north carolina medicaid

October 2007 (Revised 10/2/07)
Medicaid Bulletin

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

National Provider Identifier

Attention: All Providers

NPI Data Dissemination Now Available

On September 4, 2007, the Centers for Medicare & Medicaid Services (CMS) made available access to the National Plan and Provider Enumeration System (NPPES). The data that is available includes only that health care provider data disclosable under the Freedom of Information Act (FOIA). In accordance with the e-FOIA Amendments, CMS is disclosing this data via the Internet. Data is available in two forms:

1. A query-only database, known as the NPI Registry. The NPI registry operates in a real-time environment and can be found here: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do. UserIDs and passwords are not needed to use the NPI Registry. There is no charge to use the NPI Registry.
2. A downloadable file which will be replaced and updated each month.   It can be found here: http://nppesdata.cms.hhs.gov/cms_NPI_files.html. At the writing of this article, this function is not yet available. We recommend that you periodically check this link for its activation by CMS. CMS is recommending that providers view their NPI information on the NPI registry to ensure its validity.

If information regarding your NPI is incorrect, please update your information immediately. Providers can log into the NPPES website at https://nppes.cms.hhs.gov to make corrections. For questions regarding updates, contact the NPI enumerator by email at customerservice@npienumerator.com or by phone at 1-800-465-3203.

In addition to using this database to validate your information, we recommend that you search this database in the event you need the NPI of a referring provider and the information is not otherwise available. For more information, refer to the data dissemination instructions at: http://www.cms.hhs.gov/NationalProvIdentStand/06a_DataDissemination.asp.

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

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

Attention: All Providers (Except Pharmacy)

Submit both NPI and Medicaid Provider Number on Claims

With the exception of Pharmacy providers who do not have the capability, N.C. Medicaid encourages providers to begin submitting immediately both the NPI and the Medicaid Provider Number on all claims. This information is needed for testing the NPI changes to MMIS.

If your software is not updated to submit the NPI number, please contact your clearinghouse or software vendor as soon as possible to obtain the appropriate updates. We are aware that the NCECSWeb tool currently does not save the NPI. Updates will be made to NCECSWeb prior to NPI implementation. Please ensure that you keep the capability to submit the Medicaid Provider Number along with the NPI. N.C. Medicaid will continue to process claims using the Medicaid Provider Number until NPI is implemented.

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

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

Attention: All Providers

Accepting a Medicaid Recipient (Revised 10/2/07)

According to 10A NCAC 22J.0106 a provider has a choice whether or not to accept or refuse a patient as a Medicaid patient. However, providers may not discriminate against Medicaid recipients based on the recipient's race, religion, national origin, color, or handicap. Providers are reminded of the following:
- Medicaid providers must be consistent with their policy and procedures when accepting or refusing Medicaid recipients.
- Acceptance of the recipient's Medicaid ID card and/or submission of a claim for payment to the Medicaid program constitute agreement to accept the Medicaid payment (in addition to any authorized co-payment or third party payment) as payment in full.
- Recipients may not be billed for the difference between the charges and the Medicaid payment in addition to co-payment and third-party payment.
- Recipients may not be billed for any service covered by the Medicaid program unless the provider has specifically informed the recipient that Medicaid will not be billed, and the recipient understands and agrees to accept liability for payment. Providers are encouraged to obtain a signed statement from the patient agreeing to be financially responsible for these charges.
- Recipients must be informed of, and agree to liability for non-covered services *before* such services are rendered.
- Recipients may not be billed for covered services for which the provider is denied payment because the provider failed to follow program regulations. This includes errors on the claim form, late submission, lack of prior approval, failure to bill third-party resources, etc.

A provider *may* bill a Medicaid recipient if the recipient, rather than the provider, receives payments from either the commercial insurance or Medicare; if the recipient fails to provide proof of eligibility by presenting a current Medicaid card; if the recipient loses eligibility for Medicaid as defined in 10A NCAC 21B; or if the recipient owes an allowable Medicaid deductible or co-payment. The following services may also be billed to the recipient:
- Services not covered by Medicaid if the recipient has MEDICARE-AID coverage (MQB-Q; buff colored card)
- Prescriptions in excess of the 11-per month limit, unless the recipient is locked into their pharmacy of record
- Visits in excess of the 24 ambulatory visit limit for the state fiscal year (July 1 through June 30)
- The portion of psychiatric services for a Medicare-eligible recipient that is subject to the 37.5% psychiatric reduction in Medicare reimbursement

For recipients under the age of 21 and EPSDT requirements see Section 2 and 6 of the *Basic Medicaid Billing Guide*, available at www.ncdhhs.gov/dma/medbillcaguide.htm.

