday.

Providers may use the Automated Voice Response system to check the eligibility status of these recipients. The telephone number is 1-800-723-4337.

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

Attention: Outpatient Hospital Clinics and Physicians

Phase II Outpatient Cardiac Rehabilitation

Effective with date of service April 1, 2008, Phase II Outpatient Cardiac Rehabilitation programs are covered by N.C. Medicaid. Please see Clinical Coverage Policy 1R-1, available on DMA's website at http://www.ncdhhs.gov/dma/mp/mpindex.htm, for details.

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

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 DMA's website at http://www.ncdhhs.gov/dma/hipaa.htm.

With the implementation of standards for electronic transactions mandated by 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 list is current as of the date of publication. Providers will be notified of changes to the list through the general Medicaid bulletin.

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

Attention: Enhanced Mental Health Service Providers and Local Management Entities

Billing Reminder for Community Support Services

Authorization and billing for Community Support Services is assigned to a specific provider number, is site specific, and is predicated upon the assumption that the site is responsible for the delivery and accountability of the services rendered and billed. Alternative billing actions are unacceptable. Any such activity will be referred for investigation and constitutes a violation of the DMA provider enrollment agreement, on the part of both the provider seeking to avoid the sanctions and any other provider that may be involved in the alternative billing scheme. This information was originally communicated to Community Support Providers on November 5, 2007, as part of the Implementation Update #36, which can be found on the Division of Mental Health, Developmental Disability and Substance Abuse Services Enhanced Services Implementation Update web page at http://www.dhhs.state.nc.us/mhddsas/servicedefinitions/servdefupdates/index.htm.

Program Integrity
DMA, 919-647-8000

Attention: CAP/DA Lead Agencies

Automated Quality and Utilization Improvement Program Quarterly Training Seminar

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

The third quarterly training session for this year will be held on September 23, 2008, 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 new users in their counties who should attend this session. New AQUIP users should contact their CAP/DA lead agency to verify that their name is on the required attendance list. We recommend that all attendees read and become familiar with the AQUIP User Manual prior to the training session. The manual is available on the AQUIP website (https://www2.mrnc.org/aquip) under "Downloads." Current users who would like to attend the session may do so if space is available. However, the information presented is intended for new users.

The session will provide information on Resource Utilization Group (RUG) scores, and will focus on 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 the age of 21.

The seminar is scheduled to begin at 9:00 a.m. and end at 3:00 p.m. Pre-registration is required. Online registration for the seminar will be available beginning September 2, 2008, and can be accessed by going to https://www2.mrnc.org/aquip and clicking on "Training Sessions." Attendees will receive a computer-generated confirmation number, which they should bring to the seminar. Check-in will be from 8:30 a.m. until 9:00 a.m. on the day of the seminar; lunch will be on your own.

Directions to the AQUIP Training Seminar

HICKORY

Park Inn Gateway Conference Center

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

CCME, 1-800-682-2650

Attention: Dental Providers and Health Department Dental Centers

Dental Rate Change

Effective with date of service September 1, 2008, reimbursement rates for the following dental procedures were increased. **No adjustments will be accepted from providers for these dental rate changes.** Providers are reminded to bill their usual and customary charges rather than the Medicaid rate**.**

