October 2008 Medicaid Bulletin

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

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

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

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

Attention: All Providers

Automated Voice Response System Update

The Automated Voice Response (AVR) System now allows a provider to query by entering either a Medicaid Provider Number (MPN) or a National Provider Identifier (NPI). If an NPI is entered and the response is MPN-specific, such as claim status or prior approval information, the provider will have to choose the appropriate MPN from a list. If a provider has more than 15 MPNs associated with 1 NPI, the specific MPN related to the query may not be included. The provider must hang up, call again and query using the MPN. Providers can reach the AVR System by calling 1-800-723-4337.

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: HIV Case Management Providers

Recommended Taxonomy Code for HIV Case Management Providers

N.C. Medicaid strongly recommends the use of the taxonomy code **2084P0015X** for claims billed for HIV case management services. Taxonomy codes are used for claims processing only. Providers are not required to change the taxonomy code that was previously reported to NPPES or to DMA Provider Enrollment. Simply begin submitting the new taxonomy code on claims.

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: Nursing Facility Providers

Recommended Taxonomy Codes for Nursing Facility Head Level and Vent Level Services

N.C. Medicaid strongly recommends the use of the taxonomy codes **364SP0813X or 310500000X** for all claims billed for head-level nursing facility services and **2278S1500X** for vent-level nursing facility services. Taxonomy codes are used for claims processing only. Providers are not required to change the taxonomy code that was previously reported to NPPES or to DMA Provider Enrollment. Simply begin submitting the new taxonomy code on claims.

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

Implementation Delayed for the PASARR Segment of the Medicaid Uniform Screening Tool

It was previously announced that the PASARR segment of the Medicaid Uniform Screening Tool (MUST) would be implemented on September 12, 2008. DMA has decided to delay implementation of the PASARR segment of the screening tool to November 3, 2008, to ensure that the user community has a smooth transition to the new system.

Why Is DMA Delaying Implementation?

Numerous concerns have been expressed by the provider community regarding the MUST registration process. To address these concerns, a pre-registration period, which will precede the implementation date indicated above, will be offered. The focus of the pre-registration period will be to assist providers with completing the registration process. The dates of the pre-registration period will be announced on the MUST website at http://www.ncmust.com/ as well as by e-mail. Check the MUST website often for announcements.

What Can I Do To Prepare?

Providers should acclimate themselves to the registration process by reviewing the "Getting Started" page (http://www.ncmust.com/mustapp/gettingstarted.jsp) on the MUST website. This page will also list the date of the pre-registration period as well as detailed instructions on how to register your organization.

What If I Already Submitted My Organization Registration Form?

For those organizations that have already submitted the Confidentiality and Security Agreement, as well as the Organization Registration form, please be assured that those forms will be retained and will be processed on the pre-registration start date.

In order for these forms to be processed and approved, providers must complete the NCID registration process by assigning themselves to the USP Application Group. After completing this step, providers will also need to login and complete the user exam. Once both of these steps have been completed, registration can be approved. Please be sure to follow the instructions located on the Getting Started page at http://www.ncmust.com/mustapp/gettingstarted.jsp.

What If I Need Help?

Help and support is available from the MUST website. Contact information for both NCID registration assistance and MUST assistance can be found on the new "Help and Support" page (http://www.ncmust.com/Contacts/helpandsupport.jsp). The ability to provide Remote Assistance has also been added. Please be sure to read about it on the Help and Support page.

Training

Two additional half-day training sessions for the PASARR segment of the new N.C. Uniform Screening Program (USP) and the N.C. Medicaid Uniform Screening Tool have been scheduled for October 14, 2008, in Greensboro at the site listed below. The morning training session begins at 8:30 a.m. and ends at 12:00 noon. The afternoon session begins at 1:00 p.m. and ends at 4:30 p.m. Providers should arrive at least 30 minutes prior to each session to complete the registration process. Because meeting room temperatures vary, dressing in layers is strongly advised.

Pre-registration (using the online registration form at http://www.ncmust.com) is required. A valid e-mail address is required to send a confirmation notice to each registered participant.

Training materials are available from the MUST website at http://www.ncmust.com. **Please print the Provider Training Manual and bring it with you to the training.** Although an online training will also be available, attendance at a regional training session is strongly recommended.

Greensboro
October 14, 2008
Embassy Suites – Greensboro Airport
204 Centreport Dr.
Greensboro NC 27409
336-668-4535

Directions to the MUST Training Sessions

GREENSBORO
Embassy Suites – Greensboro Airport
Traveling North from Charlotte
Take I-85 North to I-40 West. Take Exit 210 (Airport exit). Turn right at the bottom of the exit onto Hwy 68 North. Go to the first stoplight. Turn left onto Triad Center Drive. The hotel driveway is immediately on the left.

