North Carolina Medicaid Bulletin

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In This Issue . . .

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

Attention: All Providers

Billing Guidelines for ICD-9-CM Diagnosis Code 799.9

The following information is a clarification of the Mental Health and Substance Abuse Services Guidelines, Special Bulletin IV, December 2001:

For new clients, Medicaid covers six unmanaged visits without a diagnosis of mental illness. The first two visits can be coded with ICD-9-CM diagnosis code 799.9 and the following four visits should be coded with "V" diagnosis codes.

OR

The first visit should be coded with diagnosis 799.9 and the remaining five should be coded with "V" diagnosis codes.

A specific diagnosis code must be used as soon as a diagnosis is established.

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

Attention: All Providers

NCLeads Update

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

Thomas Liverman, Provider Relations
Office of MMIS Services
919-855-3112

Attention: All Providers

New Managed Care Consultant Regions

Effective October 1, 2004, the regions that the Division of Medical Assistance's Managed Care Consultants serve have been reorganized. Refer to the following table for a list of the consultants and the region they serve.

Region 1 **Lisa Catron** **(828)** **683-8812**	**Region 2** **LaRhonda Cain** **(919)** **647-8190**	**Region 3** **Lisa Gibson** **(919)** **319-0301**	**Region 4** **Julia McCollum** **(919)** **647-8179**	**Region 5** **Jerry Law** **(252)** **321-1806**	**Region 6** **Rosemary Long** **(910)** **738-7399**
Avery	Alexander	Davidson	Alamance	Beaufort	Bladen
Buncombe	Alleghany	Davie	Caswell	Bertie	Brunswick
Burke	Anson	Forsyth	Chatham	Camden	Carteret
Cherokee	Ashe	Guilford	Durham	Chowan	Columbus
Clay	Cabarrus	Hoke	Franklin	Currituck	Craven
Cleveland	Caldwell	Montgomery	Granville	Dare	Cumberland
Graham	Catawba	Moore	Harnett	Edgecombe	Duplin
Haywood	Gaston	Randolph	Johnston	Gates	Jones
Henderson	Iredell	Richmond	Lee	Greene	Lenoir
Jackson	Lincoln	Rockingham	Orange	Halifax	New Hanover
Macon	Mecklenburg	Scotland	Person	Hertford	Onslow
Madison	Rowan	Stokes	Vance	Hyde	Pamlico
McDowell	Stanly	Surry	Wake	Martin	Pender
Mitchell	Union	Wilkes	Warren	Nash	Robeson
Polk	Watauga	Yadkin	Wilson	Northampton	Sampson
Rutherford				Pasquotank	Wayne
Swain				Perquimans	
Transylvania				Pitt	
Yancey				Tyrrell	
				Washington	

Darryl Frazier, Managed Care
DMA, 919-647-8177

Attention: Adult Care Home Providers

Adult Care Home Personal Care Service Rate Increase

A rate increase to the Basic and Enhanced ACH/PC has been calculated and approved for reimbursement of Personal Care Services provided on or after October 1, 2004. The reimbursement rates effective on October 1, 2004 are:

- The transportation rate will remain at $0.60 per Medicaid resident per day.
- The Assessment Fees Miscellaneous (W8299) will remain at $0.15.

Procedure Code	Description		Old Rate	New Rate
W8251	Basic ACH/PC	Facility Beds 1 - 30	$16.74	**$17.33**
W8258	Basic ACH/PC	Facility Beds 31 and Above	$18.34	**$18.98**
W8255	Enhanced ACH/PC	Ambulation and Locomotion	$2.64	**$2.73**
W8256	Enhanced ACH/PC	Eating	$10.33	**$10.69**
W8257	Enhanced ACH/PC	Toileting	$3.69	**$3.82**
W8259	Enhanced ACH/PC	Eating and Toileting	$14.02	**$14.51**

Providers must bill their usual and customary charges. Adjustments will not be made to previously processed claims.

Bruce Habeck, Finance Operations
DMA, 919-857-4015

Attention: All Providers

Remittance and Status Reports Changes for Medicare Primary Claims

Effective with the October 5, 2004 checkwrite, Medicaid claims that process with Medicare as the primary payer will be reported under a new section of the Remittance and Status Report called Medicare Primary Claims. This Medicare primary section was formerly titled the crossover section. Claims that are filed directly to Medicaid from Medicare and those claims filed directly to Medicaid from the provider indicating Medicare's payment on the claim will be reported in this new section.

Remittance and Status Reports will also carry a new EST AMT DUE field. This field will populate with the dollar value entered in estimated amount due field (form locator 55) of the UB-92. This field will only be populated when the field is completed by the provider and the claim is processed as a Medicare Primary claim. The Original Billed Amount field will now show the Medicare Coinsurance and Deductible when a claim is processed as a Medicare primary claim.