CDT 2007/2008 Code	Description	Reimbursement Rate
D0140	Limited oral evaluation - problem focused	$ 38.50
D0150	Comprehensive oral evaluation - new or established patient	46.72
D0160	Detailed and extensive oral evaluation – problem focused, by report	71.50
D0170	Re-evaluation – limited, problem focused (established patient; not post-operative visit)	30.09
D0220	Intraoral -periapical first film	15.62
D0230	Intraoral - periapical each additional film	12.60
D0240	Intraoral - occlusal film	16.74
D0270	Bitewing - single film	11.88
D0272	Bitewings - two films	19.38
D0273	Bitewings - three films	26.46
D0274	Bitewings - four films	33.60
D0330	Panoramic film	62.05
D0340	Cephalometric film	54.88
D0470	Diagnostic casts	44.80
D1110	Prophylaxis - adult	39.90
D1120	Prophylaxis - child	28.50
D1203	Topical application of fluoride (prophylaxis not included) - child	16.80
D1204	Topical application of fluoride (prophylaxis not included) - adult	16.80
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	16.80
D2140	Amalgam - one surface, primary or permanent	67.62
D2150	Amalgam - two surfaces, primary or permanent	85.68
D2160	Amalgam - three surfaces, primary or permanent	99.20
D2161	Amalgam - four or more surfaces, primary or permanent	109.20
D2330	Resin-based composite - one surface, anterior	69.02
D2331	Resin-based composite - two surfaces, anterior	85.26
D2332	Resin-based composite - three surfaces, anterior	100.80
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	127.68
D2390	Resin-based composite crown, anterior	181.50
D2391	Resin-based composite - one surface, posterior	83.79
D2392	Resin-based composite - two surfaces, posterior	124.25
D2393	Resin-based composite - three surfaces, posterior	151.11
D2930	Prefabricated stainless steel crown – primary tooth	151.11

CDT 2007/2008 Code	Description	Reimbursement Rate
D2931	Prefabricated stainless steel crown - permanent tooth	$ 162.50
D2932	Prefabricated resin crown	177.55
D2933	Prefabricated stainless steel crown with resin window	198.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	198.00
D2970	Temporary crown (fractured tooth)	146.34
D3220	Therapeutic pulpotomy (excluding final restoration)	84.93
D3310	Root canal therapy - anterior (excluding final restoration)	297.00
D3320	Root canal therapy - bicuspid (excluding final restoration)	351.00
D3330	Root canal therapy - molar (excluding final restoration)	429.30
D3351	Apexification/recalcification - initial visit	144.72
D3352	Apexification/recalcification - interim medication replacement	105.30
D3353	Apexification/recalcification - final visit	210.60
D3410	Apicoectomy/periradicular surgery - anterior	272.16
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth per quadrant	260.28
D4211	Gingivectomy or gingivoplasty - one to three teeth per quadrant	96.66
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth per quadrant	306.72
D4241	Gingival flap procedure, including root planing - one to three teeth per quadrant	259.20
D4341	Periodontal scaling and root planing - four or more contiguous teeth per quadrant	105.30
D7111	Extraction, coronal remnants - deciduous tooth	54.00
D7140	Extraction, erupted tooth or exposed root	66.55
D7210	Surgical removal of erupted tooth	114.40
D7220	Removal of impacted tooth - soft tissue	130.14
D7230	Removal of impacted tooth - partially bony	173.85
D7240	Removal of impacted tooth - completely bony	202.50
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	243.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	124.74
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	221.40
D7280	Surgical access of an unerupted tooth	199.26
D7283	Placement of device to facilitate eruption of impacted tooth	224.10
D7940	Osteoplasty - for orthognathic deformities	1,456.38
D7941	Osteotomy - mandibular rami	3,806.46
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft	3,505.68
D7944	Osteotomy - segmented or subapical	2,911.68
D7945	Osteotomy - body of mandible	3,024.00
D7946	LeFort I (maxilla - total)	3,546.72
D7947	LeFort I (maxilla - segmented)	3,585.06
D7948	LeFort II or LeFort III - without bone graft	4,105.08
D7949	LeFort II or LeFort III - with bone graft	4,714.74

CDT 2007/2008 Code	Description	Reimbursement Rate
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$ 185.22
D8670	Periodic orthodontic treatment visit (as part of contract)	100.80
D9220	Deep sedation/general anesthesia - first 30 minutes	156.06
D9221	Deep sedation/general anesthesia - each additional 15 minutes	66.42
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	162.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	62.10
D9420	Hospital call	123.95

For current pricing on these and all dental codes, please refer to the fee schedule on DMA's website at http://www.ncdhhs.gov/dma/fee/fee.htm.