Traveling East on I-40
Take I-40 East to Exit 210 (Airport exit). Turn left at the light onto Hwy 68 North. Go to second stoplight. Turn left onto Triad Center Drive. The hotel driveway is immediately on the left.

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

Attention: All Providers

Revised List of Diagnosis Codes That Are Not Subject to the Annual Visit Limitation

The list of ICD-9-CM diagnosis codes that are not subject to the annual visit limitation has been revised. Refer to DMA's website at http://www.ncdhhs.gov/dma/AnnualVisitLimit.htm for a copy of the list.

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

Attention: All Providers

Influenza Vaccine and Reimbursement Guidelines for 2008/09

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 2008/09 flu season can be found in the July 17, 2008, *Morbidity and Mortality Weekly Report* (MMWR) at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr57e717a1.htm?s_cid=rr57e717a1_e. Additional information regarding the 2008/09 flu season can be found at http://www.cdc.gov/flu/.

The 2008 recommendations include four principal changes or updates:

- Beginning with the 2008/09 influenza season, annual vaccination of all children ages 5 through 18 years is recommended. Annual vaccination of all children ages 5 through 18 years should begin in September or as soon as vaccine is available for the 2008/09 influenza season, if feasible. Annual vaccination of all children ages 5 through 18 years should begin no later than during the 2009/10 influenza season.
- Annual vaccination should continue for all children ages 6 months through 4 years (59 months) and for older children with conditions that place them at increased risk for complications from influenza. Children and adolescents at high risk for influenza complications should continue to be a focus of vaccination efforts as providers and programs transition to routinely vaccinating all children.
- Either trivalent inactivated influenza vaccine (TIV) or live, attenuated influenza vaccine (LAIV) can be used when vaccinating healthy persons ages 2 through 49 years. Children ages 6 months through 8 years should receive 2 doses of vaccine if they have not been vaccinated previously at any time with either LAIV or TIV (doses separated by 4 weeks or more); 2 doses are required for protection in these children. Children ages 6 months through 8 years who received only 1 dose in their first year of vaccination should receive 2 doses the following year. LAIV should not be administered to children under 5 years of age with possible reactive airways disease, such as those who have had recurrent wheezing or a recent wheezing episode. Children with possible reactive airways disease, persons at higher risk for influenza complications because of underlying medical conditions, children ages 6 through 23 months, and persons older than 49 years should receive TIV.
- The 2008/09 trivalent vaccine virus strains are A/Brisbane/59/2007 (H1N1)-like, A/Brisbane/10/2007 (H3N2)-like, and B/Florida/4/2006-like antigens.

N.C. Universal Childhood Vaccine Distribution Program/Vaccine for Children (UCVDP/VFC)

The N.C. 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:

- All children 6 months through 59 months of age, regardless of their insurance status
- Children ages 5 through 18 years who
  - ♦ are VFC eligible (Medicaid-eligible, uninsured, underinsured, Native American, and Alaskan Native); or
  - ♦ are at high risk for influenza-related complications, as identified in the ACIP, regardless of their insurance status; or
  - ♦ are a household contact of (live with)
    - o any child ages 0 through 59 months or
    - o any child or adult at high risk for influenza-related complications

For the 2008/09 influenza season, these criteria effectively make all Medicaid children 6 months through 18 years of age eligible for state-supplied vaccine.

Please note that children 6 months through 8 years of age who have not received influenza vaccine in previous years, or who received only one dose in their first year of vaccination, should receive two doses, 30 days apart. The recommended dosage for children 6 months through 35 months of age is 0.25 ml per dose. The recommended dosage for children 3 years of age or older is 0.5 ml per dose.

Billing/Reporting Influenza Vaccines

The following tables indicate the vaccine codes that can be either 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 in the April 2008 Special Bulletin, *Health Check Billing Guide 2008*, on pages 20 through 32 (http://www.ncdhhs.gov/dma/healthcheck.htm).

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) **Note:** Providers may bill more than one unit of 90466EP as appropriate.
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.

Administration CPT Code(s) to Bill	CPT Code Description
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). **Note:** Providers may bill more than one unit of 90472EP as appropriate.
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.

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

Use the following codes to **bill** Medicaid for an influenza vaccine **purchased** and administered to recipients **19 through 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)

Table 3: Influenza Billing Codes for Recipients 21 Years of Age and Older

Use the following codes to **bill** Medicaid for an influenza vaccine **purchased** and administered to recipients **21 years of age and older.**

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 of age or 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.

Note: For federally qualified health centers and rural health clinics, influenza is one of the four vaccines that may be billed to Medicaid for recipients 21 years of age and older. The cost of the vaccine and the administration code should be included on the cost report.