Providers are encouraged to make use of the resources available to assist in filing claims
- <u>General and special</u> bulletins
- (www.ncdhhs.gov/dma/cptclickbulletin.htm)
- Clinical coverage policies containing billing information
- (www.ncdhhs.gov/dma/mp/mpindex.htm)
- Provider Relations staff at EDS, 1-800-688-6696
- Division of Medical Assistance staff
- EDS voice response system for eligibility verification 1-800-723-4337

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

Attention: All Providers
Clinical Coverage Policies

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

5B, Orthotics and Prosthetics

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

Coverage for CPT Codes 59015, 76945, 76820, and 76821

Four procedures were added to Clinical Coverage Policy 1E-4, *Fetal Surveillance,* effective with date of service April 1, 2007. These procedures are as follows:

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

Providers who received claim denials for the above codes since April 1, 2007, as non-covered procedures may resubmit new claims (not adjustments) for processing.

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

Attention: All Providers

EPSDT Policy Instructions Update

On August 17, 2007, the Division of Medical Assistance posted the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Policy Instructions Update. These instructions became effective September 1, 2007, and clarify the Division's initial EPSDT Policy Instructions issued January 28, 2005. Please review the instructions carefully. Providers and case managers should communicate the information contained in the instructions to recipients under 21 years of age and/or their representatives. Children who have previously been denied or terminated from services may be eligible for additional Medicaid services if the services are medically necessary and if a request for services is made in accordance with Medicaid's policies and procedures. The EPSDT Policy Instructions Update is available at http://www.ncdhhs.gov/dma/EPSDTprovider.htm.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

Expanded Foster Care Program

The Foster Care Independence Act of 1999 allows states to extend Medicaid coverage for former foster care recipients who have aged out of foster care.

The 2007 Appropriations Act allows former foster care recipients 18 through 20 years of age to continue to receive Medicaid if they were in foster care on their 18th birthday. This is known as the Expanded Foster Care Program (EFCP) and will be administered without regard to the recipient's assets or income levels through age 20. This policy change will be effective Oct. 1, 2007.

Providers can check eligibility through the Automated Voice Response System (800-723-4337). For further information on EFCP, contact the county Department of Social Services.

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

Attention: All Providers

Influenza Vaccine and Reimbursement Guidelines for 2007-2008

The N.C. Medicaid program reimburses for vaccines in accordance with guidelines from the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP). Information pertinent to influenza disease, vaccine and recommendations regarding those who should receive vaccine for the 2007-2008 flu season can be found in the July 13, 2007, Morbidity and Mortality Weekly Report (MMWR) at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5606a1.htm.

Additional information regarding the 2007-2008 flu season can be found at http://www.cdc.gov/flu/.

Six Principal Changes and Updates
- ACIP reemphasizes the importance of administering two doses of vaccine to all children aged 6 months through 8 years if they have not been vaccinated previously at any time with either live, attenuated influenza vaccine (LAIV) (doses separated by 6 or more weeks) or trivalent inactivated influenza vaccine (TIV) (doses separated by 4 or more weeks). This recommendation is made on the basis of accumulating data indicating that two doses are required for protection in these children (see Vaccine Efficacy, Effectiveness, and Safety).
- ACIP recommends that children aged 6 months through 8 years who received only one dose in their first year of vaccination receive two doses the following year (see Vaccine Efficacy, Effectiveness, and Safety).
- ACIP reiterates a previous recommendation that all persons, including school-aged children, who want to reduce the risk of becoming ill with influenza or of transmitting influenza to others should be vaccinated (see Box and Recommendations for Using TIV and LAIV During the 2007–08 Influenza Season).
- ACIP emphasizes that immunization providers should offer influenza vaccine and schedule immunization clinics throughout the influenza season (see Timing of Vaccination).
- ACIP recommends that health-care administrators consider the level of vaccination coverage among health-care personnel (HCP) to be one measure of a patient safety quality program and implement policies to encourage HCP vaccination (for example, obtaining signed statements from HCP who decline influenza vaccination) (see Additional Information Regarding Vaccination of Specific Populations).
- The 2007–2008 trivalent vaccine strains are A/Solomon Islands/3/2006 (H1N1)-like (new for this season), A/Wisconsin/67/2005 (H3N2)-like, and B/Malaysia/2506/2004-like viruses. (see Recommendations for Using TIV and LAIV During the 2007–08 Influenza Season).