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

NORTH CAROLINA MEDICAID
REMITTANCE AND STATUS REPORT

PROVIDER, JOE
123 ANY STREET
ANY CITY, NC 12345

PROVIDER NUMBER 7700000 REPORT SEQ. NUMBER DATE 09/30/2004 PAGE

NAME / RECIPIENT ID	SERVICE DATE FROM	SERVICE DATE TO	DAYS OR UNITS	PROCEDURE/ACCOMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES
Paid Claims										
Mcare Primary										
RECIPIENT JOE A **CO=92 RCC= CLAIM NUMBER= 252002004250001NCXIX**										**EST AMT DUE=**
900000000k pat acct=123456789							**MED REC= 123456**			**ATTN PROV= 7700000**
NCXIX	**09062004 09062004**		**1 B**	**E1390 OXYGEN CONCENTRATOR, CAPABL RR**	**50000**	**00**	**50000**	**40000**	**7500**	**0**
DEDUCTBLE= .00	*PAT LIAB= .00*		*CO PAY= .00*	*TPL= 0*	*50000*	*00*	*50000*	*40000*	*7500*	*0*
ORIGINAL BILLED AMOUNT= 100.00			*ORIGINAL DETAIL COUNT =*		*1*	*TOTAL FINANCIAL PAYERS=*			*1*	

Attention: Adult Care Home Providers

Medicaid ACH-PCS Cost Settlements – FYE-2005

Pending approval from the Centers for Medicare and Medicaid Services (CMS), effective with the Fiscal Year Ending in 2005, the Medicaid ACH-PCS Cost Settlement will no longer be required of private or public providers. The North Carolina Administrative Code (NCAC) 10A, Attachment 4.19-B, Section 23 (f), Page 6 has been amended as follows:

"Reimbursement is determined by the Division of Medical Assistance based on a capitation per diem fee derived from review of industry costs and determination of reasonable costs with annual inflation adjustments. The initial basic per diem fee is based on one hour of services per patient day. Additional payments may be made utilizing the basic one hour per diem fee as a factor, for Medicaid eligible that have a demonstrated need for additional care. The initial basic one hour fee is computed by determining the estimated salary, fringes, direct supervision and allowable overhead. Effective January 1, 2000 the cost of medication administration and personal care services direct supervision shall be added to the basic per diem. The per diem rates may be recalculated from a cost reporting period selected by the state. Notwithstanding any other provision, if specified these rates will be adjusted as shown on supplement 1 to the 4.19-B section of the state plan. Payments may not exceed the limits set in 42 CFR 447.362. Effective with the Cost Report fiscal year ending June 30, 2005 or September 30, 2005, payments to private providers of Medicaid ACH-PCS will no longer be cost settled."

Note: Providers will be notified should CMS not approve our State Plan Amendment to move cost settlement to prospective payment.

and:

"Public providers will be paid on an interim basis using the same reimbursement methods applicable to private providers. Effective with the Cost Report fiscal year ending June 30, 2005 or September 30, 2005, payments to public providers of Medicaid ACH-PCS will no longer be cost settled."

Bruce Habeck, Finance Operations
DMA 919-857-4015

Attention: Medicaid ACH – PCS Cost Settlements

FYE-2004 Medicaid Cost Report - Family Care Homes

The "Medicaid Cost Report – Family Care Homes" and the instructions for the reporting period of October 1, 2003 through September 30, 2004 are available on the Division of Medical Assistance's website. The "Medicaid ACH-PCS Cost Settlement" reports for Adult Care Homes with 6 or less beds and for Adult Care Homes with 7 beds or more for the Fiscal Year Ending 2004 are also available.
The web address is: http://www.dhhs.state.nc.us/dma/prov.htm. The reports are in the section titled Cost Reports.

To receive the FYE-2004 reports by mail, please contact Bruce Habeck at (919) 857-4015.

Bruce Habeck, Finance Operations
DMA 919 857-4015

Attention: CMS-1500 Billers

Changes to NCECS-Web to Accommodate Medicare Payment Information

Beginning September 6, 2004, changes went into effect regarding Medicare Crossover claims. These changes are detailed in the August 2004, Special Bulletin V, Medicare Part B Billing. As a result of this implementation, changes have been made to NCECS-Web to allow users to submit Medicare primary claims to Medicaid for processing. An Insured Information Section has been added to the CMS-1500 Add/Edit Screen where service detail information is entered. The fields in the Insured Information Section include:

- **Insurer Detail Allowed Amount**
- **Insurer Detail Paid Amount**
- **Insurer Detail Deductible**
- **Insurer Detail Coinsurance**
- **Insurer Detail Paid Date**

Users should only complete the fields in the Insured Information Section when Medicare has made a payment. Do not complete the Insured Information Section when Medicare has denied. Do not complete the Insured Information Section for commercial insurance.

For assistance and questions, please contact EDS Provider Services at 1-800-688-6696 or 919-851-8888, option 3.

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

Attention: Dental Providers (Including Health Department Dental Clinics)

2002 American Dental Association (ADA) Claim Form

The Division of Medical Assistance (DMA) and EDS have updated the Medicaid claims processing system to accept the 2002 ADA claim form. The implementation date for the new form is October 1, 2004. Providers will be given a three-month transition period, October 1, 2004 through December 31, 2004, to begin using the 2002 claim form. During this transition period, both the 1999 and 2002 forms will be accepted. Effective January 1, 2005, only the 2002 ADA claim form will be accepted. Claim forms can be ordered directly from the ADA. Listed below are the web address, toll-free telephone number, and mailing address:

http://www.ada.org/ada/prod/catalog

1-800-947-4746

American Dental Association
Attn: Salable Materials Office
211 E. Chicago Avenue
Chicago, IL 60611

The claim form is available as a single or two-part form. The single form must be used when submitting claims for payment. The two-part form must be used when requesting prior approval. The original is returned to the provider and serves as the prior approval/claim copy. The second page is retained by EDS.

For specific information regarding required fields for prior approval requests or claims for payment, refer to Clinical Policy #4A, Dental Services, which has been updated to include the 2002 ADA claim form. The updated policy is available on the Division of Medical Assistance's website at http://www.dhhs.state.nc.us/dma/dental.htm.

Dr. Ron Venezie, Dental Director
DMA, 919-857-4033

Attention: Durable Medical Equipment Providers

HCPCS Code Conversions for Wheelchair Seat Frames and Cushions

In order to comply with Centers for Medicare and Medicaid Services' HCPCS coding changes, the following code conversions are effective with date of service October 1, 2004.

