September 2009 Medicaid Bulletin

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

Attention: All Providers

Provider Enrollment and Re-credentialing Fee

Session Law 2009-451 mandated that DMA begin collecting a $100 enrollment fee from providers upon initial enrollment with the N.C. Medicaid Program and at 3-year intervals when the provider is re-credentialed. This process will begin on September 1, 2009, and will apply to applications received on or after that date.

CSC, 1-866-844-1113

Attention: All Providers

Electronic Funds Transfer Requirement

Effective with the second checkwrite in September 2009, the N.C. Medicaid Program will no longer issue paper checks for claims payment. All payments will be made electronically by automatic deposit to the account specified in the provider's Electronic Funds Transfer (EFT) Authorization Agreement for Automatic Deposits.

Providers were first notified of this cost-saving measure in the June 2009 Medicaid Bulletin. Additional information about the electronic funds transfer requirement and other budget initiatives are available on DMA's Budget Initiatives web page at http://www.ncdhhs.gov/dma/provider/budgetinitiatives.htm.

Providers who are currently receiving paper checks for claims payment must complete and submit an EFT Authorization Agreement for Automatic Deposits immediately to ensure that there is no disruption to payments. The form is available on DMA's website at http://www.ncdhhs.gov/dma/provider/forms.htm.
Once the EFT Authorization Agreement has been submitted, a test with the bank will be performed to validate the account information. This test will be done on the first checkwrite in which financial activity occurs, following receipt of the completed form. Normally it will require one checkwrite to complete the process. Once the testing process is complete, payments will be electronically deposited directly to the provider's bank account one business day after the checkwrite day

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

Attention: All Providers

Notice of Medicaid Identification Card Changes

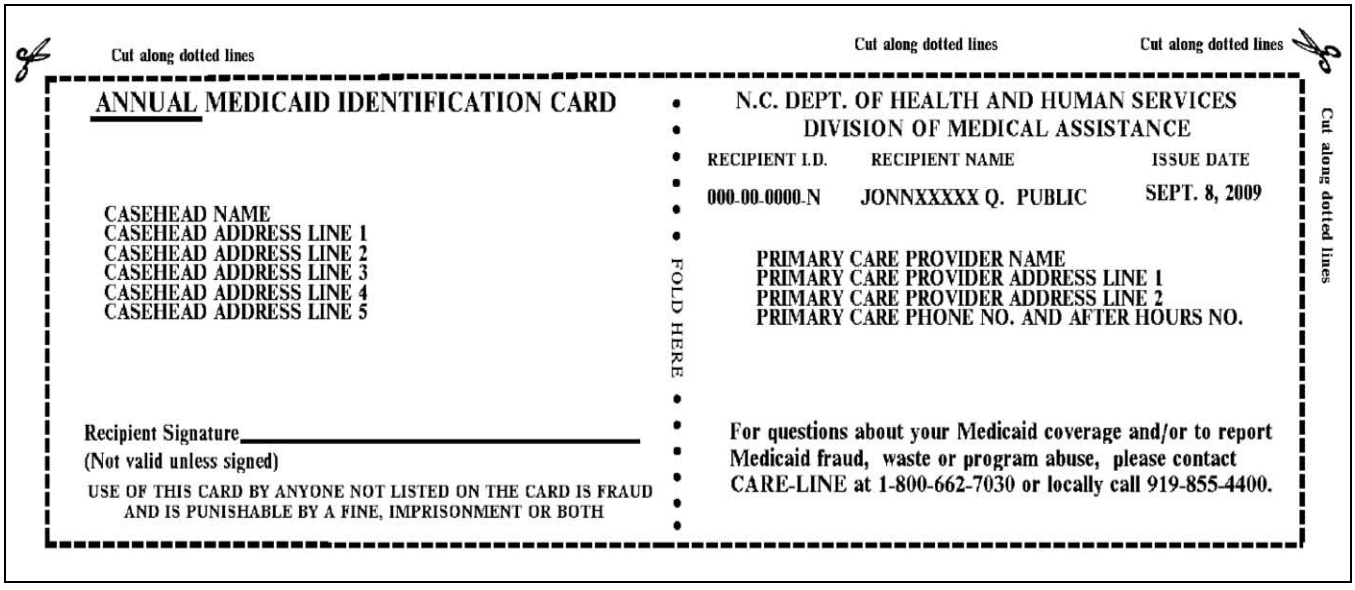
On September 8, 2009, the N.C. Medicaid Program will begin issuance of one Medicaid identification (MID) card per year to each recipient. Currently, the N.C. Medicaid Program issues each recipient a new MID card each month. The new annual cards will be printed on gray card stock. DMA will phase out the blue, pink, green, and buff-colored MID cards. The new cards will include the case head name, recipient's name, MID number, issue date, and CCNC/CA primary care provider information (if applicable). The new cards do not indicate dates of eligibility. Recipients who are issued new cards may have been approved for prior months only, the current month only, or an ongoing period of up to 12 months. (See new card sample below.)

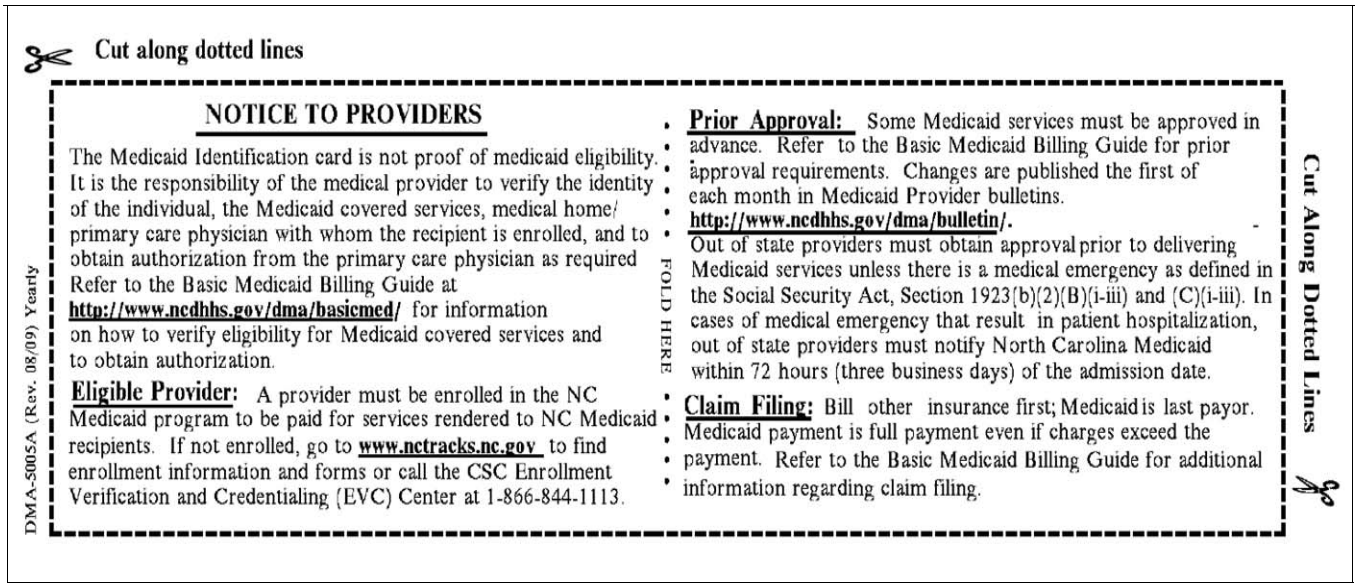
Because the new card no longer serves as proof of eligibility, it is essential that at each visit providers verify the recipient's

- Identity (if an adult)
- Current eligibility
- Medicaid program (benefit category)
- CCNC/CA primary care provider information
- Other insurance information

Current recipients and individuals approved for Medicaid prior to September 8, 2009, will be issued an old version of the monthly MID card. Providers will continue to see the blue, pink, green, and buff-colored cards and the new gray-colored cards during the month of September 2009. Old monthly cards with September or earlier eligibility dates continue to serve as proof of eligibility for the months shown on the card.

It is anticipated that a web-based recipient eligibility verification tool will be available in September (refer to the article titled *Electronic Recipient Eligibility Verification Tool* on page 5 for additional information). Instructions for using the tool are available in the September 2009 Special Bulletin, *North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool Instruction Guide*, on DMA's website at http://www.ncdhhs.gov/dma/bulletin/. For additional information about verifying recipient eligibility refer to the *Basic Medicaid Billing Guide* (http://www.ncdhhs.gov/basicmed/.





Cut along dotted lines

NOTICE TO PROVIDERS

The Medicaid Identification card is not proof of medicaid eligibility. It is the responsibility of the medical provider to verify the identity of the individual, the Medicaid covered services, medical home/ primary care physician with whom the recipient is enrolled, and to obtain authorization from the primary care physician as required Refer to the Basic Medicaid Billing Guide at **http://www.ncdhhs.gov/dma/basicmed/** for information on how to verify eligibility for Medicaid covered services and to obtain authorization.

Eligible Provider: A provider must be enrolled in the NC Medicaid program to be paid for services rendered to NC Medicaid recipients. If not enrolled, go to **www.nctracks.nc.gov** to find enrollment information and forms or call the CSC Enrollment Verification and Credentialing (EVC) Center at 1-866-844-1113.

