# October 2009 Medicaid Bulletin

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## *Attention: All Providers*

# *Electronic Claim Submission EOB Code*

Effective with date of processing October 2, 2009, the N.C. Medicaid Program will require all providers to file claims electronically. Claims received on or after October 2, 2009, are subject to denial if the claim is not in compliance with the electronic claim mandate. Information on the electronic claim mandate, originally published in the July 2009 Medicaid Bulletin, is available on DMA's budget initiatives web page at http://www.ncdhhs.gov/dma/provider/budgetinitiatives.htm.

Prior to submitting electronic claims, providers must have an Electronic Claim Submission (ECS) Agreement on file with N.C. Medicaid. If an ECS Agreement is not on file, providers may obtain the form on the NC Tracks website at http://www.nctracks.nc.gov/provider/forms/.

To prepare for the electronic claim submission requirement, providers should familiarize themselves with the following EOB code.

EOB 8700 – Per legislative mandate this Medicaid claim must be filed electronically for adjudication.

**If a paper claim is submitted and is not included on the list of ECS exceptions, the claim will be denied.** The list of exceptions (see page 5) to the requirement for electronic claim submissions has been revised and is available on DMA's website at http://www.ncdhhs.gov/dma/provider/ECSExceptions.htm. Only claims that comply with these exceptions may be submitted on paper. All other claims are required to be submitted electronically.

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

## *Attention: All Providers*

# *Updated EOB Code Crosswalk to HIPAA Standard Codes*

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

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 crosswalk is current as of the date of publication. Providers will be notified of changes to the crosswalk through future general Medicaid bulletins.

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

## *Attention: All Providers*

# *Electronic Funds Transfer*

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

Providers who are currently receiving paper checks for claims payment must complete and submit an EFT Authorization Agreement for Automatic Deposits (http://www.ncdhhs.gov/dma/provider/forms.htm) immediately to ensure that there is no disruption to payments.

**Pharmacy** claims submitted via point of sale on or after September 11, 2009, without an EFT Authorization Agreement on file and processed by the N.C. Medicaid Program will be denied. For all **other providers,** claims submitted after 5:00 p.m. on September 10, 2009, will suspend if an EFT Authorization Agreement for Automatic Deposit has not been submitted to and processed by the N.C. Medicaid Program.

Below are fax numbers available for providers to send EFT Authorization Agreements to EDS:

- 919-816-3186
- 919-816-3181
- 919-816-4399

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

## *Attention: All Providers*

# *Paper Claim Submissions*

If a claim meets one of the exceptions to the electronic claims submission requirement (see page 5), providers should submit the original claim and not a carbon copy or photocopy of the claim. Because paper claims are manually keyed into the system, submitting the original will decrease the number of denials that providers receive due to keying errors.

When completing the paper claim form, use **black ink only.** Do not submit carbon copies or photocopies. EDS uses optical scanning technology to store an electronic image of the claim and the scanners cannot detect carbon copies, photocopies, highlighted data or any color of ink other than black. For auditing purposes, all claim information must be visible in an archive copy. Carbon copies, photocopies, and claims containing a color of ink other than black will not be processed and will be returned to the provider.

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

## *Attention: All Providers*

# *Notice of Legislative Mandate for PASARR*

The House and Senate voted and approved a $19 billion state budget. With the budget passed, the N.C. Legislature will mandate the use of electronic transactions by all providers who are required to conduct a Preadmission Screening and Annual Resident Review (PASARR).

### Who Will this Affect?

This mandate will affect all those providers who are currently submitting PASARR requests and Tracking forms by fax, regular mail or phone. Beginning on December 1, 2009, all providers will be required to submit PASARR screenings or Tracking forms through the Department's web-based tool or through a third-party vendor with interface capabilities into the State's web-based tool.

### What is the Effective Date?

The effective date of the bill is September 1, 2009; however, DMA will continue to accept fax transmissions for up to 90 days as providers transition to the web-based tool. Effective December 1, 2009, all providers will be required to submit PASARR screenings and Tracking forms through the Department's web-based tool or through a third-party vendor with interface capabilities into the State's web-based tool.

The North Carolina Health Care Facilities and Hospital Associations have worked with EDS and DMA to ease the facilitation of compliance with this mandate. The PASARR form that is available by virtue of DMA's contract with EDS has been reduced to required information, is equipped with user-friendly auto population of information, and has easy to use default mechanisms. The Associations believe that the time required to complete the automated form will be minimal.

**Note:** Organizations currently submitting PASARR screenings and Tracking forms through Provider Links Online Application can continue to use this method.

Also, on November 1, 2009, DMA and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services will no longer require an annual review for PASARR level II recipients. Nursing facilities are still responsible for referring recipients with condition changes for a re-screening of a level I PASARR and if needed a Level II evaluation as per policy.