Old Code	New Code	Description	Quantity Limitation or Lifetime Expectancy	Maximum Reimbursement Rate
E0192	K0652*	Skin protection wheelchair seat cushion, width less than 22 inches, any depth	3 years	New Purchase: $386.44 Used Purchase: $289.93
	K0653*	Skin protection wheelchair seat cushion, width 22 inches or greater, any depth	3 years	New Purchase: $386.44 Used Purchase: $289.93
	K0654*	Positioning wheelchair seat cushion, width less than 22 inches, any depth	3 years	New Purchase: $185.00 Used Purchase: $138.75
	K0655*	Positioning wheelchair seat cushion, width 22 inches or greater, any depth	3 years	New Purchase: $386.44 Used Purchase: $289.93
	K0656*	Skin protection and positioning wheelchair cushion, width less than 22 inches, any depth	3 years	New Purchase: $386.44 Used Purchase: $289.93
	K0657*	Skin protection and positioning wheelchair cushion, width 22 inches or greater, any depth	3 years	New Purchase: $386.44 Used Purchase: $289.93
E0964	K0650	General use wheelchair seat cushion, width less than 22 inches, any depth	3 years	New Purchase: $75.32 Used Purchase: $56.51
K0023 K0024	K0660*	General use wheelchair back cushion, width less than 22 inches, any height, including any type mounting hardware	3 years	Rental: $10.38 New Purchase: $103.80 Used Purchase: $77.85
	K0661*	General use wheelchair back cushion, width 22 inches or greater, any height, including any type mounting hardware	3 years	Rental: $10.38 New Purchase: $103.80 Used Purchase: $77.85

HCPCS Code Conversions, continued

Old Code	New Code	Description	Quantity Limitation or Lifetime Expectancy	Maximum Reimbursement Rate
W4148	K0662*	Positioning wheelchair back cushion, posterior, width less than 22 inches, any height, including any type mounting hardware	3 years	Rental: $63.14 New Purchase: $631.35 Used Purchase: $473.51
	K0663*	Positioning wheelchair back cushion, posterior, width 22 inches or greater, any height, including any type mounting hardware	3 years	Rental: $63.14 New Purchase: $631.35 Used Purchase: $473.51
	K0664*	Positioning wheelchair back cushion, posterior-lateral, width less than 22 inches, any height, including any type mounting hardware	3 years	Rental: $63.14 New Purchase: $631.35 Used Purchase: $473.51
	K0665*	Positioning wheelchair back cushion, posterior-lateral, width 22 inches or greater, any height, including any type mounting hardware	3 years	Rental: $63.14 New Purchase: $631.35 Used Purchase: $473.51
W4698 W4699 W4700	E2201*	Manual wheelchair accessory, non-standard seat frame, width greater than or equal to 20 inches and less than 24 inches	3 years	Rental: $28.61 New Purchase: $286.10 Used Purchase: $214.58
	E2202*	Manual wheelchair accessory, non-standard seat frame width 24-27 inches	3 years	Rental: $89.67 New Purchase: $896.72 Used Purchase: $672.54
W4701 W4702	E2203*	Manual wheelchair accessory, non-standard seat frame depth, 20 to less than 22 inches	3 years	Rental: $60.66 New Purchase: $606.57 Used Purchase: $454.93

HCPCS Code Conversions, continued

Old Code	New Code	Description	Quantity Limitation or Lifetime Expectancy	Maximum Reimbursement Rate
W4703	E2204*	Manual wheelchair accessory, non-standard seat frame depth 22-25 inches	3 years	Rental: $59.47 New Purchase: $594.78 Used Purchase: $446.08
W4707 W4708	E2340*	Power wheelchair accessory, non-standard seat frame width, 20-23 inches	4 years	Rental: $77.84 New Purchase: $778.44 Used Purchase: $583.83
W4708 W4709	E2341*	Power wheelchair accessory, non-standard seat frame width, 24-27 inches	4 years	Rental: $108.68 New Purchase: $1086.78 Used Purchase: $815.08
W4710 W4711	E2342*	Power wheelchair accessory, non-standard seat frame depth, 20 or 21 inches	4 years	Rental: $88.96 New Purchase: $889.64 Used Purchase: $667.23
W4711 W4712	E2343*	Power wheelchair accessory, non-standard seat frame depth, 22-25 inches	4 years	Rental: $93.92 New Purchase: $939.18 Used Purchase: $703.88
W4720	K0651*	General use wheelchair cushion, width 22 inches or greater, any depth	3 years	New Purchase: $141.53 Used Purchase: $106.15

Note: HCPCS codes with an asterisk (*) require prior approval.

The coverage criteria for these items have not changed. Refer to Clinical Coverage Policy #5, Durable Medical Equipment, on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex for detailed coverage information. A Certificate of Medical Necessity and Prior Approval form must be completed for all items regardless of the requirement for prior approval.

Providers are reminded that these are maximum reimbursement rates. You must bill your usual and customary rate for all DME. Refer to Medical Coverage Policy #5, Durable Medical Equipment, Section 8.0 Billing, on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex for detailed billing guidelines. The rates provided are temporary until Medicare's established rates are published.

In addition to the code conversions, the descriptions of the following codes were changed effective with date of service October 1, 2004:

Code	Description
K0108/W4117	Wheelchair seat width greater than 27 inches
K0108/W4118	Wheelchair seat depth greater than 25 inches

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

Attention: Durable Medical Equipment Providers

HCPCS Code Conversion from B4084 to B4086

In order to comply with the Centers for Medicare and Medicaid Services HCPCS coding changes, HCPCS code B4084, gastrostomy/jejunostomy tubing, will be converted to code B4086, gastrostomy/jejunostomy tube, any material, each, effective with date of service September 30, 2004. The maximum reimbursement rate will remain at $17.09. Prior approval is not required. A Certificate of Medical Necessity and Prior Approval form must be completed regardless of the requirement for prior approval.