FOLD HERE

Prior Approval: Some Medicaid services must be approved in advance. Refer to the Basic Medicaid Billing Guide for prior approval requirements. Changes are published the first of each month in Medicaid Provider bulletins. **http://www.ncdhhs.gov/dma/bulletin/.**

Out of state providers must obtain approval prior to delivering Medicaid services unless there is a medical emergency as defined in the Social Security Act, Section 1923(b)(2)(B)(i-iii) and (C)(i-iii). In cases of medical emergency that result in patient hospitalization, out of state providers must notify North Carolina Medicaid within 72 hours (three business days) of the admission date.

Claim Filing: Bill other insurance first; Medicaid is last payor. Medicaid payment is full payment even if charges exceed the payment. Refer to the Basic Medicaid Billing Guide for additional information regarding claim filing.

DMA-5005A (Rev. 08/09) Yearly

Cut Along Dotted Lines

Medicaid Eligibility Unit
DMA, 919-855-4000

Attention: All Providers

Electronic Claim Submission Exceptions

As a cost-saving measure and to increase efficiency, beginning October 2, 2009, the N.C. Medicaid Program will require all providers to file claims electronically. Claims received on or after October 2, 2009, are subject to denial if the claim is not in compliance with the electronic claim mandate. Information on the electronic claim mandate was originally published in the June 2009 Medicaid Bulletin.

The list of exceptions (originally published in the July 2009 Medicaid Bulletin) to the requirement for electronic claim submissions has been revised and is available on DMA's website at http://www.ncdhhs.gov/dma/provider/ECSExceptions.htm. Only claims that comply with these exceptions may be submitted on paper. All other claims are required to be submitted electronically. Providers will be notified of updates to the list through the Medicaid Bulletin (http://www.ncdhhs.gov/dma/bulletin/.

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

Attention: All Providers

Electronic Recipient Eligibility Verification Tool

In September, the N.C. Medicaid Program will implement an electronic recipient eligibility verification tool. This tool will allow providers to access electronic recipient eligibility via the North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool (https://webclaims.ncmedicaid.com/ncecs/).

Use of this tool will allow providers to immediately verify recipient information such as

- Current eligibility
- Medicaid program (benefit category)
- Medicare participation
- CCNC/CA (Carolina ACCESS) participation
- Transfer of asset information
- Other insurance information

This will be the same information that providers receive today through the Automated Voice Response (AVR) system but the Recipient Eligibility Tool will be quicker and easier to use. In order to use this tool, providers must have access to the Web Tool. DMA encourages you to begin immediately the process of obtaining this access.

Providers who currently have an Web logon ID and password can utilize this same logon information to access recipient eligibility verification. You do not need to take any further action.

Providers who do not currently have access to the Web Tool must take the following action.

Step One:

Submit a completed and signed Electronic Claims Submission (ECS) Agreement to CSC. (Refer to the NC Tracks website at http://www.nctracks.nc.gov/provider/forms/ for a copy of the form and instructions.)

Note: Providers who have previously submitted the ECS Agreement do not need to resubmit the form.

Step Two:

Contact the EDS Electronic Commerce Services Unit (1-800-688-6696 or 919-851-8888, option 1) to obtain instructions and a logon ID and password for the Web Tool.

For additional information on verifying recipient eligibility refer to the *Basic Medicaid Billing Guide* on DMA's website at http://www.ncdhhs.gov/dma/basicmed/. For detailed information on the Web Tool, refer to the September 2009 Special Bulletin, *North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool Instruction Guide*, on DMA's website at http://www.ncdhhs.gov/dma/bulletin/.

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

Attention: All Providers

Helpful Hints When Billing National Drug Codes

Providers are reminded that the dose reported by the HCPCS units must equal the dose reported by the National Drug Code (NDC) units. Refer to the following examples.

- For Lovenox, the HCPCS unit and the NDC units must report the same dose.

  Example: The patient receives an 80-mg dose. Report 8 units of J1650 (injection, enoxaparin sodium, 10 mg) and NDC for Lovenox 40-mg/0.4-ml pre-filled syringe. NDC units can be reported as UN2 (2 syringes equal an 80-mg dose) or ML0.8 (number of milliliters equal to 80-mg dose).
- In an outpatient setting, bill the amount of insulin administered to the patient, not the entire multidose vial, with the appropriate HCPCS procedure code and the NDC units reported as the number of milliliters.

  Example: The patient receives 10 units of insulin R (regular), 100 units/ml. Report 2 units of J1815 (injection, insulin, per 5 units) and NDC units ML0.1 or UN0.1 (number of milliliters).
- The patient receives 2 grams of cefotetan-dextrose, 1gm/50-ml bag. Report 4 units of S0074 (injection, cefotetan disodium, 500 mg) and NDC units as ML100 or UN100.
- The patient receives 1000 ml of normal saline solution, 500 ml per bag. Report 2 units of J7040 [infusion, normal saline solution, sterile (500 ml = 1 unit)] and NDC units as ML1000 or UN1000.
- The patient receives 40 mg of Protonix intravenously. Report 1 unit of S0164 (injection, pantoprazole sodium, 40 mg) and NDC units as UN1 (number of vials).
- The patient receives a 0.4-mg dose of fentanyl citrate, 0.05 mcg/ml. Report 4 units of J3010 (injection, fentanyl citrate, 0.1 mg) and NDC units as ML8 or UN8.
- The patient receives a 115-mg injection of Emend. Report 115 units of J1453 (injection, fosaprepitant, 1 mg) and NDC units as UN1 (number of vials).
- For eye drops or ear drops administered in outpatient setting, it is appropriate to bill for the entire bottle or dropperette (in milliliters).

Additionally, in an outpatient setting, providers are reminded to write a prescription for maintenance medications or acute treatment medications, like oral antibiotic tablets or suspensions, for patient pick-up at a local pharmacy, if appropriate.

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/:

- 8A, Enhanced Mental Health and Substance Abuse Services

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

Top 10 EOBs

The following table contains the top eight EOB codes for all claims denied during June 2009.

EOB	EOB Description	Resolution
286	Incorrect authorization number on claim form. Verify number and refile claim	Referring NPI on processed claim does not match the recipient's eligibility file for submitted date of service. Contact referring PCP, obtain the correct referral information and resubmit claim.
9271	Payment included in DRG reimbursement on first accommodation detail	Refer to first accommodation detail. If payment is indicated, no action necessary. If denial code is indicated, correct and resubmit claim based on EOB description given.
270	Billing provider is not the recipient's Carolina Access PCP. Authorization is missing or unresolved. Contact PCP for authorization or EDS Prov. Svcs. if authorization is correct	Submitted claim requires a referring NPI. The referring NPI is either not found on the claim or is unresolved (cannot map to single MPN). Correct and resubmit the claim.
1170	This procedure or procedure/modifier combination is edited for units, therefore billing a span of days is not allowed. Please bill each date of service on a separate detail	Affected procedure or procedure/modifiers should be submitted on separate details with corresponding units. Correct and resubmit the claim.
8925	Allowable reduced for deductible/patient liability	Prior payment amount exceeds the N.C. Medicaid allowable, or reduces the N.C. Medicaid allowable by the prior payment amount. No action necessary.
21	Exact duplicate	Exact claim has previously paid in history. If previous payment is incorrect, submit a replacement claim to address overpayment or underpayment. If payment is correct, no action necessary.
153	Ancillary charges included in per diem rate	Refer to first accommodation detail. If payment is indicated, no action necessary. If denial code is indicated, correct and resubmit claim based on EOB description given.
11	Recipient not eligible on service date	Verify recipient eligibility via a 270/271 transaction or via the Automated Voice Response System (1-800-723-4337, option 6). Refer to the *Basic Medicaid Billing Guide*, Appendix F for more details. If recipient's eligibility has updated since the original claim has processed, resubmit the claim.

The following table contains the top two EOB codes for NPI claims during June 2009.

EOB	EOB Description	Resolution
270	Billing provider is not the recipient's Carolina Access PCP. Authorization is missing or unresolved. Contact PCP for authorization or EDS Prov. Svcs. if authorization is correct	Submitted claim requires a referring NPI. The referring NPI is either not found on the claim or is unresolved (cannot map to single MPN). Correct and resubmit the claim.
8326	Attending provider ID is missing or unresolved. Attending prov is required. Verify attending provider ID and resubmit as a new claim or contact EDS prov svcs if ID is correct	Submitted claim requires an attending NPI. The attending NPI is either not found on the claim or is unresolved (cannot map to single MPN). Correct and resubmit the claim.

Although the suggested resolution is for common denial cases, each claim may propose a unique processing scenario. For further questions or claim research, contact EDS Provider Services for claim-specific diagnostics.

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

Attention: All Providers

Legislative Mandate for Uniform Screening Program Tool for PASARR Screenings

Effective September 1, 2009, Medicaid providers who are required to conduct a Preadmission Screening and Annual Resident Review (PASARR) for individuals before admission to North Carolina's nursing facilities are required to submit the PASARR screening through DMA's web-based PASARR tool **or** through a third-party vendor that can interface with the Uniform Screening Program (USP) tool.

To learn more about MUST, go to http://www.ncmust.com. To register and to start using the tool, refer to http://www.ncmust.com/mustapp/gettingstarted.jsp. Registration will not interfere with your current **web-based** method of submitting data.

Help is always available to make this transition as smooth as possible. Please feel free to contact EDS at 1-800-688-6696, option 7.