**For more information, please visit http://www.ncmust.com or call the NC PASARR team at 1-800-688-6696 or 919-851-8888, choose option 7.**

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

## *Attention: All Providers*

# *List of Exceptions for Electronic Claim Submission*

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

- Medicare HMO (Part C) primary claims
- Medicare Part A inpatient claims submitted directly to Medicaid
- Nursing home crossovers submitted directly to Medicaid
- Services that require an invoice to be submitted with the claim including, but not limited to
  - Hearing aids and related items
  - Some visual aids
  - Unclassified and unlisted procedures
  - Undelivered dentures
  - Radiopharmaceuticals
  - Compounded injectable drugs billed with an unclassified HCPCS procedure code (for example, J3490)
    **Note:** 17-P compounds do not require invoices and should be billed electronically when this provision becomes effective.
  - Some services and procedures covered through the Money Follows the Person Waiver Program
- Claims submitted with a Medicaid Resolution Inquiry Form for
  - Time limit override
  - Medicare override
  - Third-party override
  - Recipient eligibility review
- Pharmacy claims for
  - Charges over $9,999
  - Compound drugs, when the compound comprises both legend and non-legend drugs
  - Compound drugs, when the compound contains an over-the-counter drug
  - Non-covered over-the-counter drugs prior approved through EPSDT
  - Retroactive charges that exceed the time limit for filing
  - DMA-approved quantity overrides
  - Medicare deductibles
  - Synagis that does not meet the established guidelines for coverage
  - Depo-Provera that does not meet the established guidelines for coverage
- Any professional claim billed with one of the following CPT procedure codes:
  - 99082 (if more than 180 units per day)
  - 59200
  - 59830
  - 59840
  - 59841
  - 59850
  - 59851
  - 59852
  - 59855
  - 59856
  - 59867
  - 01966

- Any institutional claim billed with one of the following ICD-9 procedure codes:
  - 69.01
  - 69.51
  - 74.91
  - 75.0
  - 96.49
- Any professional or institutional claim billed with one of the following ICD-9 diagnosis codes:
  - 635.00 through 635.99
  - 638.00 through 638.99
- Any dental claim billed with one of the following ADA procedure codes:
  - D0340
  - D0470
  - D8680
- Dental claims for special consideration tooth number reviews
- Dental assistant surgeon claims with records
- Dental ambulatory surgical claims denoting total surgical time in field 24
- Visual field exams requiring medical justification billed with CPT procedure code 92081, 92082, or 92083 without one of the diagnosis codes listed in the table below:

| Diagnosis Code List 1 | | | | | | Diagnosis Code List 2 | | |
|---|---|---|---|---|---|---|---|---|
| 094.84 | 191.2 | 191.6 | 191.9 | 192.1 | 239.6 | 225.1 | 227.3 | 307.81 |
| 250 | 250.00 | 250.01 | 250.02 | 250.03 | 250.50 | 346.90 | 349.9 | 352.9 |
| 250.51 | 250.52 | 250.53 | 323.9 | 340 | 343 | 364.00 | 364.01 | 364.02 |
| 343.0 | 348.2 | 360 | 360.00 | 360.24 | 360.4 | 364.03 | 364.04 | 364.05 |
| 360.40 | 360.41 | 361 | 361.00 | 361.9 | 362.01 | 364.24 | 364.41 | 367.0 |
| 362.02 | 362.11 | 362.12 | 362.21 | 362.3 | 362.30 | 367.1 | 367.2 | 367.4 |
| 362.31 | 362.33 | 362.4 | 362.40 | 362.5 | 362.50 | 367.9 | 368.12 | 368.4 |
| 362.51 | 362.52 | 362.53 | 362.54 | 362.55 | 362.56 | 370.20 | 372.0 | 372.01 |
| 362.57 | 362.6 | 362.60 | 362.63 | 362.64 | 362.65 | 372.02 | 372.03 | 372.04 |
| 362.66 | 362.7 | 362.70 | 362.74 | 362.75 | 362.81 | 372.05 | 372.3 | 372.31 |
| 362.83 | 363.11 | 363.2 | 363.20 | 363.30 | 364.1 | 372.33 | 372.39 | 372.73 |
| 364.10 | 364.11 | 364.21 | 364.22 | 364.23 | 364.3 | 373.9 | 374.11 | 375.15 |
| 364.42 | 364.51 | 364.52 | 364.53 | 364.54 | 364.55 | 376.1 | 376.30 | 378.00 |
| 364.56 | 364.57 | 364.59 | 364.60 | 364.61 | 364.62 | 378.1 | 378.11 | 378.12 |
| 364.63 | 364.64 | 364.70 | 364.71 | 364.72 | 364.73 | 378.13 | 378.14 | 378.15 |
| 364.74 | 364.75 | 364.76 | 364.77 | 364.8 | 364.81 | 378.16 | 378.17 | 378.18 |
| 364.89 | 364.9 | 365 | 365.00 | 365.01 | 365.02 | 378.4 | 378.41 | 378.42 |
| 365.03 | 365.04 | 365.5 | 365.51 | 365.52 | 365.59 | 378.43 | 378.44 | 378.45 |
| 365.6 | 365.60 | 365.61 | 365.62 | 365.63 | 365.64 | 378.53 | 379.30 | 379.32 |
| 365.65 | 365.81 | 365.82 | 365.89 | 365.9 | 366.11 | 379.33 | 379.34 | 379.39 |
| 366.14 | 366.16 | 368.41 | 368.43 | 368.44 | 368.46 | 379.41 | 379.53 | 379.91 |
| 368.47 | 369 | 369.00 | 369.01 | 369.2 | 369.20 | 381.4 | 386.01 | 386.10 |
| 369.3 | 370 | 370.00 | 371.00 | 371.60 | 377 | 462 | 465.9 | 473.9 |
| 377.00 | 377.1 | 377.10 | 377.14 | 377.21 | 377.24 | 716.90 | 743.9 | 747.8 |
| 377.3 | 377.30 | 377.32 | 377.39 | 377.41 | 377.52 | 784.0 | 791.0 | 850.9 |
| 377.62 | 377.75 | 377.9 | 379.21 | 379.24 | 379.5 | 921 | 921.1 | 921.2 |
| 379.50 | 434.91 | 435.9 | 695.4 | 710 | 710.0 | 931 | V20.2 | V67.51 |
| 743.2 | 743.20 | 921.3 | 921.9 | 948.4 | 950 | V72.0 | V80.0 | V80.1 |
| 950.0 | 996.69 | | | | | | | |