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

Attention: All Providers

Clinical Coverage Policies

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

1A-15, Surgery for Clinically Severe Obesity
1-O-1, Reconstructive and Cosmetic Surgery
1-O-3, Rhinoplasty and/or Septoplasty
5A, Durable Medical Equipment

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

National Drug Code and the UD Modifier

The Deficit Reduction Act of 2005 (DRA) includes provisions regarding state collection and submission of data for the purpose of collecting Medicaid drug rebates from manufacturers for all Professional and Institutional claims. The DRA 2005 does not exclude 340B drugs; therefore, all providers must also meet these requirements.

Effective with **date of processing November 21, 2008**, the N.C. Medicaid Program will implement the use of the UD modifier for claims with dates of service on or after December 28, 2007. In order for providers to identify 340B drugs that have been dispensed, the UD modifier must be utilized on the claim detail. This will allow N.C. Medicaid to identify primary and secondary claim details that are for 340B drugs and exclude these claim details from the rebate collection process. The UD modifier should be used on the CMS-1500/837P and the UB-04/837I claim forms, with the applicable HCPCS Level II procedure code and National Drug Code (NDC) with NDC units used to properly identify 340B drugs. The UD modifier should be used only in this circumstance.

All non-340B drugs should be billed without the UD modifier using the applicable HCPCS and NDC pair with the NDC units. When billing for compounds or mixtures, list 340B drugs in a separate detail from the non-340B drugs in the same compound/mixture.

Below are paper claim examples showing the location of the UD modifier. For information related to 837 transactions please refer to the X12 Implementation Guides (http://www.wpc-edi.com/hipaa/hipaa_40.asp) and N.C. Medicaid Companion Guides (http://www.ncdhhs.gov/dma/hipaa/compguides.htm).

Claim Examples and the UD Modifier

Professional paper claim example with UD modifier:

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	N400009737604 ML1										1D	890XXXX
	01 01 08	01 01 08	11		J1055	UD		50.00	1	N	NPI	0123456789
2											NPI	

Institutional paper claim example with UD modifier:

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48
1	250	N400517234010ML0.05	J1756 UD	021608	1	6.88	
2							
3							
4							
5							
6							
7							

For additional information, refer to the October 2008 Special Bulletin, *National Drug Code Implementation, Phase III*, on DMA's website at http://www.ncdhhs.gov/dma/bulletinspecial.htm and also to the November 2007 NDC Seminar presentation at http://www.ncdhhs.gov/dma/services/physiciandrug.html.

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

Attention: All Providers

New Enhanced Specialty Discount on Single-source Specialty Drugs

Effective with date of service October 10, 2008, the N.C. Medicaid Outpatient Pharmacy Program will utilize a State-determined upper payment limit for select single-source specialty drugs that cost in excess of $1,500 per month. This is in compliance with a N.C. General Assembly mandate in Session Law 2008-107, Section 10.10(e). Specialty drugs in the following therapy categories will be affected:

- Anemia/neutropenia
- Anticoagulants
- Enzyme replacement
- Growth hormones
- Hemophilia
- Hepatitis
- HIV
- Hyperparathyroidism
- Immune deficiency
- Immune globulins
- Immunosuppressives
- Multiple sclerosis
- Oncology
- Osteoporosis
- Psoriasis
- Pulmonary
- Rheumatoid arthritis
- Other miscellaneous

The list of specialty drugs that are affected by this upper payment limit will be updated on a quarterly basis. This list will be available on DMA's website at http://www.ncdhhs.gov/dma/pharmacy.htm.

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

Attention: All Providers

Cytogenetic Studies

DMA is currently making changes for coverage of cytogenetic studies. The proposed policy, which has been reviewed by the N.C. Physician Advisory Group (NCPAG), will be available for comment on DMA's website at http://www.ncdhhs.gov/dma/mp/proposedmp.htm.

Providers will be notified in a future general Medicaid Bulletin when the policy is finalized.

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

Attention: All Providers

New Medicaid Eligibility Group: Health Coverage for Workers with Disabilities

Effective November 1, 2008, the N.C. Medicaid Program will begin offering Medicaid coverage to working individuals with disabilities. Health Coverage for Workers with Disabilities (HCWD) will allow individuals with disabilities to work or increase their hours of work and protect their Medicaid eligibility through higher income and resource limits and a less-restrictive disability determination.

Effective November 1, 2008, the income limit will be 150 percent of the federal poverty level (FPL), currently $1,300 per month for a one-person household. Effective May 1, 2009, the limit will increase to 200 percent of the FPL, currently $1,734 per month for one person.

HCWD recipients will receive a blue Medicaid card and the same benefits as Medicaid recipients with full benefit coverage.

Individuals who think they may qualify are encouraged to apply at their county department of social services.