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

Attention: All Providers

Immune Globulin (Octagam), Intravenous, HCPCS Procedure Code J1568: Renewed Coverage

Because federal guidelines prohibit the N.C. Medicaid Program from reimbursement for non-rebatable drugs, coverage of immune globulin (Octagam), intravenous, nonlyophilized (e.g., liquid), 500 mg, (HCPCS procedure code J1568) was previously end-dated. Effective with date of service June 30, 2009, coverage of Octagam was renewed due to the availability of rebatable National Drug Codes (NDCs) for this product.

Octagam is covered through the Physician's Drug Program and for outpatient hospitals when billed with HCPCS procedure code J1568 and a rebatable 11-digit National Drug Code (NDC). Providers who received claim detail denials for rebatable NDCs billed on or after June 30, 2009, may resubmit the denied charges as new day claims (not as adjustment requests) for processing.

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 a quarterly **Credit Balance Report** to the DMA Third-Party Recovery Section identifying 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, by Medicaid and a liability insurance policy) or 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 monies owed the Medicaid Program.

The Medicaid Credit Balance Report requires specific information for 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. **Electronic adjustments are the preferred method of satisfying the credit balances and can be performed through the North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool. Refer to the September 2009 Special Bulletin, *North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool Instruction Guide*, on DMA's website at http://www.ncdhhs.gov/dma/bulletin/ for specific filing instructions.**

In the event, a billing error caused an individual provider to be paid for a service in which a provider group should have been paid, a refund check will need to be sent to EDS to correct the error as it is unlikely the individual provider will have future claims to adjust. In these circumstances only, a check must be made payable to EDS and sent to EDS using the **Medicaid Provider Refund Form** (http://www.ncdhhs.gov/dma/provider/forms.htm). The information on the form must be complete and accurate in order to process the provider refund check.

Submit the Medicaid Credit Balance Report Form to:	Electronic Adjustments using the North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool	Submit Refund Checks to:
Third Party Recovery Section Division of Medical Assistance 2508 Mail Service Center Raleigh NC 27699-2508	**Refer to the September 2009 Special Bulletin, *North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool Instruction Guide* (http://www.ncdhhs.gov/dma/bulletin/)**	EDS Refunds P.O. Box 300011 Raleigh NC 27622-3011 (**Do not** send these refund checks to DMA or to the Controller's Office.)

Submit **only** the completed Medicaid Credit Balance Report to DMA. **Failure to submit a Medicaid Credit Balance Report to DMA will result in the withholding of Medicaid payment until the report is received.**

Send to DMA:

- The **original** completed Medicaid Credit Balance Report.
- Please circle "Adjustment" at bottom of original credit balance report to indicate an electronic adjustment has been performed. (**Note:** You may circle "Refund" in the event a check must be sent due to the reason stated above).

Send to EDS Refunds Department:

- Always send **live credit balance refund check(s)** to the EDS refunds address listed in this bulletin.
- Enclose a copy of the Medicaid Credit Balance Report associated with the refund.
- Include a completed **Medicaid Provider Refund Request Form** to ensure that EDS can appropriately document individual refund amounts.
- Please circle "Refund" at the bottom of the copy of the Medicaid Credit Balance Report.

A copy of the Medicaid Credit Balance Report form follows this article. The Medicaid Provider Refund Form and the Medicaid Credit Balance Report form are also available on DMA's website at http://www.ncdhhs.gov/dma/provider/forms.htm.

Debbie Odette, 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.								
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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

Prior Authorization for Non-emergency Outpatient High-tech Radiology and Ultrasound Procedures

Dates related to the implementation of prior authorization (PA) of high-tech radiology and ultrasound procedures are as follows:

Date	Procedures	Instructions for Providers
October 13, 2009 October 14, 2009 October 20, 2009 October 29, 2009 November 4, 2009	Online Training Sessions	Online provider training sessions will be provided at 9:00 a.m. and 1:00 p.m. on each day. MedSolutions will be sending a packet of information to providers via the mail with instructions on how to access the online training sessions.
October 19, 2009	CT, CTA, MR, MRA, PET	All ordering providers will begin requesting PA for tests scheduled November 1, 2009, and after.
November 1, 2009	CT, CTA, MR, MRA, PET	Institutional and professional claims submitted to EDS for testing performed on November 1, 2009, and after will require PA on file. Outpatient claims will require Revenue Codes and CPT codes on the UB-04 detail.
December 15, 2009	Ultrasounds	All ordering providers will begin requesting PA for tests scheduled January 1, 2010, and after.
January 1, 2010	Ultrasounds	Institutional and professional claims submitted to EDS for testing performed on January 1, 2010, and after will require PA on file. Outpatient claims will require Revenue Codes and CPT codes on the UB-04 detail.

MedSolutions will accept authorization requests by web, phone, and fax. Please visit http://www.medsolutionsonline.com to register for PA services and to view MedSolutions' imaging guidelines.

The ordering physician is required to obtain the PA. This authorization should be obtained before the testing is scheduled. The authorization number should be provided to the facility performing the test. The authorization is good for 60 days following its issuance.

Recipient categories exempt from prior approval are:

- Recipients that are dually eligible for Medicare and Medicaid
- Recipients with third-party insurance
- Recipients with PACE
- Recipients with Health Choice
- Recipients with Family Planning Waiver
- Recipients in the Health Insurance Premium Payments Program

Procedures performed during an inpatient stay, during an emergency department visit, during an observation stay or as a referral from a hospital emergency department do not require prior approval. Refer to the following information on billing for procedures provided in these circumstances.

Type of Stay	Billing Instruction
Inpatient stay	Enter Bill type 11x in Form Locator 4
Emergency department visit	Enter Revenue Code 450 in Form Locator 42
Observation stay	Enter Revenue Code 762 in Form Locator 42
Hospital emergency department referral	Institutional Claims: Enter appropriate CPT code with modifier U2 in Form Locator 44. Professional Claims: Enter appropriate CPT code with modifier U2 in field 24D.

The following procedure codes require prior approval:

Positron Emission Tomography (PET) Scans

CPT Code	Description
78608	Brain imaging, positron emission tomography (PET); metabolic evaluation
78609	Brain imaging, positron emission tomography (PET); perfusion evaluation
78811	Positron emission tomography (PET) imaging; limited area (eg, chest, head/neck)
78812	Positron emission tomography (PET) imaging; skull base to mid-thigh
78813	Positron emission tomography (PET) imaging; whole body
78814	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (eg, chest, head/neck)
78815	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh
78816	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; whole body

Computed Tomography Angiography (CTA)

CPT Code	Description
70496	Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing
70498	Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing
71275	Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing
72191	Computed tomography angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing
73206	Computed tomographic angiography, upper extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing
73706	Computed tomographic angiography, lower extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing
74175	Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing
75635	Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed and image postprocessing

Computed Tomography (CT) Scans

CPT Code	Description
70450	Computed tomography, head or brain; without contrast material
70460	Computed tomography, head or brain; with contrast material(s)
70470	Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections

CPT Code	Description
70480	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material
70481	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material
70491	Computed tomography, soft tissue neck; with contrast material
70492	Computed tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections
71250	Computed tomography, thorax; without contrast material
71260	Computed tomography, thorax; with contrast material(s)
71270	Computed tomography, thorax, without contrast material, followed by contrast material(s) and further sections
72125	Computed tomography, cervical spine; without contrast material
72126	Computed tomography, cervical spine; with contrast material(s)
72127	Computed tomography, cervical spine; without contrast material, followed by contrast material(s) and further sections
72128	Computed tomography, thoracic spine; without contrast material
72129	Computed tomography, thoracic spine; with contrast material(s)
72130	Computed tomography, thoracic spine; without contrast material, followed by contrast material(s) and further sections
72131	Computed tomography, lumbar spine; without contrast material
72132	Computed tomography, lumbar spine; with contrast material(s)
72133	Computed tomography, lumbar spine; without contrast material, followed by contrast material(s) and further sections
72192	Computed tomography, pelvis; without contrast material
72193	Computed tomography, pelvis; with contrast material(s)
72194	Computed tomography, pelvis; without contrast material, followed by contrast material(s) and further sections
73200	Computed tomography, upper extremity; without contrast material
73201	Computed tomography, upper extremity, with contrast material(s)
73202	Computed tomography, upper extremity, without contrast material, followed by contrast material(s) and further sections
73700	Computed tomography, lower extremity; without contrast material
73701	Computed tomography, lower extremity, with contrast material(s)
73702	Computed tomography, lower extremity, without contrast material, followed by contrast material(s) and further sections
74150	Computed tomography, abdomen; without contrast material
74160	Computed tomography, abdomen; with contrast material(s)
74170	Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections
76380	Computed tomography, limited or localized follow-up study
76497	Unlisted computed tomography procedure (eg, diagnostic, interventional)
77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)
77079	Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)

Magnetic Resonance Angiography (MRA)

CPT Code	Description
70544	Magnetic resonance angiography, head; without contrast material(s)
70545	Magnetic resonance angiography, head; with contrast material(s)
70546	Magnetic resonance angiography, head; without contrast material(s), followed by contrast material(s) and further sequences
70547	Magnetic resonance angiography, neck; without contrast material(s)
70548	Magnetic resonance angiography, neck; with contrast material(s)
70549	Magnetic resonance angiography, neck; without contrast material(s), followed by contrast material(s) and further sequences
71555	Magnetic resonance angiography, chest (excluding myocardium), with or without contrast material(s)
72159	Magnetic resonance angiography, spinal canal and contents, with or without contrast material(s)
72198	Magnetic resonance angiography, pelvis, with or without contrast material(s)
73225	Magnetic resonance angiography, upper extremity, with or without contrast material(s)
73725	Magnetic resonance angiography, lower extremity, with or without contrast material(s)
74185	Magnetic resonance angiography, abdomen, with or without contrast material(s)