Using TIV and LAIV During the 2007–08 Influenza Season
Vaccination with TIV is recommended by CDC for the following persons who are at increased risk for severe complications from influenza, or at higher risk for influenza-associated clinic, emergency department or hospital visits:
- All children 6–59 months (that is, 6 months through 4 years)
- All persons aged 50 years or or older
- Children and adolescents (aged 6 months–18 years) who are receiving long-term aspirin therapy and who therefore might be at risk for Reye syndrome
- Women who will be pregnant during the influenza season
- Adults and children who have chronic pulmonary (including asthma), cardiovascular (except hypertension), renal, hepatic, hematological or metabolic disorders (including diabetes mellitus)
- Adults and children who have immunosuppression (including that caused by medications or HIV)
- Adults and children who have any condition (for example, cognitive dysfunction, spinal cord injuries, seizure disorders or other neuromuscular disorders) that can compromise respiratory function or the handling of respiratory secretions or that can increase the risk for aspiration
- Residents of nursing homes and other chronic-care facilities

To prevent transmission to persons identified above, vaccination with TIV or LAIV (unless contraindicated) also is recommended for the following persons:
- Healthcare providers
- Healthy household *contacts* (including children) and *caregivers* of children age 59 months or younger and adults aged 50 years and older
- Healthy household *contacts* (including children) and *caregivers* of persons with medical conditions that put them at higher risk for severe complications from influenza

North Carolina Universal Childhood Vaccine Distribution Program/Vaccine for Children (UCVDP/VFC)
The North Carolina Immunization Branch distributes childhood vaccines to local health departments, hospitals and private providers under UCVDP/VFC guidelines.

UCVDP/VFC influenza vaccine is available at no charge to providers for children who meet one of the following criteria:
- 6 months through 59 months of age
- At high risk, as identified in the ACIP recommendations, and 6 months through 18 years of age
- 6 months through 18 years of age, and a household contact of (lives with)
    - any child age 0 through 59 months of age or
    - any child or adult at high risk for influenza-related complications

The following tables indicate the vaccine codes that can either be reported or billed for an influenza vaccine, depending on the age of the recipient. The tables also indicate the administration codes that can be billed, depending on the age of the recipient.

NOTE: The information in the following tables is *not* detailed billing guidance. Specific information on billing all immunization administration codes can be found on p. 12 of the March 2007 N.C. general Medicaid bulletin ("Correction to Updated CPT Codes... Coverage of Immunization Administration Codes for Oral/Intranasal Vaccines"). **Note:** As an addendum to the March information, please see "Change in Reimbursement Rates for Injectable Immunization Administration Codes" in this issue of the bulletin.

Table 1   Influenza Billing Codes for Recipients Less Than 19 Years of Age

Vaccine CPT Code to Report	CPT Code Description
90655	Influenza virus vaccine, split virus, preservative free, for children 6-35 months of age, for intramuscular use
90656	Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, for intramuscular use
90657	Influenza virus vaccine, split virus, for children 6-35 months of age, for intramuscular use
90658	Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use
90660	Influenza virus vaccine, live, for intranasal use (FluMist)