Providers should continue to use HCPCS code B9998 for low profile gastrostomy and extension kits for Medicaid recipients.

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

Attention: Personal Care Services Providers

PCS and PCS-Plus Recoupments

Effective October 2004, EDS will begin recouping any PCS overpayments since the implementation of PCS-Plus in November 2003. Recoupments will cover dates of service from November 1, 2003 to July 31, 2004 and be automatically deducted from the provider's checkwrite. Providers who have received PCS payments that exceeded 60 hours (240 units) a month or 3.5 hours a day (14 units) for PCS clients without PCS-Plus prior approval will have these payments recouped. Any providers who have received payments that exceeded 80 hours (or 320 units) a month for Medicaid recipients with PCS-Plus prior approval will have also these payments recouped. As a reminder, PCS is limited to 60 hours and 3.5 hours a day for each eligible Medicaid recipient. Medicaid recipients with DMA prior approval for PCS-Plus are eligible for up to 80 hours a month of PCS without daily limits.

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

Attention: Federal Qualified Health Centers and Rural Health Clinics

Medicare Part B Crossovers

Effective with date of service September 6, 2004, the N.C. Medicaid program returned to processing crossovers for claims billed on a CMS-1500 form to Medicare. Currently, the only two Medicare intermediaries that Medicaid accepts Medicare Part B crossovers from are Cigna and Palmetto. For providers that are required to bill to Medicare Part B on a UB-92 claim form and to Medicaid on a CMS-1500 claim form, these claims will not automatically crossover from Medicare. These claims should be filed as a secondary claim to Medicaid as an 837 professional transaction indicating the coinsurance and deductible in the COB loop or on the CMS-1500 form with the Medicare voucher attached. Medicaid will reimburse a percentage of the coinsurance and deductible from Medicare. Please refer to the Part B Reimbursement Schedule located on DMA's website http://www.dhhs.state.nc.us/dma to determine the percentage reimbursement for your facility.

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

Attention: Federally Qualified Health Centers and Rural Health Clinics

Use of the FP Modifier for Family Planning Services

Providers were instructed in the May 2004 general Medicaid bulletin that effective with date of service April 26, 2004, the FP modifier must be appended to the CPT or HCPCS code billed for the family planning service and that a family planning diagnosis code (V25.0-V25.9, except for V25.3) must be entered on the claim for family planning services. However, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) CANNOT append the FP modifier to the core visit code, T1015.

If the FQHC or RHC is certain that a procedure that is normally billed with the "C" suffix provider number was performed for family planning reasons, the FP modifier SHOULD be appended to the HCPCS code and the appropriate family planning diagnosis should be billed. An example of this situation is the administration of Depo-Provera for contraception. The family planning diagnosis code should be billed and the FP modifier should be appended to the HCPCS code, J1055.

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

Attention: Hospitals and OB/GYN Providers

Emergency Services for Undocumented Aliens

Undocumented residents are eligible for Medicaid emergency services only. Undocumented aliens are only authorized for Medicaid services for the actual days they receive an emergency medical service. Certain documented aliens are only eligible for emergency services during their first five years in the country.

The county departments of social services (DSS) determine the eligibility coverage dates when the emergency service is for labor and vaginal delivery or C-section delivery. For all other emergency services, including miscarriages and other pregnancy terminations, the Division of Medical Assistance (DMA) determines the eligibility coverage. Application for emergency Medicaid is made at the local DSS in the alien's county of residence.

Medicaid eligibility will not be authorized until after the emergency service has occurred.

Following is a listing of Medicaid program codes for aliens who are only eligible for emergency services:

HSFF	**MAAF**	**MABF**	**MADF**	**MAFF**	**MICF**
HSFH	**MAAH**	**MABH**	**MADO**	**MAFH**	**MICH**
HSFO	**MAAO**	**MABO**	**MADH**	**MAFO**	**MPWF**
HSFR	**MAAR**	**MABR**	**MADR**	**MAFR**	**MPWH**

The definition of an emergency medical service includes a vaginal or C-section delivery. The only procedure codes covered are 59409 for a vaginal delivery or 59514 for a C-section delivery. Global codes that include prenatal, postpartum care or 60-day continuation are non-covered by Medicaid for emergency services and should not be billed to Medicaid.

Non-covered codes include the following:

63.70	63.71	63.72	63.73	66.21
66.22	66.29	66.31	66.32	66.39

CPT codes:

55250	55450	58600	58605	58611
58615	58661*	58670	58671	58700*
58720*	59400	59410	59425	59426
59430	59510	59515		

***Note**: These codes will only be considered for coverage if medical documentation submitted with the claim supports that service was provided as the result of an emergency situation (such as an ectopic pregnancy). Sterilization procedures are not included in the definition of emergency services and, therefore, are non-covered for undocumented aliens.

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

Attention: All Hospital Providers

Lower Level of Care and Swing Bed Billing

Effective June 1, 2004, hospitals billing lower levels of care beds must bill only for a single level of care – nursing facility level of care. There are no separate levels for "Skilled Nursing Care" and "Intermediate Care". All lower level of care beds are now described as "nursing facility level". Hospitals requesting reimbursement for patients in a lower level of care beds will receive the state average for nursing facility reimbursement rate for those beds.