Magnetic Resonance Imaging (MRI)

CPT Code	Description
70336	Magnetic resonance (eg, proton) imaging, temporomandibular joint(s)
70540	Magnetic resonance (eg, proton) imaging, orbit, face and/or neck; without contrast material(s)
70542	Magnetic resonance (eg, proton) imaging, orbit, face and/or neck; with contrast material(s)
70543	Magnetic resonance (eg, proton) imaging, orbit, face and/or neck; without contrast material(s), followed by contrast material(s) and further sequences
70551	Magnetic resonance angiography, brain (including brain stem); without contrast material(s)
70552	Magnetic resonance angiography, brain (including brain stem);; with contrast material(s)
70553	Magnetic resonance angiography, brain (including brain stem);; without contrast material(s), followed by contrast material(s) and further sequences
71550	Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s)
71551	Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); with contrast material(s)
71552	Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s), followed by contrast material(s) and further sequences
72141	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material
72142	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s)
72146	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material
72147	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material(s)
72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material
72149	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material(s)
72156	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical

CPT Code	Description
72157	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic
72158	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar
72195	Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s)
72196	Magnetic resonance (eg, proton) imaging pelvis; with contrast material(s)
72197	Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s), followed by contrast material(s) and further sequences
73218	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s)
73219	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; with contrast material(s)
73220	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s), followed by contrast material(s) and further sequences
73221	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)
73222	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; with contrast material(s)
73223	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s), followed by contrast material(s) and further sequences
73718	Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s)
73719	Magnetic resonance (eg, proton) imaging, lower extremity other than joint; with contrast material(s)
73720	Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s), followed by contrast material(s) and further sequences
73721	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material
73722	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; with contrast material(s)
73723	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material(s), followed by contrast material(s) and further sequences
74181	Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)
74182	Magnetic resonance (eg, proton) imaging, abdomen; with contrast material(s)
74183	Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences
76498	Unlisted magnetic resonance procedure (eg, diagnostic, interventional)
77058	Magnetic resonance imaging, breast, without and/or with contrast material(s); unilateral
77059	Magnetic resonance imaging, breast, without and/or with contrast material(s); bilateral

Ultrasound

CPT Code	Description
76506	Echoencephalography, real time with image documentation (gray scale) (for determination of ventricular size, delineation of cerebral contents, and detection of fluid masses or other intracranial abnormalities), including A-mode encephalography as secondary component where indicated
76510	Ophthalmic ultrasound, diagnostic; B-scan and quantitative A-scan performed during the same patient encounter
76511	Ophthalmic ultrasound, diagnostic; quantitative A-scan only
76512	Ophthalmic ultrasound, diagnostic; B-scan (with or without superimposed non-quantitative A-scan)

CPT Code	Description
76513	Ophthalmic ultrasound, diagnostic; anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy
76514	Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)
76516	Ophthalmic biometry by ultrasound echography, A-scan:
76519	Ophthalmic biometry by ultrasound echography, A-scan: with intraocular lens power calculation
76529	Ophthalmic ultrasonic foreign body localization
76536	Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid) real time with image documentation
76604	Ultrasound, chest (includes mediastinum), real time with image documentation
76645	Ultrasound, breast(s) (unilateral or bilateral), real time with image documentation
76700	Ultrasound, abdominal, real time with image documentation; complete
76705	Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)
76770	Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; complete
76775	Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited
76776	Ultrasound, transplanted kidney, real time and duplex Doppler with image documentation
76800	Ultrasound, spinal canal and contents
76801	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; single or first gestation
76802	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; each additional gestation
76805	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or + 14 weeks 0 days), transabdominal approach; single or first gestation
76810	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or + 14 weeks 0 days), transabdominal approach; each additional gestation
76811	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation
76812	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation
76813	Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation
76814	Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; each additional gestation
76815	Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses
76816	Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal
76818	Fetal biophysical profile; with non-stress testing
76819	Fetal biophysical profile; without non-stress testing
76820	Doppler velocimetry, fetal; umbilical artery

CPT Code	Description
76821	Doppler velocimetry, fetal; middle cerebral artery
76825	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording;
76826	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording; follow-up or repeat study
76827	Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; complete
76828	Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; follow-up or repeat study
76830	Ultrasound, transvaginal
76831	Saline infusion sonohysterography (SIS), including color flow Doppler, when performed
76856	Ultrasound, pelvic (nonobstetric), real time with image documentation; complete
76857	Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)
76870	Ultrasound, scrotum and contents
76872	Ultrasound, transrectal;
76873	Ultrasound, transrectal; prostate volume study for brachytherapy treatment planning (separate procedure)
76880	Ultrasound, extremity, nonvascular, real time with image documentation
76885	Ultrasound, infant hips, real time with imaging documentation; dynamic (requiring physician manipulation)
76886	Ultrasound, infant hips, real time with imaging documentation; limited, static (not requiring physician manipulation)
76970	Ultrasound study follow-up
76999	Unlisted ultrasound procedure (eg, diagnostic, interventional)
93875	Noninvasive physiologic studies of extracranial arteries, complete bilateral study (eg, periorbital flow direction with arterial compression, ocular pneumoplethysmography, Doppler ultrasound spectral analysis)
93880	Duplex scan of extracranial arteries; complete bilateral study
93882	Duplex scan of extracranial arteries; unilateral or limited study
93886	Transcranial Doppler study of the intracranial arteries; complete study
93888	Transcranial Doppler study of the intracranial arteries; limited study
93890	Transcranial Doppler study of the intracranial arteries; vasoreactivity study
93892	Transcranial Doppler study of the intracranial arteries; emboli detection without intravenous microbubble injection
93893	Transcranial Doppler study of the intracranial arteries; emboli detection with intravenous microbubble injection
93922	Non-invasive physiologic studies of upper or lower extremity arteries, single level, bilateral
93923	Non-invasive physiologic studies of upper or lower extremity arteries, multiple levels or with provocative testing, complete bilateral study
93924	Noninvasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, complete bilateral study
93925	Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study
93926	Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study
93930	Duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study
93931	Duplex scan of upper extremity arteries or arterial bypass grafts; unilateral or limited study
93965	Noninvasive physiologic studies of extremity veins, complete bilateral study (eg, Doppler waveform analysis with responses to compression and other maneuvers, phleborheography, impedance plethysmography)
93970	Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study

CPT Code	Description
93971	Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study
93975	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study
93976	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study
93978	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study
93979	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; unilateral or limited study
93990	Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)

Other

CPT Code	Description
76376	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; not requiring imaging postprocessing on an independent workstation
76377	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; requiring imaging postprocessing on an independent workstation

Revenue Codes

RC Code	Description
350	CT Scan – General Classification
351	CT Scan – Head Scan
352	CT Scan – Body Scan
359	CT Scan – Other
402	Other Imaging Services – Ultrasound
404	Other Imaging Services – Positron Emission Tomography
409	Other Imaging Services – Other Imaging Services
610	Magnetic Resonance Technology (MRT) – General Classification
611	Magnetic Resonance Technology (MRT) – MRI Brain/Brainstem
612	Magnetic Resonance Technology (MRT) – MRI Spinal Cord/Spine
614	Magnetic Resonance Technology (MRT) – MRI Other
615	Magnetic Resonance Technology (MRT) – MRA Head and Neck
616	Magnetic Resonance Technology (MRT) – MRA Lower Extremities
618	Magnetic Resonance Technology (MRT) – MRA Other
619	Magnetic Resonance Technology (MRT) – Other MRT

A policy will be posted on the DMA website at http://www.ncdhhs.gov/dma/services/radiology.htm prior to implementation.

Practitioner and Clinic Services
DMA, 910-355-1883

Attention: Durable Medical Equipment Providers

Coverage for Augmentative and Alternative Communication Devices

Effective with date of service September 1, 2009, prior approval is required for HCPCS procedure code E2511 (speech generating software program, for personal computer or personal digital assistant). Lifetime expectancy and quantity limitations has been modified for HCPCS procedure code E2500 (speech generating device, digitized speech, using prerecorded messages, less than or equal to eight minutes recording time).

Refer to Clinical Coverage Policy 5A, *Durable Medical Equipment*, on DMA's website at http://www.ncdhhs.gov/dma/mp/ for prior approval requirements (Subsection 5.3.23) and changes in quantity limitations (Attachment E).

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

Attention: Hospitals

Transfer Pricing and Patient Discharge Status Codes

Inpatient hospital claims received on or after August 28, 2009, are subject to new requirements for transfer pricing and patient discharge status codes.

Transfer pricing logic has been modified to meet the requirements of Grouper 25 and UB-04/837I claims processing. The transfer pricing logic is as follows:

1. When an inpatient claim is processed with a Discharge Status Code "02," the claim is considered a transfer claim and the reimbursement is prorated as required in the State Plan Amendment 4.19-A, page 24, Special Situation section, paragraph (c).
2. For inpatient claims processed with one of the Discharge Status Codes from column 1 in the table below and one of the Diagnostic Related Groups (DRGs) listed in column 2, reimbursement is made using the transfer logic method defined in the State Plan Amendment 4.19-A, page 24, Special Situations section, paragraphs (c) and (d).