For coverage criteria and additional billing guidelines, please refer to Clinical Coverage Policy 4A, *Dental Services,* and Clinical Coverage Policy 4B, *Orthodontic Services,* on DMA's website at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

Dental Program
DMA, 919-855-4280

Attention: Nurse Practitioners and Physicians

Rate Increase for Physician Fluoride Varnish Services

Effective with date of service September 1, 2008, the reimbursement rate for the application of topical fluoride varnish (procedure code D1206) was increased to $16.80. **No adjustments will be accepted from providers for this rate change.** Providers are reminded to bill their usual and customary charges rather than the Medicaid rate**.**

For coverage criteria and additional billing guidelines, please refer to Clinical Coverage Policy 1A-23, *Physician Fluoride Varnish Services,* on DMA's website at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

Dental Program
DMA, 919-855-4280

Attention: Home Health Providers

Annual Fee Schedule Changes for Home Health

Effective with date of service September 1, 2008, home health rates have changed based on the normal annual review.

For current pricing on all home health codes, refer to DMA's website at http://www.ncdhhs.gov/dma/fee/fee.htm.

Providers are reminded to bill their usual and customary rates for all billing. Do not automatically bill the established maximum reimbursement rate. Payment will be the lesser of either the billed usual and customary rate or the maximum reimbursement rate.

Rate Setting
DMA, 919-855-4200

Attention: Home Infusion Therapy Providers

Annual Fee Schedule Changes for Home Infusion Therapy

Effective with date of service September 1, 2008, home infusion therapy (HIT) rates have changed based on the normal annual review.

For current pricing on all HIT codes, refer to DMA's web page at http://www.ncdhhs.gov/dma/fee/fee.htm.

Providers are reminded to bill their usual and customary rates for all billing. Do not automatically bill the established maximum reimbursement rate. Payment will be the lesser of either the billed usual and customary rate or the maximum reimbursement rate.

Rate Setting
DMA, 919-855-4200

Attention: ICF-MR Providers

Policy Change for ICF-MR Providers

Effective September 1, 2008, enrolled ICF-MR facilities are no longer required to submit a re-enrollment application for recertification as a condition of participation in the N.C. Medicaid Program. DMA Provider Services will continue to receive Medicare/Medicaid Certification and Transmittal (C&T) forms from CMS through the N.C. Division of Health Service Regulation (DHSR) indicating that the facility has been recertified, but will no longer notify ICF-MR providers of the receipt of the C&T form. Providers will be contacted only if the certification expires or if a C&T form for recertification is not received from CMS through DHSR.

Provider Services
DMA, 919-855-4050

Attention: ICF-MR Providers

Transfer of ICF-MR Beds from State-operated Developmental Centers to Community Facilities for Individuals Who Currently Occupy the Beds

As noted in the 2008 State Medical Facilities Plan, existing certified ICF-MR beds in state-operated developmental centers may be transferred through the Certificate of Need process to establish ICF-MR group homes in the community serving persons with complex behavioral and/or medical conditions. Providers proposing to develop transferred beds must submit an application to the Certificate of Need Section. At this time, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services will not enter into any written agreements with ICF-MR providers who submit an application.

Carol Donin
DMHDDSAS, 919-855-4700

Attention: Enhanced Mental Health Service Providers and Local Management Entities

Rate Changes for Enhanced Services

Medicaid providers enrolled to offer the following services, please note the rate changes:

Service Code	Service Description	Service Unit	Current Rate	New Rate
H0015	Substance Abuse (SA) Intensive Outpatient Program	per diem	$131.93	$148.52
H2035	SA Comprehensive Outpatient Treatment Program	per hour	45.76	51.20
H0012 HB	SA Non-Medical Community Residential Treatment	per diem	145.50	175.91
H0013	SA Medically Monitored Community Res. Treatment	per diem	265.25	272.99
H0010	Non-Hospital Medical Detoxification	per diem	325.88	367.57
H0014	Ambulatory Detoxification	per 15 min	20.43	23.99
H0020	Opioid Treatment	per event	19.17	18.74
H0040	Assertive Community Treatment Team	per event	323.98	301.35
H2011	Mobile Crisis Management	per 15 min	31.79	34.37
S9484	Professional Treatment Services in Facility Based Crisis	per hour	18.78	17.99
T1023	Diagnostic Assessment MH/SA	per event	169.06	261.13
H0035	Partial Hospitalization	per diem	121.69	149.38
H2017	Psychosocial Rehabilitation	per 15 min	2.90	3.03
H2015 HT	Community Support Team (MS/SA)	per 15 min	16.52	17.26