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

## *Attention: All Providers*

# *Seasonal Influenza Vaccine and Reimbursement Guidelines for 2009/2010*

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). ACIP recommendations on 2009/2010 *seasonal* influenza can be found on the CDC website at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5808a1.htm?s_cid=rr5808a1_e.

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

The N.C. Immunization Branch distributes all required and some recommended childhood vaccines to local health departments, hospitals, and private providers under UCVDP/VFC guidelines. For the 2009/2010 influenza season, UCVDP/VFC influenza vaccine is available at no charge to providers for **all children 6 months through 18 years of age, regardless of their insurance status.**

### Billing/Reporting Seasonal Influenza Vaccines

The following tables indicate the vaccine codes that can be either reported or billed for a *seasonal* influenza vaccine, depending on the age of the recipient and the formulation of the vaccine. 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 2009 Special Bulletin, *Health Check Billing Guide 2009* (http://www.ncdhhs.gov/dma/healthcheck/).

**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).<br>**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.<br>**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).<br>**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).<br>**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).<br>**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).<br>**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 (FQHCs) and rural health clinics (RHCs), for recipients 0 through 20 years of age, if the vaccine was obtained at no cost to the clinic, the clinic may bill only for the administration costs under the C suffix provider number. For recipients 21 years and older, the costs of the vaccine and its administration may be included on the cost report and cannot be billed to Medicaid.
- Private providers, health departments, FQHCs, and RHCs may bill Medicaid for the vaccine and administration fees for the seasonal influenza vaccine administered to Medicaid Pregnant Women (MPW) recipients. Refer to the guidelines listed above.

**Watch for a future bulletin article on the H1N1 influenza vaccine.**

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

## *Attention: All Providers*

## *DMA Budget Initiative Web Page*

DMA will implement a number of changes in response to legislated budget reductions. Providers will be notified of operational changes and coverage and policy changes via the Medicaid Bulletin. These changes will also be listed on DMA's website at http://www.ncdhhs.gov/dma/provider/budgetinitiatives.htm.

**Provider Services**
**DMA, 919-855-4050**

## *Attention: All Providers*

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

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

| Date | Procedures | Instructions for Providers |
|---|---|---|
| October 7, 2009<br>October 8, 2009<br>October 13, 2009<br>October 14, 2009<br>October 15, 2009<br>October 16, 2009<br>October 20, 2009<br>October 29, 2009<br>November 4, 2009 | Online Training Sessions | Online provider training sessions will be provided at 9:00 a.m. and 1:00 p.m. on each day. Registration instructions are given below on how to access the online training sessions. |
| October 19, 2009 | CT, CTA, MR, MRA, PET | All ordering providers will begin requesting PA for tests scheduled November 1, 2009, and after. |
| November 1, 2009 | CT, CTA, MR, MRA, PET | Institutional and professional claims submitted to EDS for testing performed on November 1, 2009, and after will require PA on file. Outpatient claims will require Revenue Codes and CPT codes on the UB-04 detail. |
| December 15, 2009 | Ultrasounds | All ordering providers will begin requesting PA for tests scheduled January 1, 2010, and after. |
| January 1, 2010 | Ultrasounds | Institutional and professional claims submitted to EDS for testing performed on January 1, 2010, and after will require PA on file. Outpatient claims will require Revenue Codes and CPT codes on the UB-04 detail. |

### Orientation Session

Online provider training sessions will be provided at 9:00 a.m. and 1:00 p.m. on the dates listed above. Additional online provider training sessions are being considered. Providers should check the MedSolutions website if additional dates are added. During these sessions, prior approval requirements and the functionality of the MedSolutions website (http://www.medsolutionsonline.com) will be discussed. This will be followed by a question-and-answer session.

### How to Register

1. Once you have chosen a date and time, please go to http://medsolutions.webex.com/.
2. Click on the "Training Center" tab at the top of the web page.
3. Find the date and time of the conference you wish to attend by clicking the "upcoming" tab. All of the Provider Orientation Sessions will be names "North Carolina Medicaid Provider Orientation Session."
4. Click "Register."
5. Enter the registration information.
6. After you have registered for the conference, you will receive an email containing:
   - The toll-free phone number and pass code you will need for the audio portion of the conference.
   - A link to the web portion of the conference.
   - The conference password.