Column 1	Column 2 – DRG	
Discharge Status Code	**Prior to October 1, 2008 (Grouper Version 24 and older)**	**On or After October 1, 2008 (Grouper 25)**
03, 05, 06, 62, 63, 65 (New)	14, 113, 209, 210, 211, 236, 263, 264, 429, 483	28, 29, 30, 40, 41, 42, 219, 220, 221, 477, 478, 479, 480, 481, 482, 492, 493, 494, 500, 501, 502, 515, 516, 517, 956

New Discharge Status Codes

In addition to the patient discharge status codes currently allowed, the claims processing system is able to process discharge status codes 43, 50, 51, 65, and 66. These status codes should be placed on the UB-04 claim form in form locator 17. Refer to the NUBC Manual at http://www.nubc.org for description and usage guidelines. Providers should use the code that is supported by the patient's medical record to file the claim for reimbursement or any subsequent adjustment claims.

Updates to the *Hospital Manual* and the *Basic Medicaid Billing Guide* are forthcoming.

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

Attention: Hospitals and Nursing Facilities

Medicare Crossover Claim Adjustments

On August 13, 2009, the N.C. Medicaid Program began processing electronic 837 void and replacement transactions from hospitals and nursing facilities when the adjustments were submitted directly to EDS by GHI, the Medicare Coordination of Benefits Contractor (COBC). Providers will notice that on their Remittance and Status Reports, the Internal Claim Number assigned to these adjustment claims begins with either a 90 or 95 for a void transaction or a 97 for a replacement transaction.

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

Attention: Nurse Practitioners and Physicians

Antithrombin (Recombinant) for Injection (ATryn, HCPCS Procedure Code J3590): Billing Guidelines

Effective with date of service June 5, 2009, the N.C. Medicaid program covers antithrombin (recombinant) injectable (ATryn) for use in the Physician's Drug Program when billed with HCPCS procedure code J3590 (unclassified biologics). ATryn is available as single-use vials containing approximately 1,750 IU per vial.

ATryn is a recombinant antithrombin and is not formulated with human plasma proteins. It is indicated for the prevention of perioperative and peripartum thromboembolic events in hereditary antithrombin deficient patients.

Treatment with ATryn should be initiated before delivery or approximately 24 hours prior to surgery and should be individualized for each patient. The goal should be restoring and maintaining antithrombin activity levels between 80% and 120% (0.8 to 1.2 U/mL) of normal.

For Medicaid Billing

- The ICD-9-CM diagnosis code required for billing ATryn is 289.81 (primary hypercoagulable state).
- Providers must bill ATryn with HCPCS procedure code J3590 (unclassified biologics).
- One Medicaid unit of coverage is 1 IU. The maximum reimbursement rate, per 1 IU, is $2.20. An entire single-use vial may be billed.
- Providers must indicate the number of HCPCS units used.
- Providers must bill 11-digit National Drug Codes (NDCs) with appropriate NDC units. The NDC units must be reported as in "units." For example, if billing for the entire single-use vial, report the NDC units as "UN1." If the drug was purchased under the 340B Drug Pricing Program, place a "UD" modifier in the modifier field for that drug detail.

  Note: When billing for compounds or mixtures, list 340B drugs in a separate detail from the non-340B drugs in the same compound/mixture.

  Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III*, on DMA's website (http://www.ncdhhs.gov/dma/bulletin/) for additional instructions.
- Medicaid covers only rebatable NDCs.
- Providers must bill their usual and customary charge.

The fee schedule for the Physician's Drug Program is available on DMA's website at http://www.ncdhhs.gov/dma/fee/.

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

Attention: Nurse Practitioners and Physicians

Degarelix Single-use Vials for Injection (Firmagon, HCPCS Procedure Code J3490): Billing Guidelines

Effective with date of service April 1, 2009, the N.C. Medicaid program covers degarelix injectable (Firmagon) for use in the Physician's Drug Program when billed with HCPCS procedure code J3490 (unclassified drug). Firmagon is available as single-use vials containing either 80 mg or 120 mg of powder for injection.

Firmagon is a gonadotropin-releasing hormone (GnRH) receptor antagonist indicated for the treatment of advanced prostate cancer. Firmagon is for use in males only and can cause fetal harm if administered to pregnant women.

Firmagon is administered as a subcutaneous injection (SC) and is **not** to be administered intravenously. Treatment is started with a dose of 240 mg, given as two injections of 120 mg each. The starting dose is followed by maintenance doses of 80 mg administered as a single SC injection every 28 days.

For Medicaid Billing

- The ICD-9-CM diagnosis code required for billing Firmagon is 185.0 (malignant neoplasm of prostate).
- Providers must bill Firmagon with HCPCS procedure code J3490 (unclassified drug).
- One Medicaid unit of coverage is 80 mg. The maximum reimbursement rate, per 80 mg, is $349.88. An entire single-use vial may be billed.
- Indicate the number of HCPCS units being billed.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. When calculating the NDC units, consider the drug in its original state, **not** the reconstituted amount. The NDC units for Firmagon must be reported in "units." For example, if billing for either the 80-mg or the 160-mg single-use vial, report the NDC units as "UN1." If the drug was purchased under the 340B Drug Pricing Program, place a "UD" modifier in the modifier field for that drug detail.
  Note: When billing for compounds or mixtures, list 340B drugs in a separate detail from the non-340B drugs in the same compound/mixture.
  Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III*, on DMA's website (http://www.ncdhhs.gov/dma/bulletin/) for additional instructions.
- Medicaid covers only rebatable NDCs.
- Providers must bill their usual and customary charge.

The fee schedule for the Physician's Drug Program is available on DMA's website at http://www.ncdhhs.gov/dma/fee/.

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

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

Venipuncture Supplies

Effective with date of service September 1, 2009, HCPCS procedure code T5999 was end-dated and can no longer be used to bill for venipuncture supplies. These supplies are covered as an administrative cost and cannot be billed as a separate charge. The cost is included in the reimbursement for the skilled nursing visit.

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

Attention: Nurse Practitioners and Physicians

Fibrinogen Concentrate (Human) Single-use Vials for Injection (RiaSTAP, HCPCS Procedure Code J3590): Billing Guidelines

Effective with date of service June 12, 2009, the N.C. Medicaid program covers fibrinogen concentrate (human) injectable (RiaSTAP) for use in the Physician's Drug Program when billed with HCPCS procedure code J3590 (unclassified biologics). RiaSTAP is available in single-use vials that contain approximately 1 gm (900 mg to 1300 mg) of lyophilized fibrinogen concentrate powder for reconstitution. **Note:** The actual fibrinogen potency for each lot is printed on the vial label and carton.

RiaSTAP is a fibrinogen concentrate made from pooled human plasma that is indicated for the treatment of acute bleeding episodes in patients with congenital fibrinogen deficiency, including afibrinogenemia and hypofibrinogenemia. RiaSTAP is not indicated for dysfibrinogenemia.

Fibrinogen dosing, duration of dosing, and frequency of administration should be individualized based on the extent of bleeding, laboratory values, and the clinical condition of the patient.

For Medicaid Billing

- The ICD-9-CM diagnosis codes required for billing RiaSTAP are
  - ♦ 286.3 (congenital deficiency of other clotting factors)

  OR

  - ♦ 286.9 (other and unspecified coagulation defects)
- Providers must bill RiaSTAP with HCPCS procedure code J3590 (unclassified biologics).
- One Medicaid unit of coverage is 1 mg. The maximum reimbursement rate, per 1 mg, is $1.02. An entire single-use vial may be billed.
- Indicate the number of HCPCS units billed (900 to 1300 mg). For example, for a single-use vial containing a total of 925 mgs, the HCPCS units should be billed as 925.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for RiaSTAP should be reported as "units." When calculating the NDC units, the drug in its original state must be considered, **not** the reconstituted amount. If billing for an entire 925 mg single-use vial, report the NDC units as "UN1." If the drug was purchased under the 340B Drug Pricing Program, place a "UD" modifier in the modifier field for that drug detail.

  Note: When billing for compounds or mixtures, list 340B drugs in a separate detail from the non-340B drugs in the same compound/mixture.

  Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III*, on DMA's website (http://www.ncdhhs.gov/dma/bulletin/) for additional instructions.
- Medicaid covers only rebatable NDCs.
- Providers must bill their usual and customary charge.

The fee schedule for the Physician's Drug Program is available on DMA's website at http://www.ncdhhs.gov/dma/fee/.

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

Attention: Nurse Practitioners and Physicians

Temozolomide Single-use Vials for Injection (Temodar, HCPCS Procedure Code J9999): Billing Guidelines

Effective with date of service April 1, 2009, the N.C. Medicaid program covers temozolomide injectable (Temodar) for use in the Physician's Drug Program when billed with HCPCS procedure code J9999 (not otherwise classified, antineoplastic drugs). Temodar is available as single-use vials that contain 100 mg of temozolomide lyophilized powder for reconstitution.

Temodar is an alkylating antineoplastic agent indicated for the initial treatment of newly diagnosed glioblastoma multioforme (GBM), in combination with radiotherapy, and then as maintenance treatment. It is also indicated for the treatment of refractory anaplastic astrocytoma.