Medicaid Eligibility Unit
DMA, 919-855-4000

Attention: All Providers

New Prior Authorization Program for Qualaquin

On November 3, 2008, the N.C. Medicaid Outpatient Pharmacy Program will require prior authorization (PA) on the antimalarial drug Qualaquin. Coverage will be provided when the drug is used for the treatment of malaria.

Prescribers can request PA by contacting ACS at 866-246-8505 (telephone) or 866-246-8507 (fax). The criteria and PA request form for this medication will be available on the N.C. Medicaid Enhanced Pharmacy Program website at http://www.ncmedicaidpbm.com.

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

Attention: All Providers

Prior Authorization Criteria for Botulinum Toxin Types A and B

On November 3, 2008, the N.C. Medicaid Outpatient Pharmacy Program will add the following indications to the prior authorization (PA) criteria for coverage of botulinum toxin Type A (Botox):

- Sialorrhea
- Schilder's disease
- Quadriplegia

The following indication will be added to the PA criteria for coverage of botulinum toxin Type B (Myobloc):

- Sialorrhea

Prescribers can request PA by contacting ACS at 866-246-8505 (telephone) or 866-246-8507 (fax). The updated criteria and PA request form for this medication will be available on the N.C. Medicaid Enhanced Pharmacy Program website at http://www.ncmedicaidpbm.com.

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

Attention: All Providers

Registration for Basic Medicaid Seminars

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

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

Because of limited seating, registration is limited to two staff members per office. Pre-registration is required. Unregistered providers are welcome to attend if space is available. Providers may register for the seminars by completing and submitting the registration form online at http://www.ncdhhs.gov/dma/prov.htm. Providers may also complete the Seminar Registration Form on the following page and fax it to the number listed on the form. Please indicate on the registration form the session that you plan to attend.

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

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

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

Directions to the Basic Medicaid Seminars

MORGANTON

Western Piedmont Community College

Traveling West on I-40

From Hickory, take Exit 103 and turn right onto Burkemont Avenue (US 64). Western Piedmont Community College is on the right.

Traveling East on I-40

From Asheville, take Exit 103 and turn left onto Burkemont Avenue (US 64). Cross the bridge over I-40. Western Piedmont Community College is on the right.

Traveling on NC 18 from Lenoir

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

Traveling on NC 64 from Rutherfordton

Driving into Morganton, cross over I-40. Western Piedmont Community College is on the right, one block beyond I-40.

WILLIAMSTON

Martin Community College

Traveling East on US 64

Take US 64 West to the intersection at McDonald's in Williamston. Turn left on the US 13/US 17 Bypass. The name will change to Old Highway 64 Bypass. Continue approximately 2.3 miles and turn left on Kehukee Park Road. The college is located on the right approximately 0.5 miles from the intersection.

Traveling West on US 64

Take US 64 East to exit 512 (Prison Camp Road). (Look for the sign just before exit 512 for Senator Bob Martin Agricultural Center and Martin Community College.) Turn right on Prison Camp Road. Drive for approximately 0.5 miles and turn left on Kehukee Park Road. The college is located on the right approximately 0.5 miles from the intersection.

Traveling North on US 13/US 17

Take US 13/US 17 South to Williamston. Continue to follow US 13/US 17 until it becomes Old Highway 64 Bypass. Continue driving for approximately 2.5 miles. Turn left on Kehukee Park Road. The college is located on the right approximately 0.5 miles from the intersection.

RALEIGH

Wake Technical Community College

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

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

Basic Medicaid Workshops
October 2008 Seminar Registration Form
(No Fee)

Provider Name _____

Medicaid Provider Number _____ NPI Number _____

Mailing Address _____

City, Zip Code _____ County _____

Contact Person _____ E-mail _____

Telephone Number (____) _____ Fax Number _____

1 or **2** person(s) will attend the seminar at _____ on _____
(circle one) (location) (date)

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

Attention: All Providers

Registration for Independent Practitioner Program Seminars

Independent Practitioner Program seminars are scheduled for November 2008. Registration information, a list of dates, and site locations for the seminars are listed below.

The seminars in Hickory and Wilmington will begin at 9:00 a.m. and will end at 12:00 noon. Providers are encouraged to arrive by 8:45 a.m. to complete registration. The seminar in Raleigh will begin at 1:00 p.m. and will end at 3:00 p.m. Providers are encouraged to arrive by 12:45 p.m. to complete registration. Lunch will not be provided at the seminars. **Because meeting room temperatures vary, dressing in layers is strongly advised.**

Because of limited seating, registration is limited to two staff members per office. Pre-registration is required. Unregistered providers are welcome to attend if space is available. Providers may register for the seminars by completing and submitting the registration form online at http://www.ncdhhs.gov/dma/prov.htm under "Announcements." Providers may also complete the Seminar Registration Form on the following page and fax it to the number listed on the form. Please indicate on the registration form the session you plan to attend.