Administration CPT Code(s) to Bill	CPT Code Description
90465EP	Immunization administration under 8 years of age (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); when the physician counsels patient/family; first injection (single or combination vaccine/toxoid), per day
90466EP	each additional injection (single or combination vaccine/toxoid), per day (list separately in addition to code for primary procedure)
Administration CPT Code(s) to Bill	**CPT Code Description**
90467EP	Immunization administration under age 8 years (includes intranasal or oral routes of administration) when the physician counsels the patient/family; first administration (single or combination vaccine/toxoid), per day. **Note:** billing CPT code 90468 for a second administration of an intranasal/oral vaccine when physician counseling was performed is not applicable at this time.
90468EP	each additional administration (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure). **Note:** billing CPT code 90468 for a second administration of an intranasal/oral vaccine is not applicable at this time.
90471EP	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)
90472EP	each additional vaccine (single and combination vaccine/toxoid) (List separately in addition to code for primary procedure)
90473EP	Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid). **Note:** billing CPT code 90474 for a second administration of an intranasal/oral vaccine is not applicable at this time.
90474EP	each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure). **Note:** billing CPT code 90474 for a second administration of an intranasal/oral vaccine is not applicable at this time.

Use the following codes (Table 2) to **bill** Medicaid for an influenza vaccine **purchased** and administered to a recipient **19 through 20 years of age.**

Table 2   Influenza Billing Codes for Recipients 19 and 20 Years of Age

Vaccine CPT Code to Bill	CPT Code Description
90656	Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, for intramuscular use
90658	Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use
90660	Influenza virus vaccine, live, for intranasal use (FluMist)
Administration CPT Code(s) to Bill	**CPT Code Description**
90471EP	Immunization administration; (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)
90472EP	each additional vaccine (single and combination vaccine/toxoid) (List separately in addition to code for primary procedure
90473EP	Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)
90474EP	each additional vaccine (single and combination vaccine/toxoid) (List separately in addition to code for primary procedure).

Use the following codes (Table 3) to **bill** Medicaid for an influenza vaccine **purchased** and administered to a recipient **21 years of age or older.**

Table 3   Influenza Billing Codes for Recipients ≥ 21 Years of Age

Vaccine CPT Code to Bill	CPT Code Description
90656	Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, for intramuscular use
90658	Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use
Administration CPT Code(s) to Bill	**CPT Code Description**
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)
90472	each additional vaccine (single and combination vaccine/toxoid) (List separately in addition to primary procedure)

For a recipient 21 years and older receiving an influenza vaccine, an Evaluation and Management (E/M) code cannot be reimbursed to any provider on the same day that injection administration fee codes (90471 or 90471 and 90472) are reimbursed, unless the provider bills an E/M code for a separately identifiable service by appending modifier 25 to the E/M code.

EDS, 1-800-688-6696 or (919) 688-6696

Attention: All Providers

NCECS WebTool Security Reminders

To update a current password for the NCECS WebTool, submit a request to the EDS Electronic Commerce Services (ECS) department. ECS cannot initiate a password change unless a request is submitted by the user.

Do not share your password with anyone who does not need access to your claims information. If an employee leaves your company, contact ECS immediately to have their password cancelled and changed.

Providers may contact the ECS unit (800-688-6696, option 1) to request either the Change of Password form or an emergency password change. More detailed information on the NCECS WebTool is available in the July 2007 Special Medicaid Bulletin, *NCECSWeb Instruction Guide* (www.ncdhhs.gov/dma/bulletin.htm).

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

Attention: All Providers

Place of Service for CPT code 58150

CPT code 58150, total abdominal hysterectomy, with or without removal of tube(s), with or without removal of ovary(s), is covered in an inpatient or outpatient hospital place of service. Timely filed claims which have denied for outpatient place of service can be resubmitted as a new claim.

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

Attention: All Providers

Registration for National Drug Code (NDC) Seminars

National Drug Code (NDC) seminars will be held during the month of November 2007. Registration information, a list of dates, and site locations for the seminars are listed below. Seminars will begin at 9:00 a.m. and end at 12:00 p.m. Providers are encouraged to arrive by 8:45am to complete registration. Lunch will not be provided at the seminars. **Because meeting room temperatures vary, dressing in layers is strongly advised.**

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

Providers may register for the National Drug Code (NDC) seminars by completing and submitting the following registration form online at http://www.ncdhhs.gov/dma/prov.htm and look under "Seminar Information."

Please indicate on the registration form the session you plan to attend.

The National Drug Code (NDC) special bulletin will be used as the primary training document for the seminar. The current policy manual will be available on DMA's website at http://www.ncdhhs.gov/dma/bulletin.htm#special, titled *NDC Special Bulletin, October 2007.* Please print the current manual and bring it to the seminar.