For the treatment of newly diagnosed GBM, a 75-mg/ml injection of Temodar is administered for 42 days concomitantly with focal radiotherapy. This is followed by initial maintenance injections of 150 mg/ml once daily for days 1 through 5 of a 28-day cycle for 6 cycles. For the treatment of refractory anaplastic astrocytoma, an initial 150-mg/ml dose is administered as an injection once daily for 5 consecutive days per 28-day treatment cycle.

As bioequivalence to the oral dosage form of Temodar has been established only when given over a period of 90 minutes, infusion over a shorter or longer period of time may result in suboptimal dosing.

For Medicaid Billing

- The ICD-9-CM diagnosis code required for billing Temodar is V58.11 (admission or encounter for chemotherapy). This diagnosis is **required** in addition to the cancer diagnosis.
- Providers must bill Temodar with HCPCS procedure code J9999 (not otherwise classified, antineoplastic drugs).
- One Medicaid unit of coverage is 100 mg. The maximum reimbursement rate, per 100 mg, is $530.58. An entire single-use vial may be billed.
- Providers must indicate the number of HCPCS units billed.
- Providers must bill 11-digit National Drug Codes (NDCs) with appropriate NDC units. When calculating the NDC units, the drug in its original state must be considered, **not** the reconstituted amount. If billing for an entire single-use vial, report the NDC units as "UN1." If the drug was purchased under the 340B Drug Pricing Program, place a "UD" modifier in the modifier field for that drug detail.

  Note: When billing for compounds or mixtures, list 340B drugs in a separate detail from the non-340B drugs in the same compound/mixture.

  Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III*, on DMA's website (http://www.ncdhhs.gov/dma/bulletin/) for additional instructions.
- Medicaid covers only rebatable NDCs.
- Providers must bill their usual and customary charge.

The fee schedule for the Physician's Drug Program is available on DMA's website at http://www.ncdhhs.gov/dma/fee/.

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

Attention: Private Duty Nursing Providers

Provision of Medical Supplies for Recipients Without Private Duty Nursing Coverage

Effective with date of service September 1, 2009, private duty nursing (PDN) providers may provide certain medical supplies (see tables below) for any eligible Medicaid recipient without providing PDN services. This provision is limited to incontinent, ostomy, and urological (IOU) medical supplies. The item supplied must be medically necessary and ordered by the physician. The following criteria must be met.

- The item must be specifically ordered for the individual recipient by the physician and it must be included in the plan of care (POC). The physician's signature must be obtained annually.
- An initial home visit to assess the need for the supply must be made by a registered nurse (RN) who is employed by or under contract to the PDN agency. An RN assessment visit is required annually thereafter. The initial and annual need assessment visits must be made by an RN.
- An interim continued need visit is required every 90 days for the continued provision of the supplies. The purpose of the visit is to document usage and any changes in the recipient's condition that warrant an adjustment to the quantity or type of supply needed. The outcome of both the initial and interim assessment visits must be documented in the recipient's record. The interim continued need visit can be delegated to a licensed practical nurse in accordance with guidelines on supervision and delegation set forth by the Nurse Practice Act and the N.C. Board of Nursing (NCBON). The annual and interim assessment visits should be billed with CPT procedure code 99600 and billed in 15-minute increments (1 unit equals 15 minutes), with a limit of 4 units per visit.
- Quantity limits have been established for each IOU supply as listed below. The limits are the monthly maximum allowable for these supplies. The actual quantity supplied must be based on the recipient's medical needs and in accordance with the physician's order and POC. The initial and continued need nurse assessment documentation should support the medical need for the quantity and use. A referral should be made to a home health agency for medical needs that exceed the quantity limits. Items billed in excess of the monthly limit will not be reimbursed by the N.C. Medicaid Program.
- If a home health agency is providing services to the recipient, the medical supplies must also be provided by that agency. Medical supplies will not be reimbursed to the PDN provider for the same period of time that services are being provided by a home health agency.
- CPT procedure code 99600 should be used to bill a nurse assessment for non-PDN-approved recipients only. The nurse assessment of supplies for approved PDN recipients is covered as a part of the prior approved nursing service units and should continue to be billed under HCPCS code T1000.

The monthly quantity limit provision also includes IOU supplies provided to DMA-approved PDN recipients. There is no change in the guidelines for provision of other types of medical supplies to these recipients. PDN agencies should continue to use the information from Home Health Fee Schedule to bill all other medical supplies for DMA-approved PDN recipients.

Incontinent Supplies				
Procedure Code	**Description**	**Billing Unit**	**Maximum Allowable**	**Maximum Monthly Limit**
A4554	Disposable underpads, all sizes (e.g. Chux's)	each	$0.56	200
T4521	Adult sized disposable incontinence product, brief/diaper, small	each	$0.97	192

Incontinent Supplies				
Procedure Code	**Description**	**Billing Unit**	**Maximum Allowable**	**Maximum Monthly Limit**
T4522	Adult sized disposable incontinence product, brief/diaper, medium	each	$0.97	192
T4523	Adult sized disposable incontinence product, brief/diaper, large	each	$0.97	192
T4524	Adult sized disposable incontinence product, brief/diaper, extra large	each	$0.97	192
T4529	Pediatric sized disposable incontinence product, brief/diaper	each	$0.97	192
T4530	Pediatric sized disposable incontinence product, brief/diaper, large size	each	$0.97	192
T4533	Yw/oh-sized disposable incontinence product, brief/diaper	each	$0.97	192

Ostomy Supplies				
Procedure Code	**Description**	**Billing Unit**	**Maximum Allowable**	**Maximum Monthly Limit**
A4362	Skin Barrier; Solid, 4 X 4 or eq	each	$ 3.46	15
A4364	Adhesive (for ostomy or catheter),	1 ounce	$ 5.97	10 oz
A4365	Adhesive remover wipes, any type	1 box	$ 11.32	1 BOX
A4367	Ostomy belt, each	each	$ 6.25	2/mo
A4369	Ostomy skin barrier, liquid (spray, brush, etc.)	1 ounce	$ 3.96	6 oz
A4371	Ostomy skin barrier, powder	1 ounce	$ 6.93	2 oz
A4372	Ostomy skin barrier, solid 4X4 or eq, bui	each	$ 4.18	20
A4373	Ostomy skin barrier, flange, built-in convexity, any size	each	$ 6.28	20
A4375	Ostomy pouch, drainable, faceplate attached, plastic	each	$ 17.18	15
A4377	Ostomy pouch, drainable, for faceplate, plastic	each	$ 4.29	30
A4379	Ostomy pouch, urinary, faceplate attached, plastic	each	$ 15.02	15
A4381	Ostomy pouch, urinary, for faceplate, plastic	each	$ 4.61	30
A4385	Ostomy skin barrier, solid 4X4 or eq, ext	each	$ 5.10	20
A4388	Ostomy pouch, drainable, ex wear barrier attached, (1 Piece)	each	$ 4.36	60
A4390	Ostomy pouch, drainable, ex wear barrier attached, built in convexity (1 piece)	each	$ 9.61	60
A4394	Ostomy Deodorant, or, w/o lubricant,	fl. Oz.	$ 2.58	16 oz
A4397	Irrigation supply; sleeve	each	$ 4.07	6
A4398	Ostomy irrigation supply; bag	each	$ 13.81	1/6 mo
A4399	Ostomy irrigation supply; cone/catheter, c brush	each	$ 12.15	3

Ostomy Supplies				
Procedure Code	**Description**	**Billing Unit**	**Maximum Allowable**	**Maximum Monthly Limit**
A4400	Ostomy irrigation set	each	$ 41.54	2
A4404	Ostomy rings	each	$ 1.44	2
A4405	Ostomy skin barrier, non pectin based, paste	1 ounce	$ 4.25	6 oz
A4406	Ostomy skin barrier, pectin-based, paste	1 ounce	$ 6.30	6 oz
A4407	Ostomy skin barrier, flange , ex wear, built-in convexity, 4X4 in. or smaller	each	$ 8.82	20
A4408	Ostomy skin barrier, with flange (solid, flexible or accordion), ex wear, built-in convexity, larger than 4 x 4 inches	each	$ 9.87	20
A4409	Ostomy skin barrier, flange (solid, flexible or accordion), ex wear, w/o built-in convexity, 4 x 4 inches or smaller	each	$ 6.22	20
A4410	Ostomy skin barrier, flange , ex wear, w/o built-in convexity, larger than 4X4 in.	each	$ 9.04	20
A4411	Ostomy skin barrier, solid 4x4 or eq, ex wear, built-in convexity	each	$ 5.10	20
A4414	Ostomy skin barrier, flange (solid, flexible or accordion), w/o built-in convexity, 4 x 4 inches or smaller	each	$ 4.93	20
A4415	ostomy skin barrier, flange (solid, flexible or accordion), w/o built-in convexity, larger than 4x4 inches, each	each	$ 6.00	20
A4416	Ostomy pouch, closed, barrier attached, filter,	each	$ 2.75	30
A4417	Ostomy pouch, closed, barrier attached, built-in convexity, filter,	each	$ 3.72	20
A4418	Ostomy pouch, closed; w/o barrier, filter	each	$ 1.81	60
A4419	Ostomy pouch, closed; for barrier	each	$ 1.74	20
A4423	Ostomy pouch, closed; for barrier, locking flange,	each	$ 1.86	20
A4424	Ostomy pouch, drainable, barrier attached, filter	each	$ 4.75	20
A4425	Ostomy pouch, drainable; for barrier, non-locking flange, filter	each	$ 3.58	20
A4426	Ostomy pouch, drainable; for barrier, locking flange	each	$ 2.73	20
A4427	Ostomy pouch, drainable; for barrier, locking flange, filter,	each	$ 2.78	20
A4428	Ostomy pouch, urinary, ex wear barrier attached, faucet-type tap, valve,	each	$ 6.51	20
A4429	Ostomy pouch, urinary, barrier attached, built-in convexity, faucet-type tap, valve,	each	$ 8.25	20
A4430	Ostomy pouch, urinary, ex wear barrier attached, built-in convexity, faucet-type tap, valve (1 piece)	each	$ 8.52	15