Effective with date of service June 1, 2004 the nursing facility per diem reimbursement rates are:

Nursing Facility level of care and Swing Bed: $121.57
Ventilator-Dependent Care: $356.94

Please continue to submit claims for lower-level of care stays following the current per diem guidelines.

Prior Approval
When a patient no longer meets acute care requirements and is approved for nursing facility level of care, the hospital must bill for a lower level of care while the patient remains in the hospital. Prior approval must be obtained from EDS by submitting an FL-2 or FL-2E form before billing for the lower level of care. The FL-2E Form may be accessed online at www.providerlink.com

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

Attention: Independent Laboratories

Use of the Family Planning Modifier for Family Planning Services

Providers were instructed in the May 2004 general Medicaid bulletin that effective with date of service April 26, 2004, the FP modifier must be appended to the CPT or HCPCS code billed for family planning services and that a family planning diagnosis code (V25.0-V25.9, except for V25.3) must be entered on the claim for family planning services.

When the independent laboratory is provided a diagnosis that clearly indicates a service was performed for family planning purposes and one of the following laboratory services is performed, the FP modifier should be appended to the CPT procedure code. If the laboratory is not provided a diagnosis that indicates the service was performed for family planning purposes, the CPT procedure code should not be appended with the FP modifier.

The following CPT procedure codes are billable when a family planning service was performed.

Procedure Code	Description
81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
81001	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy
81002	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy
81003	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy
81005	Urinalysis; qualitative or semiquantitative, except immunoassays
81007	Urinalysis; bacteriuria screen, except by culture or dipstick
81015	Urinalysis; microscopic only
81020	Urinalysis; two or three glass test
81025	Urine pregnancy test, by visual color comparison methods
84702	Gonadotropin, chorionic (hCG); quantitative
84703	Gonadotropin, chorionic (hCG); qualitative
85004	Blood count; automated differential WBC count
85007	Blood count; blood smear, microscopic examination with manual differential WBC count
85008	Blood count; blood smear, microscopic examination without manual differential WBC count
85009	Blood count; manual differential WBC count, buffy coat
85013	Blood count; spun microhematocrit
85014	Blood count; hematocrit (Hct)
85018	Blood count; hemoglobin (Hgb)
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)
85041	Blood count; red blood cell (RBC) automated
85044	Blood count; reticulocyte , manual
85045	Blood count; reticulocyte, automated
85046	Blood count; reticulocytes, hemoglobin concentration
85048	Blood count; leukocyte (WBC), automated
85049	Blood count; platelet, automated
86592	Syphilis test; qualitative (e.g., VDRL, RPR, ART)
86593	Syphilis test; quantitative
86631	Antibody; chlamydia
86632	Antibody; Chlamydia, IgM
86689	Antibody; HTLV or HIV antibody, confirmatory test (e.g., Western Blot)
86694	Antibody; herpes simplex, non-specific type test
86695	Antibody; herpes simplex, type 1
86696	Antibody; herpes simplex, type 2

Laboratory Codes, continued

Procedure Code	Description
86701	Antibody, HIV-1
86702	Antibody; HIV-2
86703	Antibody; HIV-1 and HIV-2, single assay
86762	Antibody; rubella
86781	Antibody; Treponema pallidum, confirmatory test (e.g., FTA-abs)
86900	Blood typing; ABO
86901	Blood typing; Rh (D)
86903	Blood typing; antigen screening for compatible blood unit using reagent serum, per unit screened
86904	Blood typing; antigen screening for compatible unit using patient serum, per unit screened
87081	Culture, presumptive, pathogenic organisms, screening only
87110	Culture, Chlamydia, any source
87207	Smear, primary source with interpretation; special stain for inclusion bodies or parasites (e.g., malaria, coccidian, microsporidia, typanosomes, herpes viruses)
87210	Smear, primary source with interpretation; wet mount for infectious agents (e.g., saline, India ink, KOH preps)
87270	Infectious agent antigen detection by immunofluorescent technique; Chlamydia trachomatis
87273	Infectious agent antigen detection by immunofluorescent technique; herpes simplex, type 2
87274	Infectious agent antigen detection by immunofluorescent technique; herpes simplex, type 1
87285	Infectious agent antigen detection by immunofluorescent technique; treponema pallidum
87320	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; Chlamydia trachomatis
87390	Infectious agent antigen detection by immunofluorescent technique; HIV-1
87391	Infectious agent antigen detection by immunofluorescent technique; HIV-2
87490	Infectious agent detection by nucleic acid (DNA or RNA); chlamydia trachomatis, direct probe technique
87491	Infectious agent detection by nucleic acid (DNA or RNA); chlamydia trachomatis, amplified probe technique
87492	Infectious agent detection by nucleic acid (DNA or RNA); chlamydia trachomatis, quantification
87528	Infectious agent detection by nucleic acid (DNA or RNA); herpes simplex virus, direct probe technique
87529	Infectious agent detection by nucleic acid (DNA or RNA); herpes simplex virus, amplified probe technique
87530	Infectious agent detection by nucleic acid (DNA or RNA); herpes simplex virus, quantification
87534	Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, direct probe technique
87535	Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, amplified probe technique