After the online training sessions, please contact MedSolutions for additional concerns or questions.

## Accuracy Management Assessment

To ensure that recipients obtain the highest quality of care from imaging providers, MedSolutions shall assess all outpatient radiology providers who perform radiology procedures covered by this policy. The assessment process is conducted through a questionnaire that requests information about imaging equipment, applicable personnel, and imaging policies and procedures. MedSolutions shall notify each provider in writing of the provider's privileged or non-privileged status.

The dates for the Accuracy Management process are listed below:

| Program | Letter Mailed | Questionnaire To Be Completed By | Results to Providers |
|---|---|---|---|
| CT, CTA, MR, MRA, PET | August 28, 2009 | September 30, 2009 | October 13, 2009 |
| Ultrasound | October 1, 2009 | October 31, 2009 | November 20, 2009 |

If you did not receive a letter, please contact the Accuracy Management Department at MedSolutions at 1-800-457-2759 between 9:00 a.m. to 6:00 p.m., EST, Monday through Friday. The questionnaire can be obtained online at http://www.accuracymanagement.com or by contacting the MedSolutions Privileging Department at 1-800-457-2759.

## Exemptions

Radiology procedures performed in the following **situations** are exempt from the prior approval requirement:

1. During an inpatient hospitalization (identified by the presence of Bill Type 111)
2. During an observation stay (identified by the presence of Revenue Code 762)
3. During an emergency room visit (identified by the presence of Revenue Code 450)
4. As a referral from a hospital emergency department or an urgent care facility (identified by the presence of Modifier U2)
5. As an emergency procedure (refer to the *Basic Medicaid Billing Guide* at http://www.ncdhhs.gov/dma/basicmed/ for the definition of emergency procedures)

**Note:** Procedures that are exempt from the prior approval requirement must meet current N. C. Medicaid policies that define medical necessity criteria and unit limitations for claims payment. Bypassing prior approval by having the procedures performed in the emergency room is not a guarantee of payment.

Services provided to the following **recipients** do not require prior approval:

1. Recipients who are dually eligible (for Medicare and Medicaid) (excludes recipients with a 4th character in the Medicaid program [benefit category] code of B, Q, or E)
2. Recipients who have one of the following third-party insurance:
   - Major Medical Coverage
   - Indemnity Coverage
   - Basic Medicare Supplement
3. Recipients enrolled in one of the following Medicaid programs:
   - Program of All-Inclusive Care for the Elderly (PACE)
   - Health Choice
   - Family Planning Waiver
   - Health Insurance Payment Plan (HIPP)

## Prior Approval Procedures

For routine prior approval requests, the ordering physician shall contact MedSolutions with the required medical information prior to the procedure being scheduled and performed.

Prior approval requests for outpatient diagnostic imaging procedures may be submitted through MedSolutions' secure website (http://www.medsolutionsonline.com) 24 hours a day, 7 days a week. Prior approval requests may also be made to MedSolutions by telephone (888-693-3211) or by fax (888-693-3210) during normal business hours (8:00 a.m. to 9:00 p.m. EST).

**Note:** Prior approval for diagnostic imaging procedures does not replace Carolina ACCESS referral authorization for recipients with a Carolina ACCESS primary care provider. If a specialist requests prior approval for an imaging procedure and the recipient is a Carolina ACCESS enrollee, a referral authorization is required from the recipient's primary care provider.

Prior approvals and referral authorizations should be obtained before the testing is scheduled. The prior approval number should be provided to the facility performing the test. The prior approval is good for **30** days following its issuance.

Should the radiologist believe imaging different than what is authorized is warranted, the rendering facility shall contact MedSolutions for review and authorization prior to claim submission. If there is a change in the facility performing the imaging study, the rendering facility shall contact MedSolutions prior to performing the testing.

When imaging is required in less than 48 hours due to a medically urgent condition, the ordering physician or office shall call MedSolutions (888-693-3211) with the required medical information prior to scheduling and performing the procedure, and MedSolutions will expedite the review process. Please indicate clearly that the approval is for medically urgent care. Urgent requests cannot be accepted by internet or fax. (Refer to the *Basic Medicaid Billing Guide* at http://www.ncdhhs.gov/dma/basicmed/ for the definition of urgent procedures.)

Retrospective requests for cases that are clinically urgent can be submitted up to and including two business days after the service was performed. The ordering physician or office shall call MedSolutions (888-693-3222) with the required medical information. Approvals on retrospective requests are valid for the date of service only. Requests that are submitted beyond the established time limit, or if medical necessity or clinical urgency are not met will be denied.

## Claims Submission

Providers shall submit the claim to EDS for adjudication. The prior approval number is not required on the claim. Institutional providers billing on an institutional claim (UB-04/837I), shall bill the revenue code (RC) with the appropriate CPT code. Prior approval signifies medical necessity only; it does not address the recipient's eligibility or guarantee claim payment. Claims submitted for unauthorized procedures are subject to denial. Providers shall not bill recipients in such a situation. Non-institutional providers are required to follow applicable modifier guidelines, including TC and 26.