Ostomy Supplies				
Procedure Code	**Description**	**Billing Unit**	**Maximum Allowable**	**Maximum Monthly Limit**
A4431	Ostomy pouch, urinary; barrier attached, faucet-type tap, valve,	each	$ 6.22	20
A4432	Ostomy pouch, urinary; for barrier, non-locking flange, faucet-type tap, valve (2 piece)	each	$ 3.59	15
A4433	Ostomy pouch, urinary; for barrier, locking flange (two piece)	each	$ 3.34	20
A4455	Adhesive remover or solvent (for tape, cement or other adhesive)	1 ounce	$ 3.84	4 oz
A4558	Conductive paste or gel	1 jar	$ 5.45	1
A5051	Ostomy pouch, closed; barrier attached,	each	$ 2.75	31
A5052	Ostomy pouch, closed; w/o barrier attached,	each	$ 1.70	31
A5054	Ostomy pouch, closed; for barrier, flange (two piece)	each	$ 1.72	90
A5055	Stoma cap	each	$ 1.26	30
A5061	Ostomy pouch, drainable;, barrier attached,	each	$ 4.22	65
A5062	Ostomy pouch, drainable; w/o barrier attached,	each	$ 2.50	31
A5063	Ostomy pouch, drainable; for barrier, flange,	each	$ 3.07	31
A5071	Ostomy pouch, urinary; barrier attached,	each	$ 4.79	31
A5072	Ostomy pouch, urinary; w/o barrier attached,	each	$ 3.47	31
A5073	Ostomy pouch, urinary; for barrier, flange (two piece)	each	$ 3.18	31
A5120	Skin barrier, wipes or swabs, each	each	$ 0.24	25
A5121	Skin barrier; solid, 6 X 6 or eq (wafer)	each	$ 8.97	15
A5122	Skin barrier; solid, 8 X 8 or eq (wafer)	each	$ 12.54	15
A5126	Adhesive or non-adhesive; disk or foam pad	each	$ 1.12	36

Urological Supplies				
Procedure Code	**Description**	**Billing Unit**	**Maximum Allowable**	**Maximum Monthly Limit**
A4310	Insertion tray, w/o drainage bag and, w/o catheter (accessories only)	each	$ 6.56	2
A4311	Insertion tray, w/o drainage bag, indwelling catheter, Foley type, two-way latex, coating (Teflon, silicone, silicone elastomer or hydrophilic, etc)	each	$ 14.84	2
A4313	Insertion tray, w/o drainage bag, indwelling catheter, Foley type, three-way, for continuous irrigation	each	$ 18.52	2
A4314	Insertion tray, drainage bag, indwelling catheter, Foley type, two-way latex, coating (Teflon, silicone, silicone elastomer or hydrophilic, etc.)	each	$ 25.29	2
A4316	Insertion tray, drainage bag, indwelling catheter, Foley type, three-way, for continuous irrigation	each	$ 28.40	2

Urological Supplies				
Procedure Code	**Description**	**Billing Unit**	**Maximum Allowable**	**Maximum Monthly Limit**
A4320	Irrigation tray, bulb or piston syringe, any purpose	each	$ 4.53	3
A4321	Therapeutic agent for urinary catheter irrigation (acetic acid - 250 to 1,000 cc)	$4.53	$ 2.93	2
A4322	Irrigation syringe, bulb or piston	each	$ 10.25	2
A4328	Female external urinary collection device; pouch	each	$ 3.18	2
A4334	Urinary catheter anchoring device, leg strap	each	$ 4.93	2
A4335	Incontinence supply; miscellaneous (catheter care kit)	each	$ 4.40	2
A4338	Indwelling catheter; Foley type, two-way latex, coating	each	$ 10.87	2
A4340	Indwelling catheter; specialty type, (e.g., Coude, mushroom, wing, etc.)	each	$ 26.99	2
A4344	Indwelling catheter, Foley type, two-way, all silicone	each	$ 14.35	2
A4349	Male external catheter, or, w/o adhesive, disposable	each	$ 2.02	36
A4351	Intermittent urinary catheter; straight tip, or, w/o coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.)	each	$ 1.54	93
A4352	Intermittent urinary catheter; coude (curved) tip, or, w/o coating	each	$ 5.94	93
A4353	Intermittent urinary catheter, insertion supplies	each	$ 7.00	10
A4354	Insertion tray, drainage bag but, w/o catheter	each	$ 11.80	2
A4357	Bedside drainage bag, day or night, or, w/o anti-reflux device, or, w/o tube	each	$ 9.70	2
A4358	Urinary leg bag; vinyl, or, w/o tube	each	$ 6.63	4

Miscellaneous Supplies				
Procedure Code	**Description**	**Billing Unit**	**Maximum Allowable**	**Maximum Monthly Limit**
A4450	Tape, non-waterproof, per 18 sq. in.	18 sq in	$ 0.09	80u
A4452	Tape, waterproof, per 18 sq. in.	18 sq in	$ 0.36	80u
A4927	Non-sterile exam gloves	100/box	$ 11.38	1 BOX
A4217	Sterile saline or water, 500ml	500 ml	$ 2.66	2
A4244	Alcohol or Peroxide, per pint	1 pint	$ 1.02	3
A4246	Betadine or PhisoHex solution, per pint	1 pint	$ 5.94	3
A4321	Therapeutic agent for urinary catheter irrigation (acetic acid - 250 to 1,000 cc)	1 bottle	$ 7.50	2
A6216	Gauze, non-impregnated, non-sterile, pad size 16 sq. in. or less, without adhesive border	each	$ 0.05	200

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

Attention: Federally Qualified Health Centers, Health Departments, Nurse Midwives, Nurse Practitioners, Physicians (Except for Physicians Enrolled with a Specialty of Oncology, Radiology or Nuclear Medicine), and Rural Health Clinics

Requesting an Exception to the Legislative Visit Limit

Providers of mandatory Medicaid services may request an exception to the legislative visit limit. (Information about the limit can be found on DMA's website at http://www.ncdhhs.gov/dma/provider/AnnualVisitLimit.htm and in the August 2008 North Carolina Medicaid Bulletin.) This request can be made when a provider is actively managing a life-threatening disorder for a recipient and knows that the care of this condition will require an extended number of office visits.

To submit a request, the provider should complete the General Request for Prior Approval Form (372-118) (http://www.ncdhhs.gov/dma/provider/forms.htm) and submit it with records documenting the reason for the request **before the service is rendered.** Please complete boxes 2 through 7, 12, and 14 through 16. For the Type of Request, check the box by 05 and write in "**visit limit.**" This request should be sent to the EDS address listed at the top of the form.

The EDS Medical Director will review the request within five business days of receipt. If the request is approved, the form will be returned to the provider indicating what was approved. If the request is denied, the form will be returned along with a copy of the letter that will be sent to the recipient about the denial. The recipient will be provided with information on how to appeal the denial.

At this time, the EDS system cannot automatically process claims for exceptions to the visit limit. Please submit the claims electronically with the approved diagnosis code(s). If denied due to the visit limit, complete a Medicaid Claim Adjustment Form for the claim and attach a copy of the approval form to the adjustment form. These adjustments will override the denial and allow the claim to process.

Should a post-denial review be necessary for services not submitted for prior approval, claim documentation should be sent through the adjustment process.

DMA will inform providers when the system is ready for automatic processing of electronic claims for approved exceptions. Please contact EDS with any questions concerning this procedure.

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

Attention: Pharmacists and Prescribers

New Prior Authorization Requirements for Brand-name ACE Inhibitors, Angiotensin Receptor Blockers, and Renin Inhibitors

Effective with date of service August 10, 2009, the N.C. Outpatient Pharmacy Program began requiring prior authorization (PA) for brand name ACE inhibitors, angiotensin receptor blockers, and renin inhibitors. Prescribers can request PA by contacting ACS at 866-246-8505 (telephone) or 866-246-8507 (fax). The criteria and PA request form for these medications are available on the N.C. Medicaid Enhanced Pharmacy Program website at http://www.ncmedicaidpbm.com. Generic ACE inhibitors do not require prior authorization.

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

Attention: Pharmacists and Prescribers

Changes to Prior Authorization Requirements for Antinarcolepsy/Antihyperkinesis Agents

Effective with date of service August 10, 2009, the N.C. Outpatient Pharmacy Program added prior authorization (PA) requirements for Nuvigil (armodafinil). Prescribers can request PA by contacting ACS at 866-246-8505 (telephone) or 866-246-8507 (fax). The criteria and PA request form for these medications are available on the N.C. Medicaid Enhanced Pharmacy Program website at http://www.ncmedicaidpbm.com.