The October 2008 Special Bulletin, *Independent Practitioner Services*, will be used as the primary training document for the seminar. Please print the Special Bulletin and bring it to the seminar. The October 2008 Special Bulletin, *Independent Practitioner Services*, is available on DMA's website at http://www.ncdhhs.gov/dma/bulletinspecial.htm.

Raleigh	**Hickory**	**Wilmington**
November 4, 2008	**November 18, 2008**	**November 20, 2008**
1:00 p.m. to 3:00 p.m.	9:00 a.m. to 12:00 noon	9:00 a.m. to 12:00 noon
Wake Technical Community College	Lenoir-Rhyne University	Coastline Convention Center
9101 Fayetteville Rd.	Belk Centrum	501 Nutt St.
Raleigh NC 27603	625 7th Avenue NE	Wilmington NC 28403
919-866-5500	Hickory NC 28601	910-763-2800
	828-328-1741	

Directions to the Independent Practitioner Seminars

RALEIGH

Wake Technical Community College

Take I-440 to US 401 South/S. Saunders Street (exit 298). Stay to the right to continue on US 401 South/Fayetteville Road. Continue to travel on US 401 South/Fayetteville Street through Fuquay-Varina. The college is located on the left approximately 1 mile from the intersection with NC 1010. Turn left onto Chandler Ridge Circle. Visitor parking is on the left.

HICKORY

Lenoir-Rhyne University

Traveling on I-40

Take Exit 125 (Lenoir-Rhyne University). Turn north onto Lenoir-Rhyne Boulevard. Pass the Tripps and Rock-ola restaurants and go through three lights. At the fourth stoplight turn left onto Tate Boulevard. At the next stoplight, turn right onto US 127 North. At the fourth stoplight turn right. Go 0.4 mile and turn left onto Stasivich Place. Immediately turn right into the parking lot. Visitor parking is directly across the street from the admissions building in reserved parking spaces.

WILMINGTON

Coastline Convention Center

Traveling East on I-40

Take I-40 East toward Wilmington. As you approach Wilmington, look for the sign for MLK Parkway/NC 74 West/Downtown. Turn right onto MLK Parkway. Continue on this route toward downtown Wilmington. The road becomes Third Street. Follow Third Street for five blocks until you reach Red Cross Street. Turn right onto Red Cross Street and continue for two blocks. Turn right onto Nutt Street. The entrance to the Coastline Convention Center is the second driveway on the left.

Traveling South on US 17

As you approach Wilmington, US 17 becomes Market Street. Continue on Market Street until you see the sign for MLK Parkway/NC 74 West/Downtown. Take NC 74 West (MLK Parkway) toward downtown Wilmington (approximately 4 miles). Turn right onto Red Cross Street and continue for two blocks. Turn right onto Nutt Street. The entrance to the Coastline Convention Center is the second driveway on the left.

Traveling North on US 17 or NC 74/76

After crossing the Cape Fear Memorial Bridge into Wilmington, turn left at the first stoplight onto Third Street. Turn left onto Red Cross Street. At the bottom of the hill (approximately 3 blocks), turn right onto Nutt Street. The entrance to the Coastline Convention Center is the second driveway on the left.

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

Independent Practitioners Seminars
November 2008 Seminar Registration Form
(No Fee)

Provider Name _____

Medicaid Provider Number _____ NPI Number _____

Mailing Address _____

City, Zip Code _____ County _____

Contact Person _____ E-mail _____

Telephone Number (____) _____ Fax Number _____

1 or **2** person(s) will attend the seminar at _____ on _____
(circle one) (location) (date)

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

Attention: All Providers

Updated EOB Code Crosswalk to HIPAA Standard Codes

The list of standard national codes used on the Electronic Remittance Advice (ERA) has been cross-walked to EOB codes as an informational aid to adjudicated claims listed on the Remittance and Status Report (RA). An updated version of the list is available on DMA's website at http://www.ncdhhs.gov/dma/hipaa.htm.

With the implementation of standards for electronic transactions mandated by HIPAA, providers now have the option to receive an ERA in addition to the paper version of the RA.

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

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

Attention: Durable Medical Equipment Providers

Correction to Quantity Limitations for HCPCS Code B4088

Effective with date of service January 1, 2008, changes were made to Clinical Coverage Policy 5A, *Durable Medical Equipment*, to reflect the correction of the quantity limitations for HCPCS code B4088 (gastrostomy/jejunostomy tube) from **2 per month** to **4 per year**. This change was made to correct a typographical error; it does not reflect a change in actual coverage. Please refer to Attachment E in the policy (available on DMA's website at http://www.ncdhhs.gov/dma/mp/mpindex.htm) for more details.