As indicated above, procedures performed during an inpatient stay, during an emergency department visit, during an observation stay or as a referral from a hospital emergency department do not require prior approval. Refer to the following instructions when submitting claims for procedures provided in these circumstances:

| Type of Stay | Billing Instructions |
|---|---|
| Inpatient stay | Enter Bill type 11x in Form Locator 4 |
| Emergency department visit | Enter Revenue Code 450 in Form Locator 42 |
| Observation stay | Enter Revenue Code 762 in Form Locator 42 |
| Hospital emergency department or urgent care facility referral | Institutional Claims: Enter appropriate CPT code with modifier U2 in Form Locator 44.<br>Professional Claims: Enter appropriate CPT code with modifier U2 in field 24D. |

**Procedure Codes**
For a full listing of the procedure codes requiring prior approval, refer to the bulletin article in the September 2009 Medicaid Bulletin located at http://www.ncdhhs.gov/dma/bulletin/. Outpatient radiology services other than those indicated in the September 2009 Medicaid Bulletin are exempt from the prior approval requirement.

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

**Practitioner and Clinic Services**
**DMA, 910-355-1883**

## *Attention: All Providers*

## *EOB Code Revisions*

To assist with the electronic claim submission requirement, a variety of EOB codes are being revised. These descriptions will include more specific information for correcting and resubmitting claims.

The following EOB codes are a sample of the revisions:

| EOB Code | Old Definition | New Definition |
|---|---|---|
| EOB 41 | Attach sterilization consent forms to claim. | Federal sterilization consent form required. |
| EOB 74* | Rebill for services on a paper claim. | Refile as an adjustment and attach medical records, operative notes, federal statements or other pertinent documentation. |
| EOB 145 | No Hysterectomy statement on file, attach or submit appropriate statement and file as a new claim. | No hysterectomy statement on file. |
| EOB 7995 | Please resubmit claim with documentation (operative notes, discharge summary) of all surgery procedures performed by this provider for this date of service. | Refile as an adjustment with documentation (operative notes, discharge summary) of all surgery procedures performed by this provider, this date of service. |
| EOB 9600 | Adjustment denied; if claim was with adjustment, it has been resubmitted. The EOB this claim previously denied with does not require adjusting. Correct resubmit in lieu of adjustment request. | Adjustment denied. The EOB this claim previously denied with does not require adjusting. Correct/resubmit claim in lieu of adjustment request. |

*EOB 74 will now show on the Medicaid Remittance and Status Report (RA) as EOB 8701.

**If a paper claim is submitted and is not included on the list of ECS exceptions, the claim will be denied.**

The revised list of exceptions (see page 5) to the requirement for electronic claim submissions has been revised and is available on DMA's website at http://www.ncdhhs.gov/dma/provider/ECSExceptions.htm. Only claims that comply with these exceptions may be submitted on paper. All other claims are required to be submitted electronically.

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

## *Attention: All Providers*

# *2009/2010 Procedures for Prescribing Synagis for RSV Season*

Effective with date of service November 2, 2009, N.C. Medicaid reimburses for respiratory syncytial virus (RSV) immune globulin (Synagis) **only** through the Outpatient Pharmacy Program. Synagis is not covered when billed through the Physician Drug Program or when billed on institutional claims by outpatient hospitals. This does not include outpatient hospital pharmacy billing through point of sale.

The clinical criteria utilized by N.C. Medicaid for the 2009/2010 RSV season are consistent with currently published Red Book guidelines (on the web at http://aapredbook.aappublications.org/cgi/content/full/2009/1/3.110; or in *Red Book: 2009 Report of the Committee on Infectious Diseases, 28th Edition*). Prescribers and pharmacists are responsible for ensuring the appropriate usage of Synagis.

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

A medical necessity review for Synagis will be conducted for all requests for recipients under the age of 21 who do not meet the criteria listed on the Synagis for RSV Prophylaxis form. The medical necessity review will follow Early and Periodic Screening, Diagnosis and Treatment (EPSDT) guidelines. Please use the North Carolina Medicaid Prior Authorization Synagis Drug Request form (**PA Synagis Drug Request form**) for a medical necessity review for Synagis under EPSDT guidelines. Prescribers shall request coverage of Synagis doses exceeding policy or coverage outside of the defined seasonal period using the **Non-covered State Medicaid Plan Services Request form for Recipients under 21 Years of Age,** available online at http://www.ncdhhs.gov/dma/provider/forms.htm (under Prior Approval).

N.C. Medicaid will begin coverage of Synagis on November 2, 2009. During the season, N.C. Medicaid will cover up to five monthly doses of Synagis. Pharmacies shall bill N.C. Medicaid in accordance with policy and shall adjust the number of doses billed if an infant received the first dose prior to a hospital discharge. Delays in request processing can occur if the recipient does not have a N.C. Medicaid identification number or the form is not complete.