The new rates will be effective with dates of service beginning October 1, 2008.

Child and Adolescent Day Treatment services are currently being reviewed. Please continue to look for bulletin articles and refer to DMA's website at http://www.ncdhhs.gov/dma/fee/mhfee.htm for additional rate updates which will be posted as changes are made.

Providers must always bill their usual and customary charges.

Rate Setting
DMA, 919-855-4200

Attention: Local Education Agencies

Local Education Agency Services Trainings

North Carolina's Department of Public Instruction (DPI) and DMA will offer four training sessions across the state to provide information regarding the amended State Medicaid Plan as it applies to Local Education Agency (LEA) providers. No registration is required. LEA providers and specifically school nurses, Exceptional Children Program directors, finance staff, and compliance staff are strongly encouraged to attend.

A copy of the presentation is available on DPI's Medicaid web page at http://www.ncpublicschools.org/ec/medicaid/. Please print a copy of the presentation and bring it with you to the training session.

Information sessions are scheduled from 9:00 a.m. until 4:00 p.m. as follows:

Enka **September 3, 2008** Western Region Education Service Alliance Asheville-Buncombe Technical College Enka Campus Room 200 (large conference center located on the 2nd floor) 1459 Sand Hill Rd. Enka NC 28728	**Winston-Salem** **September 4, 2008** Atkins High School Auditorium 3605 Old Greensboro Rd. Winston-Salem NC 27101
Raleigh **September 12, 2008** NC DOT Training Center Rooms 203/204 313 Chapanoke Rd. Raleigh NC 27603	**Tarboro** **September 19, 2008** Edgecombe Community College Tarboro Campus McIntyre Auditorium 2009 W. Wilson St. Tarboro NC 27886

Directions are available on DPI's Medicaid web page at http://www.ncpublicschools.org/ec/medicaid/.

Tentative Agenda

Time	Topic	Presenters
9:00 a.m. to 11:00 a.m.	Revised Time Study	Sandy Frederick, DMA
	LEA policy addition of Nursing Services	Nora Poisella, DMA Jessica Gerdes, DPH Lauren Holahan, DPI Laurie Ray, DPI
11:00 a.m. to 11:45 a.m.	Questions and Answers	
11:45 a.m. to 12:45 p.m.	Lunch (on your own)	
1:00 p.m. to 3:00 p.m.	Cost Report/Rate Setting	Kimberly Ibrahim, DMA Paul LeSieur, DPI Stephanie English, DPI
3:00 p.m. to 3:45 p.m.	Questions and Answers	

Nora Poisella, Clinical Policy and Programs
DMA, 919-855-4310

Attention: Pharmacists and Prescribers

Procedures for Prescribing Synagis for RSV Season 2008-2009

Prior approval will not be required for Synagis for the upcoming respiratory syncytial virus (RSV) season. However, prescribers and pharmacists are responsible for ensuring the appropriate usage of Synagis. The clinical criteria utilized by N.C. Medicaid 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).*

The **Synagis for RSV Prophylaxis form** is used for patients who meet the clinical criteria for coverage. Please ensure the person completing the form has verified that the conditions exist and are accurately reported. If a patient does not meet the clinical criteria for coverage but you still wish to prescribe Synagis, you must submit your request to DMA as described below.