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

Attention: Durable Medical Equipment Providers

Coverage Ending for Ramps, Tie Downs, Car Seats, and Vests

Effective with date of request September 1, 2008, Children's Special Health Services no longer authorizes payment for ramps, tie downs, car seats, and vests.

These items are not included in the durable medical equipment covered by Medicaid, nor are they covered under Early Periodic Screening, Diagnostic, and Treatment services, which cover medical equipment and supplies suitable for use in the home for Medicaid recipients under the age of 21. However, if the recipient is covered under a Medicaid waiver, these items may be considered.

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

Attention: Hospitals

Implementation of Diagnostic Related Groups: Grouper 25

DMA has submitted a State Plan Amendment (SPA) to CMS for purposes of implementing the Diagnostic Related Groups (DRG) Grouper 25. At this time, SPA approval has not been received from CMS. Therefore, DMA will not be able to implement the new grouper on October 1, 2008. Additionally, new provider rates that were to be effective October 1, 2008, will also be delayed until such time as the SPA is approved. Until CMS approval is received, hospital inpatient claims for dates of service on or after October 1, 2008, will continue to be paid using the current grouper version and hospital specific rates.

Hospital providers can expect a future status update in upcoming general Medicaid Bulletins. The North Carolina Hospital Association will be receiving periodic updates on the approval and implementation status.

This year's DRG Grouper implementation represents significant changes in DRG descriptions as well as the addition of 286 new DRGs. Specifically, earlier versions of the DRG did not include delineation of care to premature neonates and other newborns, which required special State DRG designation. The current DRG Grouper 25 now includes the relevant delineation of care for this population, and special State designation is no longer required. Other changes with this implementation include assignment of new psychiatric inpatient and rehabilitation service codes as well as the new list of 25 transfer DRGs.

The following chart highlights the significant changes mentioned above.

	Grouper Version 24	**Grouper Version 25**
Neonates/Newborns	385, 801, 802, 803, 804, 805, 810, 389, 390, and 391	790, 791, 792, 793, 794, and 795
Psychiatric Inpatient	424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 521, 522, and 523	876, 880, 881, 882, 883, 884, 885, 886, 887, 894, 895, 896, and 897
Transfers	14, 113, 209, 210, 211, 236, 263, 264, 429, and 483	28, 29, 30,40, 41, 42, 219, 220, 221, 447, 478, 479, 480, 481, 482, 492, 493, 494, 500, 501, 502, 515, 516, 517, and 956
Rehabilitation	462	945 and 946

Please note that "Present on Admission (POA)" editing will not be incorporated with this system upgrade. The presence of POA information on a claim will not impact claim adjudication until DRG Grouper Version 26 is implemented next year.

Claims adjudicated after October 1, 2008, under DRG Grouper 24 will automatically be reprocessed once DRG Grouper 25 is implemented. Providers should not resubmit their claims.

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

Attention: Local Management Entities and Outpatient Behavioral Health Service Providers Employed in a Physicians Office/Clinic, Outpatient Hospital Clinics, Local Health Departments, or School-based Health Centers

Modification in Supervision When Practicing "Incident To" a Physician

Effective with dates of service July 1, 2008, the guidance for behavioral health practitioners supervised by a physician has been modified for services provided to a recipient with **Medicaid only.** The physician does not have to be present in the office where the practitioner is providing the service. However, the physician must be readily accessible by phone or pager and able to return to the office if the recipient's condition requires it.

Practitioners must continue to follow these guidelines for services provided "Incident To" the physician:

1. The physician has initially seen the patient.
2. The physician must be able to provide evidence of management of the patient's care.
3. The physician employs the practitioner or the practitioner is employed by the same entity that employs the physician.

When services are provided to a **dually eligible Medicare/Medicaid recipient,** the physician must provide direct supervision. Direct supervision is defined as follows:

1. The physician has initially seen the patient.
2. The physician should be present in the office where the practitioner is providing the service and immediately accessible in the event of an emergency.
3. The physician must be able to provide evidence of management of the patient's care.

Please refer to the May 2005 Special Bulletin, *Expansion of Provider Types for Outpatient Behavioral Health Services Phase II*, on DMA's website at http://www.ncdhhs.gov/dma/bulletinspecial.htm for additional information.

Behavioral Health Services
DMA, 919-855-4290

Attention: Nurse Practitioners and Physicians

Hemin, 1 mg (Panhematin, HCPCS Procedure Code J1640) – Billing Guidelines

Effective with date of service January 1, 2008, the N.C. Medicaid Program covers hemin (Panhematin) when billed with HCPCS procedure code J1640. Panhematin is indicated for the treatment of recurrent attacks of acute intermittent porphyria (AIP), a rare genetic disorder.

Panhematin should be used only after an appropriate period of alternate therapy (carbohydrate loading) has been tried. It is intended to prevent porphyria attacks from becoming critical; it is not intended to repair neuronal damage resulting from attacks.