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

Attention: Pharmacists and Prescribers

Changes to Prior Authorization Requirements for Proton Pump Inhibitors

Effective with date of service August 10, 2009, the N.C. Outpatient Pharmacy Program amended the prior authorization (PA) requirements for proton pump inhibitors to allow patients receiving Plavix (clopidogrel) concomitantly with pantoprazole to be exempt from PA criteria on pantoprazole. The criteria are available on the N.C. Medicaid Enhanced Pharmacy Program website at http://www.ncmedicaidpbm.com.

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

Attention: Adult Care Home (Family Care Home) Providers

Cost Report for Personal Care Services in Adult Care Homes/Family Care Homes for 2009

Each year, DMA requests cost data from adult care home personal care service (ACH-PCS) providers in accordance with the Medicaid Participation Agreement. In contrast to previous years, the ACH-PCS cost reports **will not** be mailed to facilities and providers. The cost report package is available online at http://www.ncdhhs.gov/dma/cost/familycarehomesreports.htm. Instructions on how to complete the cost report, the deadline for submitting the report, and where to send the report are included in the package.

Rate Setting
DMA, 919-855-4200

Attention: HIV Case Management Providers

Limits for Medicaid HIV Case Management Services

In accordance with Session Law 2009-451, Section 10.68A.(a) (2)(b), on October 1, 2009, the N.C. Medicaid Program will implement limits on the number of units that may be reimbursed each calendar month per recipient. The number of billable units of HIV Case Management services provided to a recipient shall not exceed 16 units per calendar month.

This limit may not apply to recipients under the age of 21 years as long as all criteria for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Medicaid for Children, are met. For further information about EPSDT, visit DMA's website at http://www.ncdhhs.gov/dma/epsdt/.

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

Attention: Children's Developmental Service Agencies, Health Departments, Home Health Agencies, Hospital Outpatient Clinics, Independent Practitioners, Local Management Entities, and Physicians

Outpatient Specialized Therapies

Clinical Coverage Policy #10A, *Outpatient Specialized Therapies*, which was finalized earlier this year, will be posted to DMA's website (http://www.ncdhhs.gov/dma/mp/) on November 1, 2009. At that time, a revised prior approval process will be put into place for all therapy treatment visits. Instructions on how to obtain prior approval will be announced in the October Medicaid Bulletin.

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

Attention: Dental Providers and Health Department Dental Centers

Dental Program Changes Included in the 2009 Budget Bill (SL 2009-451)

Effective with date of service October 1, 2009, the following changes will be implemented for the N.C. Medicaid Dental Program. These changes are outlined in the Conference Committee Money Report attached to the budget bill, which refers to dental policy adjustments resulting in program cost savings of approximately $3.7 million in State appropriations. Acting upon the direction of DHHS/DMA leadership, the Dental Program staff worked with a fiscal workgroup composed of dentists from the enrolled provider community and our colleagues at the Department of Public Health's Oral Health Section to identify policy changes that would save money and at the same time make sense from a clinical perspective. These proposed changes to Clinical Coverage Policy 4A, *Dental Services*, can be reviewed on DMA's Proposed Medicaid Clinical Coverage Policies web page at http://www.ncdhhs.gov/dma/mpproposed/.

- Limit panoramic films (D0330) to recipients ages 6 and older.
- Discontinue coverage of **premolar** sealants (D1351) for all recipients.
- Reduce age limits for sealants (D1351) on all permanent molars from under age 21 to under age 16.
- Reduce age limits for sealants (D1351) on primary molars from under age 10 to under age 8.

Other dental policy adjustments may be forthcoming depending on the need for further cost-saving measures.

In addition to the changes listed above, the Medicaid reimbursement for all covered procedure codes will be reduced by approximately 3% for SFY 2010. The effective date of this change has not been determined; however, when the effective date is determined, the complete Dental Fee Schedule, located on the DMA website at http://www.ncdhhs.gov/dma/fee/, will be updated. Providers are reminded to bill their usual and customary charges rather than the Medicaid rate.

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

Dental Program
DMA, 919-855-4280

Attention: Dental Providers

Dental Seminars

Dental seminars are scheduled for the month of October 2009. Information presented at these seminars will include a review of clinical coverage guidelines, prior approval, and billing procedures for dental services. The seminars are scheduled at the locations listed below. Clinical Coverage Policy #4A, *Dental Services*, (October 1, 2009 revision) will be used as the primary training document for the seminar. The revised policy will be available after October 1, 2009. Please review and print the Policy (on DMA's website at http://www.ncdhhs.gov/dma/mp/) once it is available, and bring it to the seminar.

Pre-registration is required. Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

Providers may register for the dental seminars online at http://www.ncdhhs.gov/dma/provider/seminars.htm. Sessions will begin at 10:00 a.m. and end at 1:00 p.m. Providers are encouraged to arrive by 9:45 a.m. to complete registration. Lunch will not be provided at the seminars. **Because meeting room temperatures vary, dressing in layers is strongly advised.**

Date	Location
Wednesday, October 14, 2009	Wilmington Hampton Inn – Medical Park 2320 S. 17th Street Wilmington NC 28401
Monday, October 19, 2009	Raleigh Hilton North Raleigh 3415 Wake Forest Road Raleigh NC 27609-7330
Wednesday, October 21, 2009	Williamston Martin Community College 1161 Kehukee Park Road Williamston NC 27892-4425
Wednesday, October 28, 2009	Salisbury Holiday Inn Salisbury 530 Jake Alexander Boulevard, South Salisbury NC 28147
Thursday, October 29, 2009	Asheville Mountain Area Health Education Center 501 Biltmore Avenue Asheville NC 28801

Directions to the Dental Seminars

ASHEVILLE
Mountain Area Health and Education Center
Traveling East on I-40: Take I-40 East to Exit 50. Turn onto Hendersonville Road. Stay in the right-hand lane through five traffic lights. At the 6th traffic light, turn left onto the Mission Hospitals emergency entrance. Take the first right and then another immediate right into the parking deck.

Traveling West on I-40: Take I-40 West to Exit 50B onto Hendersonville Road. Stay in the right-hand lane through five traffic lights. At the 6th traffic light, turn left into the Mission Hospitals emergency entrance. Take the first right and then another immediate right into the parking deck.

Traveling East on I-26: Take I-26 to I-240 East to Exit 5B for Charlotte Street. Exit right onto Charlotte Street. At the 4th traffic light, turn left onto Biltmore Avenue. Proceed through three traffic lights. At the 4th light, turn right into the Mission Hospitals emergency entrance. Take the first right and then another immediate right into the parking deck.

RALEIGH
Hilton North Raleigh
Traveling East on I-40: Take I-40 to I-440 East (inner beltline). Follow I-440 North to Exit 10 for Wake Forest Road. At the bottom of exit ramp turn left. The hotel is located on the left approximately 0.5 mile from the exit ramp.

Traveling West on I-40: Take I-40 to I-440 West (outer beltline). Follow I-440 South to Exit 10 for Wake Forest Road. At the bottom of exit ramp turn right. The hotel is located on the left approximately 0.5 mile from the exit ramp.

SALISBURY
Holiday Inn Salisbury
Traveling South on I-85: Take I-85 to Exit 75. At the end of the exit ramp, turn right onto Jake Alexander Boulevard. Travel approximately 0.5 mile. The Holiday Inn is located on the right.

Traveling North on I-85: Take I-85 to Exit 75. At the end of the exit ramp, turn left onto Jake Alexander Boulevard. Travel approximately 0.5 mile. The Holiday Inn is located on the right.

WILLIAMSTON
Martin Community College
Building 2 Auditorium
Traveling East on US 64: Take US 64 West to the intersection at McDonald's in Williamston. Turn left on the US 13/US 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 0.5 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 0.5 mile and turn left on Kehukee Park Road. The college is located on the right approximately 0.5 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 2.5 miles. Turn left on Kehukee Park Road. The college is located on the right approximately 0.5 mile from the intersection.

WILMINGTON
Hampton Inn – Medical Park
Traveling East on I-40: Take I-40 East into Wilmington. I-40 becomes Highway 132/College Road. Follow S. College Road to Shipyard Boulevard. Bear right onto Shipyard Boulevard. Turn right onto 17th Street. The hotel is located on the left approximately 0.5 mile from the intersection.

Traveling South on US 17/US 74/76: Follow US 17 South into Wilmington. US 17/US 74/76 becomes Dawson Street. Turn right onto 16th Street at the 4th stoplight. (16th Street merges with S. 17th Street.) Travel approximately 2.5 miles. The hotel is located on the right, two blocks past the New Hanover Regional Medical Park.

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

Dental Workshops
October 2009 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

Early and Periodic Screening, Diagnosis 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, Diagnosis 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/basicmed/
- *Health Check Billing Guide:* http://www.ncdhhs.gov/dma/healthcheck/
- EPSDT provider information: http://www.ncdhhs.gov/dma/epsdt/.

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/mpproposed/. 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.

2009 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
September	9/3/09	9/9/09
	9/10/09	9/15/09
	9/17/09	9/24/09
October	10/1/09	10/6/09
	10/8/09	10/14/09
	10/15/09	10/20/09
	10/22/09	10/29/09
	10/29/09	11/3/09

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.

Craigan L. Gray, MD, MBA, JD
Director
Division of Medical Assistance
Department of Health and Human Services

Melissa Robinson
Executive Director
EDS, an HP Company