Laboratory Codes, continued

Procedure Code	Description
87536	Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, quantification
87537	Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, direct probe technique
87538	Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, amplified probe technique
87539	Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, quantification
87590	Infectious agent detection by nucleic acid (DNA or RNA); neisseria gonorrhoeae, direct probe technique
87591	Infectious agent detection by nucleic acid (DNA or RNA); neisseria gonorrhoeae, amplified probe technique
87592	Infectious agent detection by nucleic acid (DNA or RNA); neisseria gonorrhoeae, quantification
87810	Infectious agent detection by immunoassay with direct optical observation; chlamydia trachomatis
87850	Infectious agent detection by immunoassay with direct optical observation; neisseria gonorrhea
88141	Cytopathology, cervical or vaginal (any reporting system); requiring interpretation by physician (list separately in addition to code for technical support)
88142	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision
88143	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with manual screening and rescreening under physician supervision
88147	Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision
88148	Cytopathology smears, cervical or vaginal; screening by automated system with manual rescreening under physician supervision
88150	Cytopathology, slides, cervical or vaginal; manual screening under physician supervision
88152	Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening under physician supervision
88153	Cytopathology, slides, cervical or vaginal; with manual screening and rescreening under physician supervision
88154	Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening using cell selection and review under physician supervision
88160	Cytopathology, smears, any other sources; screening and interpretation
88161	Cytopathology, smears, any other sources; preparation, screening and interpretation
88162	Cytopathology, smears, any other sources; extended study involving over 5 slides and/or multiple stains

Laboratory Codes, continued

Procedure Code	Description
88164	Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision
88165	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and rescreening under physician supervision
88166	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening under physician supervision
88167	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening using cell selection and review under physician supervision
88174	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision
88175	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening, under physician supervision
88302	Surgical pathology, gross and microscopic examination
89300	Semen analysis; presence and/or motility of sperm including Huhner test (post coital)
89310	Semen analysis; motility and count (not including Huhner test)
89320	Semen analysis; complete (volume, count, motility and differential)
89325	Sperm antibodies
G0001	Routine venipuncture for collection of specimen(s)

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

Attention: Mental Health Services Providers

Prior Approval and Medicare

Prior approval is not required for Medicare covered mental health services rendered to Medicare/Medicaid dually eligible recipients when Medicare is their primary payer. Because Medicare does not require providers to request prior approval for services, it is not necessary for Medicaid providers to request authorization from ValueOptions for inpatient or outpatient services to these clients. Authorization must be obtained from ValueOptions in accordance with Medicaid requirements for Medicare non-covered services when services are rendered or billed by Area Mental Health Programs/Local Management Entities.

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

Attention: Nursing Facility Providers

Therapeutic Leave

When billing for therapeutic leave days, please remember to bill RC 183 and not RC 100. RC 100 is for room and board when the recipient is in the nursing facility.

Please note, page 8-29 of the N.C. Medicaid Nursing Facility Provider Manual, under "Billing Therapeutic Leave Days", "Claim 2", the dates for billing therapeutic leave in the example should be 04-12-2000 to 04-14-2000, and not 04-13-2000. This allows for the 2 covered therapeutic leave days in the example that are billable.

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

Attention: Optical Providers

Reminder: Medicare Part B Billing and Optical Copayments

The current North Carolina Medicaid copayment amount for optical services is $2.00 per visit as illustrated in the May 2004 general Medicaid Billing/Carolina Access Policies and Procedures Guide. (http://www.dhhs.state.nc.us/dma/medcabillguide.htm.)

Optical providers should not place the $2.00 copayment amount in the block 29 when filing claims to North Carolina Medicaid.

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

Attention: Physicians, Nurse Practitioners

Azacitidine, 25 mg (Vidaza, HCPCS Code J9999) – Billing Guidelines

Effective with date of service October 1, 2004, the N.C. Medicaid program covers azacitidine for injectable suspension (Vidaza). The FDA approved the use of Vidaza for the treatment of the following myelodysplastic syndrome (MDS) subtypes:

Refractory anemia (RA) or refractory anemia with ringed sideroblasts (RARS) (if accompanied by neutropenia or thrombocytopenia or requiring transfusions) Refractory anemia with excess blasts (RAEB) Refractory anemia with excess blasts in transformation (RAEB-T) Chronic myelomonocytic leukemia (CMMoL)

The recommended starting dose is 75 mg/m2 subcutaneously, daily for seven days, every four weeks.
The ICD-9-CM diagnosis codes required when billing for Vidaza are:

V58.1 – admission or encounter for chemotherapy

AND EITHER

238.7 – Neoplasm of uncertain behavior of other lymphatic and hematopoietic tissues
(for anemias associated with the myelodysplastic syndrome)

OR

205.10 – Myeloid leukemia, chronic, without mention of remission (for chronic myelomonocytic leukemia)

Providers must bill J9999, the unclassified drug code for antineoplastic agents, with an invoice attached to the CMS-1500 claim form. An invoice must be submitted with each claim. The paper invoice must indicate the recipient's name and Medicaid identification number, the name of the medication, the dosage given, the National Drug Code (NDC) number from the vial(s) used, the number of vials used, and the cost per dose.

Providers must indicate the number of units given in block 24G on the CMS-1500 claim form. For Medicaid billing, one unit of coverage is 25 mg. The maximum reimbursement rate per unit is $107.40. Providers must bill their usual and customary charge.

Add this drug to the list of injectable drugs published in the April 2004 general Medicaid bulletin.

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

Attention: Physicians, Nurse Practitioners

Gemtuzumab Ozogamicin, 5 mg. (Mylotarg, J9300) - Billing Guidelines

Effective with date of service May 1, 2004, the N.C. Medicaid program covers gemtuzumab ozogamicin (Mylotarg) for use in the Physician's Drug Program when billed with HCPCS code J9300. The FDA indication for Mylotarg is the treatment of acute myeloid leukemia in patients with first relapse who are 60 years of age or older and who are not considered candidates for other cytotoxic chemotherapy. The FDA's recommended dosing schedule is 9 mg/m2, administered as a 2-hour infusion, with a total of two doses with 14 days between the doses.