A medical necessity review for Synagis will be conducted for all requests for recipients under the age of 21 who do not meet the criteria listed on the Synagis for RSV Prophylaxis form. The medical necessity review will follow Early Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. Please use the **Request for Medical Review for Synagis Outside of Criteria form** for a medical necessity review for Synagis under EPSDT guidelines. Requests for a sixth dose or more of Synagis, or for coverage outside of the defined seasonal period, should be made on the **Non-covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age**, available online at http://www.ncdhhs.gov/dma/formsprov.html (under Prior Approval).

N.C. Medicaid will begin coverage of Synagis on October 15, 2008. During the season, five monthly doses of Synagis can be obtained. The number of doses should be adjusted if an infant received the first dose prior to a hospital discharge. Delays in request processing can occur if the patient does not have a Medicaid identification number or the form is not complete.

The Synagis for RSV Prophylaxis form must be signed by the prescriber and submitted to the pharmacy distributor of choice. The Request for Medical Review for Synagis Outside of Criteria form must be signed by the prescriber and faxed to DMA at 919-715-1255. Please refer to the guidelines below when submitting a request for Synagis.

Requesting Synagis for RSV Prophylaxis When Criteria Are Met

Submit requests using the Synagis for RSV Prophylaxis form. (If the recipient does **not** meet the criteria below, please see the paragraph below titled "Requesting Synagis for RSV Prophylaxis When Criteria Are Not Met.")

For the following four diagnoses, the date of birth (DOB) must be on or after **October 15, 2006.**

Chronic lung disease of prematurity (bronchopulmonary dysplasia): The infant has chronic lung disease (bronchopulmonary dysplasia) and has needed treatment (supplemental oxygen, bronchodilator, diuretic, 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 (CHF), moderate to severe pulmonary hypertension, and/or cyanotic heart disease. Infants not at increased risk from RSV who generally should **not** receive immunoprophylaxis include those with hemodynamically insignificant heart disease, such as secundum atrial/septal defect, small ventricular septal defect (VSD), pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, patent ductus arteriosus (PDA), lesions adequately corrected by surgery

unless the infant continues on medication for CHF, or mild cardiomyopathy for which 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: The infant has severe combined immunodeficiency disease or severe acquired immunodeficiency syndrome.

In addition to the four conditions listed above, a premature infant may qualify for RSV prophylaxis, as follows:

- Born at an estimated gestational age (EGA) of ≤28 weeks, and DOB is on or after October 15, 2007; or
- Born at an EGA of 29 to 32 weeks, and DOB is on or after April 15, 2008; or
- Born at an EGA of 32 weeks and 1 day through 35 weeks and 0 days, and DOB is on or after April 15, 2008, and has **two** or more of the following risk factors:
  - ♦ School-age siblings
  - ♦ Attendance at day care
  - ♦ Severe neuromuscular disease
  - ♦ Exposure 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)
  - ♦ Congenital abnormalities of the airways

Requesting Synagis for RSV Prophylaxis When Criteria Are Not Met

Please submit requests using the Request for Medical Review for Synagis Outside of Criteria form (fax it to DMA at 919-715-1255). This form is to be used for patients who do not explicitly meet the criteria listed on the Synagis for RSV Prophylaxis form.

Please use the Non-covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age to request a sixth or subsequent dose of Synagis or for Synagis administration outside the defined seasonal period. A medical review will consider a request for Synagis under EPSDT (see http://www.ncdhhs.gov/dma/EPSDTprovider.htm); if the information provided justifies medical need, an approval letter will be faxed to the provider.

The Synagis for RSV Prophylaxis form and the Request for Medical Review for Synagis Outside of Criteria form are available on the DMA website at http://www.ncdhhs.gov/dma/synagis.html. For further information about EPSDT or for a copy of the Non-covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age, go to http://www.ncdhhs.gov/dma/EPSDTprovider.htm.