- The prescriber shall complete the Synagis for RSV Prophylaxis form and submit it to the pharmacy distributor of choice.
- If the recipient does not meet the criteria for coverage, complete and sign the PA Synagis Drug Request form and fax it to ACS at 1-866-246-8507.
- N.C. Medicaid does not participate in RSV Connection. Do not submit N.C. Medicaid forms to RSV Connection for review.
- Before billing N.C. Medicaid for Synagis, the pharmacy shall have on file evidence of a complete and accurate Synagis for RSV Prophylaxis form or a PA notice of approval.
- Please refer to the guidelines below when submitting a request for Synagis.

### Requesting Synagis for RSV Prophylaxis When Criteria Are Met

Submit the Synagis for RSV Prophylaxis form. (If the recipient does **not** meet the criteria, please refer below to **Requesting Synagis for RSV Prophylaxis When Criteria Are Not Met.**)

### Criteria for a Maximum of Five Doses

For the following two diagnoses, date of birth (DOB) shall be on or after November 3, 2007.

- Chronic lung disease of prematurity (bronchopulmonary dysplasia): Infants and children younger than 24 months of age who have received treatment (supplemental oxygen, bronchodilator, diuretic, or chronic corticosteroid therapy) in the six months before the start of the season.

- Hemodynamically significant congenital heart disease: Infants younger than 24 months of age who are most likely to benefit include those receiving medication to control congestive heart failure (CHF), moderate to severe pulmonary hypertension, or cyanotic heart disease.
  - ♦ Infants not at increased risk from RSV who generally should **not** receive immunoprophylaxis include those with hemodynamically insignificant heart disease, such as secundum atrial septal defect, small ventricular septal defect (VSD), pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, patent ductus arteriosus (PDA), lesions adequately corrected by surgery unless the infant continues on medication for CHF, or mild cardiomyopathy for which the infant is not receiving medical therapy.

In addition to the two conditions listed above, a premature infant may qualify for five doses of Synagis as follows. Prematurity shall be counted to the exact day.

- Born at an estimated gestational age (EGA) of ≤28 weeks 6 days and DOB is on or after November 3, 2008.
- Born at an EGA of 29 weeks 0 days to 31 weeks 6 days and DOB is on or after May 3, 2009.
- Born at an EGA of ≤34 weeks 6 days **and** DOB is after March 31, 2009, and has either severe neuromuscular disease or congenital abnormalities of the airways, either of which compromises handling of respiratory secretions.

### Criteria for a Maximum of Three Doses; Last Dose Administered at 3 Months of Age (90 Days of Life)

Born at an EGA of 32 weeks 0 days to 34 weeks 6 days, and DOB is on or after August 3, 2009, and has at least one of the two following defined risk factors:

- Attends child care (defined as a home or facility where care is provided for any number of infants or young toddlers [toddler age is up to the third birthday]).
- Has a sibling younger than 5 years of age in the home.

The Red Book includes a detailed chart (shown for beginning prophylaxis on November 1) of the maximum number of Synagis [palivizumab] doses for RSV prophylaxis of preterm infants without chronic lung disease, on the basis of birth date, gestational age, and presence of risk factors (American Academy of Pediatrics. Respiratory Syncytial Virus. In: Pickering LK, Baker CJ, Kimberlin DW, Long SS, eds. Red Book: 2009 Report of the Committee on Infectious Diseases. 28th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2009: 560-569; Table 3.61). The chart is available online at http://aapredbook.aappublications.org/cgi/content-nw/full/2009/1/3.110/TABLE3-61. With the exception of following, a November 2, 2009, season start date, N.C. Medicaid follows guidance the chart provides, accordingly, on the recommended number of doses.

### Requesting Synagis for RSV Prophylaxis When Criteria Are Not Met

Prior approval will be required for Synagis when criteria are not met. Submit prior approval requests using the PA Synagis Drug Request Form by faxing it to ACS at 866-246-8507. This PA form is to be used for recipients who do not explicitly meet the criteria listed on the Synagis for RSV Prophylaxis form.

Generally, the following conditions do not singularly justify medical necessity for Synagis prophylaxis:

- an RSV episode during the current season
- repeated pneumonia
- sickle cell disease
- being one member of a multiple birth, another member of which is approved for Synagis
- apnea or respiratory failure of newborn

Please use the Non-covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age to request Synagis doses exceeding policy or for Synagis administration outside the defined seasonal period. A medical review will be completed to consider a request for Synagis under EPSDT (refer to

http://www.ncdhhs.gov/dma/epsdt/). If the information provided justifies medical need; an approval notification will be faxed to the provider and pharmacy.

## Submitting Synagis Requests Using N.C. Medicaid Forms and Point of Sale Overrides

The N.C. Medicaid Synagis for RSV Prophylaxis form and the PA Synagis Drug Request form are available on the DMA website at http://www.ncdhhs.gov/dma/pharmacy/. The PA Synagis Drug Request form is also available on the ACS website at http://www.ncmedicaidpbm.com/. The forms will be available on the websites prior to October 5, 2009. For further information about EPSDT or for a copy of the Non-covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age, go to http://www.ncdhhs.gov/dma/epsdt/.

The N.C. Medicaid PA Synagis Drug Request form can be submitted to ACS starting on October 5, 2009. Please call the ACS Prior Authorization help desk at 1-866-246-8505 for questions about the form.