Asheville, NC **November 6, 2007** **Crown Plaza Hotel** **One Resort Dr.**	**Salisbury, NC** **November 7, 2007** **Holiday Inn Conference Center** **530 Jake Alexander Blvd.**
Fayetteville, NC **November 8, 2007** **Prince Charles Clarion Hotel** **450 Hay St.**	**Greenville, NC** **November 13, 2007** **Hilton Greenville** **207 SW Greenville Blvd.**
Raleigh, NC **November 14, 2007** **Velvet Cloak Inn** **1505 Hillsborough St.**	

Directions to the NDC Seminars:

Asheville, NC - Crowne Plaza
Traveling East on I-40
Take Exit 46 (left exit) for I-240 East. Continue on I-240 and stay the left lane. Take Exit 3A. Circle around right and exit onto Patton Avenue. Turn right at the second light into Regent Business Park (between Denny's and Pizza Hut). Turn right; the entrance is on the left around a curve approximately 1000 yards. Follow Resort Drive to the main entrance of the resort on the left.
Traveling West on I-40
Take Exit 53 to I-240 West. Pass downtown Asheville. As you cross the French Broad River Bridge, stay in the right lane and take Exit 3B - Westgate and Resort Drive (former Holiday Inn Drive). Pass the Westgate Shopping Center on your right. After passing Mr. Transmission, you will see our entrance sign. Turn right onto Resort Drive and proceed to the main entrance.

Salisbury, North Carolina - Holiday Inn Conference Center
Traveling South on I-85
Take exit 75. Turn right onto Jake Alexander Boulevard. Travel approximately ½ mile. The Holiday Inn is located on the right.
Traveling North on I-85
Take exit 75. Turn left onto Jake Alexander Boulevard. Travel approximately ½ mile. The Holiday Inn is located on the right.

Prince Charles Clarion Hotel – Fayetteville, North Carolina

From Fayetteville Regional Airport: Approximate distance to the hotel is seven miles.

Traveling on I-95

Follow I-95-BUS North, then turn right onto NC-87 North. Continue on US-401-BUS North. Take Exit 104B/Hay Street toward downtown. Turn right on Hay Street.
The hotel is located on the left.

Greenville, NC – Hilton

Traveling East: - take 64 east to 264 east. Follow 264 east to Greenville. Turn right on Allen Rd. once you enter Greenville. Go approx. 2 miles and Allen Rd. turns into Greenville Blvd/Alternate 264. Follow Greenville Blvd. for 2 1/2 miles, the Hilton Greenville is located on the right.

Traveling South: Take 64 to US-13 S/NC-11 S. Continue to follow NC-11 S. Turn left onto US-Greenville Blvd. The hotel is on the left.

Traveling North: Take NC Highway 11 North to Greenville. Turn right onto Greenville Blvd. Hotel is approximately one mile ahead on the right.

Raleigh, NC – Velvet Cloak Inn

From I-40 East

Take exit 289 which becomes Wade Ave. At the third traffic light make a left onto Faircloth Street. At first traffic light make a left onto Hillsborough Street. The Velvet Cloak Inn is approximately two miles on the right.

From I-40 West

Merge with beltline I-440 – stay left. Take exit 298-B (South Saunders Street and Downtown). Turn right at the bottom of the exit. Stay right and head into downtown Raleigh. (Note: South Saunders Street will turn into McDowell Street). Turn left onto Edenton Street. Turn left onto Salisbury Street. Turn right onto Hillsborough Street. The Velvet Cloak Inn is one mile on the left.

National Drug Code (NDC)
November 2007 Seminar Registration Form
(No Fee)

Provider Name_____

Medicaid Provider Number_____ NPI Number_____

Mailing Address_____

City, Zip Code_____ County_____

Contact Person_____ E-mail_____

Telephone Number(_____)_____Fax Number(_____)_____ _____

1 or **2** person(s) will attend the seminar at _____on_____
                                            (location)   (date)
Please fax completed form to: 919-851-4014
Please mail completed form to:
EDS Provider Services
P.O. Box 300009
Raleigh, NC 27622

Attention: All Providers

Tax Identification Information

The N.C. Medicaid program must have the correct tax information on file for all providers. This ensures that 1099 MISC forms are issued correctly each year and that correct tax information is provided to the IRS. Incorrect information on file with Medicaid can result in the IRS's withholding 28% of a provider's Medicaid payments. The individual responsible for maintenance of tax information must receive the information contained in this article.