The ICD-9-CM diagnosis codes required when billing for Mylotarg are:

V58.1 – admission or encounter for chemotherapy

AND

A diagnosis code in the range of 205.00 through 205.01 – acute myeloid leukemia

For Medicaid billing, one unit of coverage is the 5 mg vial. Providers must indicate the number of units given in block 24G on the CMS-1500 claim form. The maximum reimbursement rate per unit is $1,953.94. Providers must bill their usual and customary charge.

Add this drug to the list of injectable drugs published in the April 2004 general Medicaid bulletin.

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

Attention: Physicians

HCPCS Code Changes for the Physician's Drug Program

Effective with date of service October 1, 2004, the N.C. Medicaid program covers the individual HCPCS codes for the drugs listed in the following table. Claims submitted for dates of service on or after October 1, 2004 using the unlisted drug codes J3490 or J9999 for these drugs will deny.

OLD CODE	DESCRIPTION	UNIT	NEW CODE	DESCRIPTION	UNIT	MAXIMUM FEE
J9999	Bevacizumab (Avastin)	4 ml vial	S0116	Bevacizumab	100mg	$618.75
J3490	Laronidase (Aldurazyme)	2.9 mg/5ml	S0158	Laronidase (Aldurazyme)	.58mg	$139.95
J3490	Agalsidase beta (Fabrazyme)	35mg	S0159	Agalsidase beta (Fabrazyme)	35mg	$4500.00
J3490	Risperidone (Risperdal Consta)	25 mg	S0163	Risperidone, long acting (Risperdal Consta)	12.5 mg	$124.92

Note: The unit of coverage and fees on some of these drugs has changed. The units and fees that have changed are in bold print in the above table.

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

Attention: Physicians

Physician Management of ESRD - Code Changes and Billing Guidelines

Effective with date of service October 1, 2004, the Division of Medical Assistance (DMA) has aligned with Medicare in the coverage of HCPCS "G" codes for billing End- Stage Renal Disease (ESRD) related services for recipients receiving dialysis. HCPCS codes G0308 through G0327 may be billed retroactive to January 1, 2004 but they must not be billed in conjunction with CPT codes for the same service. CPT codes 90918 through 90925 will be end-dated effective November 30, 2004. Only the G codes may be billed effective with dates of service on or after December1, 2004.

Billing and Documentation Guidelines for Recipients Other Than Home Dialysis
HCPCS codes G0308 through G0319 are used to bill ESRD related services for recipients who receive dialysis treatment in a setting other than the home. The codes are based on the age of the recipient and the number of face-to-face physician visits per month but not per full month. If a recipient is hospitalized during the month, bill the code that reflects the number of face-to-face visits during the month on days when the patient was not in the hospital (either admitted as an inpatient or in observation status).

Home Dialysis Recipients - Full Month
HCPCS codes G0320 through G0323 are used to bill ESRD related services for recipients who receive dialysis treatment in the home. The codes are based on the age of the recipient. The codes are billed for the full month but do not specify the frequency of visits made during the month.

Home Dialysis Recipients – Partial Month
HCPCS codes G0324 through G0327 may be billed for the days the recipient is not in the hospital, if a recipient is hospitalized during the month. If the recipient receives dialysis in a dialysis center or other facility during the month, the physician receives the management fee for the appropriate home dialysis code billed in the range G0324 through G3027. HCPCS codes G0308 through G0319 and CPT codes 90935 or 90937 may not be billed even though the physician may see the recipient at the dialysis center.

Other Guidelines
Providers must continue to bill monthly ESRD related services once per month on the last day of the month that the service is provided. The physician must document the face-to face visits in the recipient's record. The documentation should reflect that the recipient was seen and include the decisions that were made relevant to the recipient's care. The physician must perform some portion of the service in a face-to-face encounter, one or more visits per month, when non-physician practitioners are utilized to provide service. Only one practitioner may receive payment for the monthly ESRD related service codes. The physician who provides the complete assessment, establishes the recipient's plan of care and provides ongoing management must bill for the monthly service. Providers should bill CPT code 90935 when rendering service to a recipient for whom they are not the primary provider when the recipient is traveling or is seen away from their home service area.

The following table below includes the HCPCS codes and descriptions.

Code	Description
G0308	End Stage Renal Disease (ESRD) related services during the course of treatment, for patients under 2 years of age to include monitoring the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month.

Code	Description
G0309	End Stage Renal Disease (ESRD) related services during the course of treatment, for patients under 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2 or 3 face-to-face physician visits per month.
G0310	End Stage Renal Disease (ESRD) related services during the course of treatment, for patients under 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month.
G0311	End Stage Renal Disease (ESRD) related services during the course of treatment, for patients between 2 and 11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month.
G0312	End Stage Renal Disease (ESRD) related services during the course of treatment, for patients between 2 and 11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2 or 3 face-to-face physician visits per month.
G0313	End Stage Renal Disease (ESRD) related services during the course of treatment, for patients between 2 and 11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month.
G0314	End Stage Renal Disease (ESRD) related services during the course of treatment, for patients between 12 and 19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month.
G0315	End Stage Renal Disease (ESRD) related services during the course of treatment, for patients between 12 and 19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2 or 3 face-to-face physician visits per month.
G0316	End Stage Renal Disease (ESRD) related services during the course of treatment, for patients between 12 and 19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month.
G0317	End Stage Renal Disease (ESRD) related services during the course of treatment, for patients 20 years of age and over; with 4 or more face-to-face physician visits per month.
G0318	End Stage Renal Disease (ESRD) related services during the course of treatment, for patients 20 years of age and over; with 2 or 3 face-to-face physician visits per month.
G0319	End Stage Renal Disease (ESRD) related services during the course of treatment, for patients 20 years of age and over; with 1 face-to-face physician visit per month.
G0320	End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients under two years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents
G0321	End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients two to eleven years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents.