Panhematin should be administered under the supervision of a physician experienced in the management of porphyrias. Panhematin is administered as an intravenous infusion containing a dose of 1 to 4 mg/kg/day of hematin over a period of 10 to 15 minutes for 3 to 14 days, based on clinical signs. In more severe cases, this dose may be repeated no earlier than every 12 hours. No more than 6 mg/kg in any 24-hour period should be given. Safety and effectiveness for use in children younger than 16 years of age has not been established.

For Medicaid Billing

- The ICD-9-CM diagnosis code required for billing Panhematin is **277.1** (disorders of porphyrin metabolism, including hematoporphyria; hematoporphyrinuria; hereditary coproporphyria; porphyria; porphyrinuria; protocoproporphyria; protoporphyria; and pyrroloporphyria).
- Bill Panhematin using HCPCS procedure code J1640.
- One Medicaid unit of coverage is 1 mg. The National Drug Code (NDC) units must be indicated on the claim. When calculating the NDC units, the drug in its original state must be considered, **NOT** the reconstituted amount.

  Refer to the October 2008 Special Bulletin, *National Drug Code Implementation, Phase III* (http://www.ncdhhs.gov/dma/bulletinspecial.htm), for instructions.
- Providers must indicate the number of HCPCS units used in block 24G on the CMS-1500 claim form.
- The maximum reimbursement rate per unit is $7.31. Providers must bill their usual and customary charges.

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

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

Attention: Nurse Practitioners and Physicians

Oxaliplatin (Eloxatin, HCPCS Procedure Code J9263) – Additional Diagnosis Codes

The N.C. Medicaid Program covers oxaliplatin (Eloxatin) for the treatment of patients with metastatic carcinoma of the colon or rectum whose disease has recurred or progressed during, or within six months of, completion of first-line therapy with the combination regimen of 5-fluorouracil, leucovorin, and irinotecan.

DMA is changing the coverage of Eloxatin to include malignant neoplasm of the pancreas, effective with date of service December 1, 2007.

For Medicaid Billing

The ICD-9-CM diagnosis codes required for billing Eloxatin are

- V58.11 (encounter for antineoplastic chemotherapy)

  AND

- one of the following:
  - 153 through 153.9; 154.0 (malignant neoplasm of rectosigmoid junction)

    OR
  - 154.1 (malignant neoplasm of rectum)

    OR
  - 154.8 (malignant neoplasm of other sites of rectum, rectosigmoid junction and anus)

    OR
  - 157.0 through 157.9 (malignant neoplasm of pancreas)

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

Providers who received claim detail denials related to the diagnosis of malignant neoplasm of the pancreas for dates of service December 1, 2007, and after, may resubmit the denied charges as a new claim (not as an adjustment request) for processing.

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

Attention: Enhanced Mental Health Service Providers and Local Management Entities

Revised Effective Date for Enhanced Services Rate Changes

The effective date for the following rate decreases that were published in the September 2008 general Medicaid bulletin has been changed from October 1, 2008, to January 1, 2009.

Service Code	Service Description	Service Unit	Current Rate	New Rate
H0020	Opioid Treatment	per event	$ 19.17	$ 18.74
H0040	Assertive Community Treatment Team	per event	323.98	301.35
S9484	Professional Treatment Svcs in Facility Based Crisis	per hour	18.78	17.99

The effective date for the following rate increases remains October 1, 2008.

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

Fee schedules are available on DMA's website at http://www.ncdhhs.gov/dma/fee/mhfee.htm. Providers must always bill their usual and customary charges.

Rate Setting
DMA, 919-855-4200

Attention: Outpatient Behavioral Health Service Providers

Medicaid Reimbursement for the Psychiatric Reduction

DMA hereby provides notification of its amendment to the Medicaid State Plan. The change will provide reimbursement to cover the allowable portion of the Medicare payment reduction for outpatient psychiatric crossover claims for dually-eligible recipients of Medicare and Medicaid, up to 95 percent of the Medicare rate. This change is subject to existing eligibility restrictions.

This amendment will be implemented with an effective date of April 1, 2008. The implementation is subject to necessary system modifications. Please refer to future general Medicaid Bulletins for an implementation date. Providers should continue to file claims utilizing the current guidelines.

Rate Setting
DMA, 919-855-4200

Attention: Certified Nurse Midwives, Hospitals, Nurse Practitioners, and Physicians

Claims Denials Related to Fetal Nuchal Translucency Measurement

CPT procedure code 76813 (ultrasound, pregnant uterus, real time image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation) is covered by N.C. Medicaid effective with date of service January 1, 2007.