N.C. Medicaid will allow Synagis claims processing to begin on October 27, 2009, to allow sufficient time for pharmacies to provide Synagis by November 2, 2009. Payment of Synagis claims prior to October 27, 2009, and after March 31, 2010, will not be allowed.

Point of sale claims billed for recipients requesting Synagis using the N.C. Medicaid Synagis for RSV Prophylaxis form require an override code. A "1" in the PA field (461-EU) will override the PA edit. The override code should be used only in instances where the form is complete and the recipient meets N. C. Medicaid criteria. Inappropriate use of the override will result in recoupment of payment for Synagis claims. These overrides will be monitored by DMA Program Integrity.

Pharmacy providers shall always indicate an accurate days' supply when submitting claims to N.C. Medicaid. Claims for Synagis doses that include multiple vial strengths shall be submitted as a single compound drug claim. Synagis doses that require multiple vial strengths that are submitted as individual claims shall be subject to recoupment by DMA Program Integrity. Physicians and pharmacy providers are subject to audits of Synagis records by DMA Program Integrity.

## Pharmacy Distributor Information

The pharmacy distributor shall maintain the **Synagis for RSV Prophylaxis** form on site. This form is required to support the use of the POS override code. The pharmacy distributor shall mail a copy of the submitted forms **weekly** to DMA. Please mail submitted forms to

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

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

The pharmacy distributor shall maintain on site a copy of the approval notification for recipients evaluated under the PA Synagis Drug Request form or the Non-covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age.

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

## *Attention: All Providers*

# *Top 10 EOBs*

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

| EOB | EOB Description | Resolution |
|---|---|---|
| 286 | Incorrect authorization number on claim form. Verify number and refile claim | Referring NPI on processed claim does not match the recipient's eligibility file for submitted date of service. Contact referring PCP, obtain the correct referral information and resubmit claim. |
| 9271 | Payment included in DRG reimbursement on first accommodation detail | Refer to first accommodation detail. If payment is indicated, no action necessary. If denial code is indicated, correct and resubmit claim based on EOB description given. |
| 270 | Billing provider is not the recipient's Carolina Access PCP. Authorization is missing or unresolved. Contact PCP for authorization or EDS Prov. Svcs. if authorization is correct | Submitted claim requires a referring NPI. The referring NPI is either not found on the claim or is unresolved (cannot map to single MPN). Correct and resubmit the claim. |
| 473 | Nursing Home Days Denied Or Recouped to Pay Inpatient Hospital Days | Verify the patient was not in the nursing home facility while admitted to an inpatient hospital stay. |
| 8925 | Allowable reduced for deductible/patient liability | Prior payment amount exceeds the N.C. Medicaid allowable, or reduces the N.C. Medicaid allowable by the prior payment amount. No action necessary. |
| 21 | Exact duplicate | Exact claim has previously paid in history. If previous payment is incorrect, submit a replacement claim to address overpayment or underpayment. If payment is correct, no action necessary. |
| 169 | Bill Medicare Part A Carrier | Recipient is eligible for Medicare. Claim should be filed to Medicare. |
| 11 | Recipient not eligible on service date | Verify recipient eligibility via a 270/271 transaction or via the AVRS (1-800-723-4337, option 6). Refer to the *Basic Medicaid Billing Guide*, Appendix F for more details. If recipient's eligibility has updated since the original claim has processed, resubmit the claim. |

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

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

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

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

## *Attention: All Providers*

# *Medicaid Recipient Appeals*

Session Law 2009-526, signed into law on August 26, 2009, makes various clarifying changes to the requirements of the Medicaid Fair Hearing and Appeals process. Changes are summarized below. (Refer to Session Law 2009-526 at http://www.ncleg.net/enactedlegislation/sessionlaws/pdf.2009-2010/sl2009-526.pdf for full details.)

**Section 2 (a)** changes the effective date of an adverse decision from 30 days to **10 days** from the date the notice of decision was mailed. (The date the notice is mailed is the date of the notice). This section also states that where a request for hearing concerns an adverse decision related to Medicaid recipient services, upon the receipt of a timely appeal, the Department of Health and Human Services (DHHS) shall reinstate authorization for the services to the level or manner prior to action by the DHHS as permitted by federal law or regulation. This means that if the recipient or his/her guardian requests the appeal within 10 days of the date the notice was mailed **and** the recipient was receiving services the day before the notice was mailed, authorization for his/her services will continue without interruption, at the last level of service authorized or the level requested by the provider, whichever is less, as long as the recipient remains otherwise Medicaid eligible.

If the recipient appeals the decision within 30 days of the date the notice was mailed, any services that ended or were reduced will be reinstated at the last level of service authorized or the level requested by the provider, whichever is less. Please note that should the recipient request a hearing 11 to 30 days from the date the notice was mailed and was receiving services the day before the notice was mailed, there could be a delay in payment for the service beginning day 11 from the date the notice was mailed to the date the appeal is received by the Office of Administrative Hearings (OAH). This does not change the rule that if a recipient loses an appeal, the recipient may still be required to pay for services that were authorized because of the appeal.