Medicaid will allow Synagis claims processing to begin on October 13, 2008, to allow sufficient time for pharmacies to provide Synagis by October 15, 2008. Payment of Synagis claims prior to October 13, 2008, and after March 31, 2009, will not be allowed. Pharmacy providers should always indicate an accurate days' supply when submitting claims to N.C. Medicaid. Claims for Synagis doses that include multiple vial strengths must be submitted as a single compound drug claim. Synagis doses that require multiple vial strengths that are submitted as individual claims will be subject to recoupment by DMA Program Integrity. Physicians and pharmacy providers are subject to audits of Synagis records by DMA Program Integrity.

Pharmacy Distributor Information

The Synagis for RSV Prophylaxis form must be maintained at the pharmacy distributor's location. The pharmacy distributor must mail a copy of the submitted forms **weekly** to DMA. Please mail submitted forms to

NC Division of Medical Assistance
Pharmacy Program
2501 Mail Service Center
Raleigh NC 27699-2501

Pharmacy distributors who fill a large volume of Synagis claims are asked to submit information from the forms on a compact disk. Please call Charlene Sampson at 919-855-4300 to coordinate this process.

A copy of the approval letter for recipients evaluated under the Request for Medical Review for Synagis Outside of Criteria form or the Non-covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age must be maintained at the pharmacy distributor's location.

Charlene Sampson, Outpatient Pharmacy Program
DMA, 919-855-4300

Attention: Private Duty Nursing Providers

Annual Fee Schedule Changes for Private Duty Nursing

Effective with date of service September 1, 2008, private duty nursing (PDN) rates have changed based on the normal annual review.

For current pricing on all PDN codes, refer to the Home Care Fee Schedule on DMA's web page at http://www.ncdhhs.gov/dma/fee/fee.htm.

Providers are reminded to bill their usual and customary rates for all billing. Do not automatically bill the established maximum reimbursement rate. Payment will be the lesser of either the billed usual and customary rate or the maximum reimbursement rate.

Rate Setting
DMA, 919-855-4200

Attention: All Providers

Clarification from CMS on the Use of Plain Paper for Computer-generated Prescriptions

Since issuing its last guidance on computer-generated prescriptions and the tamper-resistance prescription pad requirements, CMS has clarified that while special tamper-resistant paper can be used to achieve copy resistance, it is not necessary. Copy resistance can also be achieved with plain paper when utilizing two features that can be incorporated into plain paper computer-generated prescriptions. The first of these is microprinting, which is the use of very small font that is readable when viewed at 5x magnification or greater, and is illegible when copied. The second feature is a "Void" pantograph accompanied by a reverse "Rx", which causes a word such as "Void" or "Illegal" to appear when the prescription is photocopied.

In response to this recent clarification from CMS, DMA is updating its September 2007 guidance document as follows:

- Microprinting has been added as an acceptable feature to prevent unauthorized copying of a prescription.
- Features 1a and 1c have been revised by removing the word "entire" so that if the words "Void" or "Illegal" are present, they do not have to be across the entire face of the prescription.
- The word "copy" appearing across the front of the prescription blank when photocopied or scanned has been added as an acceptable feature to prevent unauthorized copying of a prescription.

The updated guidance document also reflects April 1, 2008, as the effective date for the first phase of implementation, which was originally scheduled for October 1, 2007, before Congress delayed the effective date for six months.

For the updated guidance document and additional information on tamper-resistant prescription pads, please refer to DMA's website at http://www.dhhs.state.nc.us/dma/pharmacy/president_delay_pad_requirement.html.

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

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

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

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

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

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

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

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

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

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

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

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

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

Proposed Clinical Coverage Policies

In accordance with NCGS §108A-54.2, proposed new or amended Medicaid clinical coverage policies are available for review and comment on DMA's website at http://www.ncdhhs.gov/dma/mp/proposedmp.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.

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.

2008 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
September	09/04/08	09/09/08
	09/11/08	09/16/08
	09/18/08	09/25/08
October	10/02/08	10/07/08
	10/09/08	10/14/08
	10/16/08	10/21/08
	10/23/08	10/30/08

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.

William W. Lawrence, Jr. M.D.
Acting Director
Division of Medical Assistance
Department of Health and Human Services

Melissa Robinson
Executive Director
EDS