Code	Description
G0322	End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients 12 to 19 years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents.
G0323	End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients twenty years of age and older.
G0324	End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients under two years of age.
G0325	End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients between two and 11 years of age.
G0326	End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients between 12 and 19 years of age.
G0327	End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients 20 years of age and over.

Refer to the following table when billing for ESRD related services.

For dates of service January 1, 2004 through November 30, 2004, Bill	**For dates of service on or after December 1, 2004, Bill**
90918 or G0308, G0309, G0310	G0308 or G0309 or G0310
90919 or G0311, G0312, G0313	G0311or G0312 or G0313
90920 or G0314, G0315, G0316	G0314 or G0315 or G0316
90921 or G0317, G0318, G0319	G0317 or G0318 or G0319
G0320	G0320
G0321	G0321
G0322	G0322
G0323	G0323
90922 or G0324	G0324
90923 or G0325	G0325
90924 or G0326	G0326
90925 or G0327	G0327

Billing Examples:

Dialysis Site	**Number of Face-to-Face Visits**	**Recipient Age**	**Recipient Hospitalized**	**Bill HCPCS G Code**	**Number of Units**
Other than home	4 or more	Under 2 years	No	G0308	1
Other than home	2	12-19 years	Yes	G0315	1
Home	Any number	Under 2 years	No	G0320	1
Home	Bill the number of days recipient was not in the hospital	12- 19 years	Yes. 10 days of a 30 day month	G0327	20

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

Attention: Physicians, Dentists, Chiropractors, Osteopaths, Optometrists and Podiatrists

Provider Enrollment Directly through DMA

In the near future, the practitioners listed above who are seeking initial enrollment or updating information on their provider status in the N.C. Medicaid program will access application forms on the DMA's website. Effective with this implementation, providers will no longer enroll with Blue Cross Blue Shield of North Carolina to enroll as a Medicaid provider. Upcoming bulletins will provide more information regarding this change.

Angela Floyd, Provider Services
DMA, 919-857-4015

Attention: All Providers

Clinical Coverage Policies

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

1A–12 – Breast Surgeries
4A – Dental Services
4B – Orthodontic Services
5 – Durable Medical Equipment
8A – Area Mental Health, Developmental Disabilities, 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.

Gina Rutherford, Clinical Policy and Programs Section
DMA, 919-857-4020

Attention: Prescriber and Pharmacy Providers

Synagis and Respigam Forms

For the upcoming RSV season, Synagis will not require prior approval (PA) for Medicaid recipients. However, the responsibility for appropriate usage for both Synagis and Respigam will be placed on prescribers and pharmacy providers. PA may be resumed at any time if the Division of Medical Assistance (DMA) suspects inappropriate drug utilization. The North Carolina Physicians Advisory Group (NCPAG) has met with specialists in the state and members of the Pediatric Red Book committee to develop three Synagis usage criteria forms. Please ensure that the person completing the forms has verified that the conditions exist and are accurate. If a patient does not fit the criteria explicitly for category 1, 2 or 3, and you still wish to prescribe Synagis, you must submit your request to DMA on the *Request for Medical Review for Synagis Outside of Criteria* form and fax the request to DMA at 919-715-1255.

The start of the Synagis season is October 15, 2004. **No more than 5 monthly doses of Synagis or RespiGam can be obtained by using these forms. The number of doses should be adjusted if an infant received the first dose prior to a hospital discharge**. Delays in getting a request processed can occur if the patient does not have a Medicaid identification number or the form is not complete.

The criteria forms must be signed by the prescriber and submitted to the pharmacy distributor of choice.

The Request for Medical Review for Synagis Outside of Criteria form must be signed by the prescriber and submitted to DMA.

Please refer to the following guidelines when submitting a request:

Criteria 1a through 1d – Infants (24 months or younger) with CLD (Chronic Lung Disease), CF (Cystic Fibrosis), CHD (Congenital Heart Disease), or Severe Immunodeficiency

Criteria 2a and 2b – Infants born at 32 weeks, 0 days gestation or earlier without CLD
Once a child qualifies for initiation of prophylaxis at the start of the RSV season, administration should continue throughout the season and not stop at the point that the infant reaches 6 or 12 months of age.

Criteria 3 – Infants Born at 32 Weeks, 1 day – 35 Weeks, 0 day Gestation without CLD
High-risk infants should be kept away from crowds and from situations in which exposure to infected individuals cannot be controlled. Participation in child care should be restricted during the RSV season for high-risk infants whenever feasible.

Request for Medical Review for Synagis Outside of Criteria

This form will be used for patients who do not explicitly meet criteria 1, 2 or 3, whose providers still wish to prescribe Synagis. Please fill out the requested information, and fax to DMA at 919-715-1255.

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

Proposed Clinical Coverage Policies

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

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

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

Checkwrite Schedule

October 5, 2004	November 2, 2004	December 7, 2004
October 12, 2004	November 9, 2004	December 14, 2004
October 19, 2004	November 16, 2004	December 22, 2004
	November 24, 2004	

Electronic Cut-Off Schedule

October 1, 2004	October 29, 2004	December 3, 2004
October 8, 2004	November 5, 2004	December 10, 2004
October 15, 2004	November 12, 2004	December 17, 2004
	November 19, 2004	

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.

Gary H. Fuguay, Director
Division of Medical Assistance
Department of Health and Human Services

Cheryll Collier
Executive Director
EDS