How to Verify Tax Information
The last page of the Medicaid Remittance and Status Report (RA) indicates the tax name and number on file with Medicaid for the provider number listed. Review the Medicaid RA throughout the year to ensure that the correct tax information is on file for each provider number. If you do not have access to a Medicaid RA, call EDS Provider Services at 919-851-8888 or 1-800-688-6696 to verify the tax information on file for each provider.

How to Correct Tax Information
All providers are required to complete a W-9 form for each provider for whom incorrect information is on file. Please go to the following to obtain a copy of a W-9 form http://www.irs.gov/pub/irs-pdf/fw9.pdf. Correct information must be received by December 01, 2007. The procedure for submitting corrected tax information to the Medicaid program is outlined below:

All providers who identify incorrect tax information must submit a completed and signed W-9 form, along with a completed and signed Medicaid Provider Change form or Carolina ACCESS Provider Information Change Form, to the address listed below:
Division of Medical Assistance - Provider Services
2501 Mail Service Center
Raleigh NC 27699-2501

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

Attention: Dental Providers and Health Department Dental Clinics

Effective November 15, 2007 2002 ADA Claim Form No Longer Accepted

Effective with **date of receipt** November 15, 2007, the 2002 American Dental Association (ADA) Claim Form will be replaced by the 2006 ADA Claim Form. In preparation for the National Provider Identifier (NPI) implementation, all paper dental claims and requests for prior approval must be submitted on the 2006 ADA Claim Form regardless of the date of service.

Providers who submit the 2002 ADA Claim Form for payment will receive denial EOB 189 on their remittance advice. EOB 189 states, "Claim denied due to submission on 2002 ADA Claim Form after 11/15/2007 deadline. Resubmit on the 2006 ADA Claim Form. Refer to New Claim Form Instructions Special Bulletin June 2007."

Providers who receive EOB 189 will need to resubmit their claims on the 2006 ADA Claim Form. 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/index.asp

1-800-947-4746
American Dental Association
Attn: Salable Materials Office
211 E. Chicago Avenue
Chicago, IL 60611-2678

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

Attention: Enhanced Mental Health Services Providers

Retroactive Authorization for Enhanced Services in Health Choice for Children

The Department of Health and Human Services, Division of Public Health, contracts with ValueOptions to provide utilization management and intensive case management of enhanced services for children who are enrolled in the North Carolina Health Choice program and have special health care needs.

Value Options reports increasing numbers of requests for Health Choice authorization of enhanced services after the treatment has begun. Such requests are considered a request for "retro review" and are typically not allowed. The following rules, endorsed by the Division of Public Health and conveyed in the 2007 Medicaid–Health Choice provider trainings, will assist providers who request enhanced services retroreviews from ValueOptions.

When Retroreviews Are Allowed
Retroreviews are not allowed by Health Choice for enhanced services, *except* when there is a change in eligibility that would have prohibited the provider from requesting prior authorization before the start of service delivery. Therefore, ValueOptions will honor a request for retroreview *only* when the child's eligibility has changed from Medicaid (or other insurance) to Health Choice, *and* the provider has either faxed or telephoned a request for Health Choice authorization within 60 days of *when the State determined the change in eligibility* (not the effective date of coverage).

The units of service already delivered at the time of the retroreview, as well as any prospective requests, will be considered for authorization based on the medical necessity of the service.

As communicated in the June 2007 Medicaid–Health Choice provider trainings, effective July 1, 2007, when there is a change in eligibility from Medicaid to Health Choice, any previously issued Medicaid authorizations will not be honored by Health Choice. These programs are separate and distinct. Unlike Medicaid, Health Choice is not an entitlement program.

Checking Eligibility—the Key to Provider Success

Checking eligibility will foster provider success in obtaining preauthorization of enhanced services. Checking eligibility will mean less need for the provider to request retroreview, and less opportunity for denied payment to the provider. Providers must check eligibility on a regular basis—that is, before requesting preauthorization of ValueOptions for any enhanced service, and at least monthly.