Systems issues occurred that may have caused some claims billed with CPT procedure codes 76801, 76805, 76811, or 76815 to be denied when they were billed on the same date of service as CPT procedure code 76813. Changes have been made to the claims payment system to correct the problem. Claims that were denied with EOB 0613 (OB ultrasound allowed once per day, same provider) that have not exceeded the timely filing limit may be refiled as a new claim (not as an adjustment request) for processing.

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

Attention: Professional (CMS-1500/837P) Billers

National Drug Code Required on Professional Crossover Claims

The Deficit Reduction Act of 2005 (DRA) includes provisions regarding state collection and submission of data for the purpose of collecting Medicaid drug rebates from manufacturers for all Professional and Institutional claim forms.

Effective with **date of processing November 21, 2008**, for claims with dates of service on or after December 28, 2007, the N.C. Medicaid Program will require providers to list the 11-digit National Drug Code (NDC) with NDC units in addition to the HCPCS codes and units on all professional claims that cross over from Medicare or are submitted directly to Medicaid by providers for all drugs administered by providers in offices, clinics, or outpatient facilities for dually eligible recipients. Claims will continue to be adjudicated in the same manner as before this requirement.

For additional information, providers may refer to the October 2008 Special Bulletin, *National Drug Code Implementation, Phase III,* on DMA's website at http://www.ncdhhs.gov/dma/bulletinspecial.htm and also to the November 2007 NDC Seminar presentation at http://www.ncdhhs.gov/dma/services/physiciandrug.html.

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

Attention: Home Health Agencies

Revenue Code Changes for Skilled Nursing Visits

Effective with date of service October 1, 2008, the revenue codes used to bill Medicaid for reimbursement of home health skilled nursing visits have been revised. The change in coding is being made to provide a more adequate description of the service provided and to comply with CMS guidelines concerning the use of national code descriptions.

- The number of choices for visit codes has been decreased to facilitate accuracy in billing. The choice of code should be based on the intent of the visit.
- There are no changes in program requirements for skilled nursing visits and there are no added visit codes included in this change.
- Revenue Code 590 (not otherwise classified) will no longer be available for billing skilled nursing visits after date of service September 30, 2008. Use of this code after this service date will result in a denial.

The revisions are listed in the charts below.

Revised Code List

Coding Description and Usage Effective October 1, 2008		
Revenue Code	**Visit Description/Use**	**CMS Description**
550	Initial assessment/reassessment Initial assessment of a new patient or 60-day re-assessment	SN HOME HEALTH
551	Treatment, teaching/training, observation/evaluation	SN VISIT
559	For a dually eligible recipient when the visit does not meet Medicare criteria: ex. not home bound	SN/OTHER
580	Venipuncture	HH-OTH VIS
581	Pre-filling insulin syringes/ Medi-Planners	HH-OTH VIS/VISIT
589	Supply only visit. No other skilled service provided.	HH-OTH VIS/OTHER
Note: Revenue Code 590 will be invalid for billing effective with date of service October 1, 2008. Use applicable nursing visit code based on reason for visit.		

Current Coding Description and Usage With Crosswalk to Revised Codes

Codes Effective Until October 1, 2008			Codes to Be Used Beginning October 1, 2008	
Revenue Code	**Visit Description/Use**	**CMS Description**	**Revenue Code**	**CMS Description**
550	Observ/eval of stable pt.	SN HOME HEALTH	551	SN VISIT
551	Pre-filling insulin syringes	SN VISIT	581	HH-OTH VIS/VISIT
559	Pre-filling Medi-Planners	SN/OTHER	581	HH-OTH VIS/VISIT
580	Venipuncture	HH-OTH VIS	580	HH-OTH VIS
581	Denied by Medicare for dually eligible	HH-OTH VIS/VISIT	559	SN/OTHER
589	Visit meeting Medicare criteria	HH-OTH VIS/OTHER	559	SN/OTHER
590	Not otherwise classified	HH SVCS/UNIT	551	SN VISIT (or applicable code based on reason for visit)

The information in this article supersedes Attachment C of Clinical Coverage Policy 3A, *Home Health Services.* Providers will be notified when the policy has been updated to reflect this change.

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

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

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

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

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

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

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

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

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

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

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

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

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

Proposed Clinical Coverage Policies

In accordance with NCGS §108A-54.2, proposed new or amended Medicaid clinical coverage policies are available for review and comment on DMA's website at http://www.ncdhhs.gov/dma/mp/proposedmp.htm. To submit a comment related to a policy, refer to the instructions on the website. Providers without Internet access can submit written comments to the address listed below.

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

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

2008 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
October	10/02/08	10/07/08
	10/09/08	10/14/08
	10/16/08	10/21/08
	10/23/08	10/30/08
November	10/30/08	11/04/08
	11/06/08	11/13/08
	11/13/08	11/20/08

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

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

Melissa Robinson
Executive Director
EDS, an HP Company