How to Check Eligibility

For Medicaid, call EDS at 800-723-4337 and follow the prompts to determine Medicaid eligibility. If no eligibility is verified for Medicaid, immediately check eligibility for Health Choice.

For Health Choice, call Blue Cross Blue Shield of North Carolina at 800-422-4658 and follow the prompts for Health Choice to speak with a customer service representative about Health Choice eligibility. If no eligibility is verified for Health Choice, immediately check eligibility for Medicaid.

Health Choice or Medicaid eligibility is made retroactive to the first day of the month in which the application was received by the State. If there is no eligibility at the time you initially call (either EDS or BCBS), continue to follow up regularly if you are certain that the client has made application.

Authorization Requirements

Correct Fax Number. Requests for authorization must be received on the Health Choice fax line (919-379-9035) at ValueOptions. It is the provider's responsibility to check eligibility and make authorization requests to the appropriate fax number. Health Choice faxes sent to the Medicaid fax line will not be honored as legitimate requests for authorization of Health Choice services.

Services. As addressed in multiple provider trainings, Health Choice requires preauthorization of the following enhanced services:

Service	Billing Code	Notes
Community Support	H0036 HA (individual) H0036 HQ (group)	for children and adolescents
Day Treatment	H2012 HA	
Intensive In-Home Services	H2022	
Multisystemic Therapy	H2033	
Targeted Case Management	T1023	for developmentally disabled clients only
Level II Therapeutic Foster	S5145	family type
Level II Group Home	H2020	program type
Level III Group Home	H0019	all bed capacities
Level IV Group Home	H0019	all bed capacities

The only Health Choice enhanced services that do not require preauthorization prior to the start of the service are these:

Diagnostic Assessment: One diagnostic assessment (billing code T1023) is allowed per fiscal year (July 1 through June 30).

Mobile Crisis: The first 32 units per episode of mobile crisis (billing code H2011) are allowed without preauthorization. The maximum length of service is 24 hours per episode. Additional authorization must occur after 32 units of service have been rendered.

Questions
If you have questions about any of this information, please contact ValueOptions Account Services staff at 800-753-3224:
extension 292648 for Stacy Tighe
extension 292363 for Charlotte Craver

Attention: Hospital Providers

Reminder: Professional Fees are excluded from Medicaid Hospital Cost Reports

The Division of Medical Assistance (DMA) reminds hospital providers that inpatient and outpatient professional fee costs and charges must be excluded from Medicaid Hospital Cost Reports (2552-96). Professional fees for Certified Registered Nurse Anesthetists (CRNAs) and other professionals must be billed on a CMS-1500 claim form and will be paid pursuant to the DMA fee schedule. If you have any questions, please contact Bill Connelly at 919-855-4193 or bill.connelly@ncmail.net.

Submit Hospital Cost Reports to

Division of Medical Assistance
Attention: Bill Connelly
1985 Umstead Drive
Raleigh NC 27603

Bill Connelly
DMA, 919-855-4193

Attention: Medical Doctors and Doctors of Osteopathic Medicine

Orthotic and Prosthetic Devices in the Physician Office

The July 2007 North Carolina Medicaid general bulletin, which announced that medical doctors and doctors of osteopathic medicine may bill for orthotic and prosthetic devices, reminded these providers that they must follow all requirements as stated in Clinical Policy 5B, *Orthotics and Prosthetics,* which is online at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

Specifically, the modifiers required in the policy include NU (new equipment), which must be filed on all orthotic and prosthetic claims; and LT (left side) and RT (right side), which must be used when appropriate. Also, place of service 12, indicating that the device will be used in the recipient's home, must be used. Refer to the billing instructions in Attachment C for additional information.

Providers who have received denials for dates of service on or after July 1, 2007, should review the policy and then refile claims as new claims (not as adjustments).

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

Attention: Orthotic and Prosthetic Providers

Enrollment of Certified Fitters of Therapeutic Shoes

Medicaid has begun enrolling providers who are Certified Fitters of Therapeutic Shoes (CFts) as designated by the American Board for Certification in Orthotics and Prosthetics. Individuals with the CFts certification will be enrolled as attending providers and thus will need to be associated with an enrolled billing durable medical equipment provider.

CFts-certified individuals will be allowed to provide only the following HCPCS codes:

- A5500—for diabetics only, fitting (including follow-up custom preparation and supply of off-the-shelf depth-inlay shoe, manufactured to accommodate multi-density insert(s), per shoe
- A5512—for diabetics only, multiple density insert, direct formed, molded to foot after external heat source of 230 degrees Fahrenheit or higher, total contact with patient's foot, including arch, base layer minimum of ¼ inch material of shore a 35 durometer or 3/16 inch material of shore a 40 durometer (or higher), prefabricated, each

Please refer to Section 5.3.1 of Clinical Coverage Policy #5B, *Orthotics and Prosthetics* (available at www.ncdhhs.gov/dma/mp/mpindex.htm), for coverage details.

To enroll as a CFts, complete the Orthotic and Prosthetic provider enrollment packet (http://www.ncdhhs.gov/dma/provenroll.htm) and submit it to the Division of Medical Assistance.

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

Attention: Physicians, Nurse Midwives, Nurse Practitioners, Federally Qualified Health Centers and Rural Health Centers

Change in Reimbursement Rates for Injectable Immunization Administration Codes

Effective with date of service Jan. 1, 2007, the reimbursement rates for the following CPT codes were adjusted: 90465, 90466, 90471 and 90472. The definitions of these codes are as follows.

- **90465:** Immunization administration younger than 8 years of age (includes percutaneous, intradermal, subcutaneous or intramuscular injections) when the physician counsels the patient/family; first injection (single or combination vaccine/toxoid), per day
- **90466**: Each additional injection (single or combination vaccine/toxoid), per day (list separately in addition to code for primary procedure)
- **90471**: Immunization administration (includes percutaneous, intradermal, subcutaneous or intramuscular injections); one vaccine (single or combination vaccine/toxoid)
- **90472**: Each additional injection (single or combination vaccine/toxoid), per day (list separately in addition to code for primary procedure)

Private providers were notified previously that they would be able to bill for all of the additional vaccine administrations provided for one date of service for Health Check recipients aged 0 through 20 years as soon as the claims payment system was ready to accept claims. The system is ready. Providers may now submit claims for the additional units of 90472EP and 90466EP administration codes, as appropriate, for dates of service from Jan. 1, 2007, forward.

Providers who previously billed for multiple units and were paid for 1 unit under 90466EP or 90472EP should submit an adjustment request for payment consideration of additional units. Providers are encouraged to call EDS Provider Services, as needed, for detailed filing instructions.

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

Attention: Residential Treatment Providers

Announcing November Training Classes for Residential Treatment Cost Report

Direct-enrolled providers of residential treatment services for children (Levels II through IV) are required to submit cost reports to the Division of Medical Assistance (DMA) by **Jan. 31, 2008**. The cost report should cover a provider's most recently closed fiscal year for which financial statements are available.

Training in completing the cost reports will be offered at DMA the first week in November, as follows.

Location	Date	Time
Room 297 Kirby Building	Monday, Nov. 5	9 a.m. – noon
1985 Umstead Drive	Monday, Nov. 5	1 p.m. – 4 p.m.
Raleigh NC 27603	Thursday, Nov. 8	9 a.m. – noon

The cost report will be posted on the DMA Web site prior to the November training classes at the following link.

http://www.ncdhhs.gov/dma/costreports.html

Providers need attend only one session. These training dates and times are tentative based on provider response.

Please complete and submit the Registration Form or the Exemption Form, as applicable.

More information about the training:
http://www.ncdhhs.gov/dma/semreg/RT_training_nov07.htm

Rate Setting
DMA, 919-855-4200

Proposed Clinical Coverage Policies

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

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

The initial comment period for each proposed policy is 45 days. An additional 15-day comment period will follow if a proposed policy is revised as a result of the initial comment period.
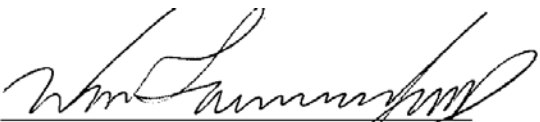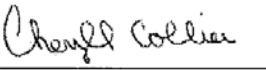
2007 Checkwrite Schedule

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

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

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

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

Cheryll Collier
Executive Director
EDS