**Section 10.15A.(h2)** provides that to the extent possible, the OAH shall schedule and hear all contested Medicaid cases within 55 days of submission of a request for appeal. (The previous requirement was 45 days). The Session Law provides that hearings will be conducted by telephone unless the recipient requests an in-person hearing. The in-person hearing will be held at the OAH in Wake County (Raleigh) unless the recipient can show good cause why he/she cannot come to Wake County. Please see Session Law 2009-526 at the website listed above for a definition of good cause and written notification requirements.

**Continuances** shall only be granted in accordance with rules adopted by the OAH and shall not be granted on the day of the hearing, except for good cause shown. If the recipient or his/her legal guardian or appointed representative fails to make an appearance at a hearing that has been properly noticed via trackable mail by the OAH, the OAH shall immediately dismiss the case.

**Mediation Timeframes and Processes**

Session Law 2009-526 requires that if the parties have resolved matters in mediation, the case shall be dismissed by the OAH. The OAH shall not conduct any contested Medicaid cases hearings until it has received notice from the mediator assigned to the case that either:

- the mediation was unsuccessful, or
- the petitioner has rejected the offer of mediation, or
- the petitioner has failed to appear at a scheduled mediation.

### New Evidence

The petitioner shall be permitted to submit evidence regardless of whether obtained prior or subsequent to the DHHS actions and regardless of whether the DHHS had an opportunity to consider the evidence in making its determination to deny, reduce, terminate or suspend a benefit. When such evidence is received, at the request of DHHS, the administrative law judge shall continue the hearing for a minimum of 15 days and a maximum of 30 days to allow DHHS to review the evidence. Subsequent to review of the evidence, if DHHS reverses its original decision, it shall immediately inform the administrative law judge.

### Issue for Hearing

For each penalty imposed or benefit reduced, terminated, or suspended, the hearing shall determine whether the DHHS substantially prejudiced the rights of the petitioner and if the DHHS, based upon evidence presented at the hearing:

- exceeded its authority or jurisdiction;
- acted erroneously;
- failed to use proper procedure; acted arbitrarily or capriciously; or
- failed to act as required by law or rule.

### Information

Further information about the Medicaid recipient services appeal process will be published in the future. Questions regarding the Medicaid recipient services appeal process may be directed to OAH (919-431-300), the toll-free CARE-LINE, Information and Referral Services (1-800-662-7030), 7:00 a.m.-11:00 p.m., or DMA (919-855-4260).

**Appeals Manager**
**DMA, 919-855-4260**

## *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/:

- 1D-4, *Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics*
- IK-6, *Radiation Oncology*

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*

# *Leuprolide Acetate Injectable (HCPCS Procedure Codes): Change in Billing Guidelines*

Effective with claims processing on or after September 1, 2009, all National Drug Codes (NDCs) for the injectable leuprolide acetate, including depot suspension, are reimbursed under one of the HCPCS procedure codes listed below. It is no longer necessary to submit invoices with HCPCS procedure code J3490 for the depot pediatric kits as instructed in previous Medicaid Bulletins. Claims processed after August 31, 2009, for any injectable leuprolide acetate NDC billed with HCPCS procedure code J3490 will be denied.

1. J1950 (leuprolide acetate [for depot suspension], per 3.75 mg); or
2. J9217 (leuprolide acetate [for depot suspension], 7.5 mg); or
3. J9218 (leuprolide acetate, per 1 mg).

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

## *Attention: Hospitals and Physicians*

# *Circumcision Updates*

Effective with date of processing October 2, 2009, providers submitting claims to Medicaid for circumcision procedures must file electronically unless the procedure allows for an exception based on the list of electronic claim mandate exceptions posted on the DMA website at http://www.ncdhhs.gov/dma/provider/ECSExceptions.htm. Providers must submit an adjustment form with medical records if additional review for medical necessity is required. Please refer to the EOB message after claim adjudication.

Information regarding circumcisions is available in Clinical Coverage Policy #1A-22, *Medically Necessary Circumcision,* on DMA's website at http://www.ncdhhs.gov/dma/mp/.

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

## *Attention: Dialysis Providers*

# *Billing for Daily Dialysis*

The 2009 CPT update designated CPT codes 90967 through 90970 as codes for daily dialysis services. The appropriate use of daily dialysis codes is described in the introductory comments of the End-Stage Renal Disease Services section of CPT. DMA has become aware of inappropriate denials of claims for daily dialysis services. System changes have been made to correct this issue. Providers who have received denials with EOB 551 (ESRD services allowed once per month) for CPT codes 90967 through 90970 may resubmit the denied charges as a new day claim. Please do not submit as an adjustment request.

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

## *Attention: Medical Doctors and Doctors of Osteopathy*

## *Reimbursement for Asthma Equipment and Supplies*

Effective with date of service September 1, 2009, medical doctors and doctors of osteopathy can be reimbursed for the following items:

1. E0570 (nebulizer, with compressor)
2. A7003 (administration set, with small volume nonfiltered pneumatic nebulizer, disposable)
3. A7004 (small volume nonfiltered pneumatic nebulizer, disposable)
4. A7005 (administration set, with small volume nonfiltered pneumatic nebulizer, non-disposable)
5. A7006 (administration set, with small volume filtered pneumatic nebulizer)
6. A7015 (aerosol mask, used with DME nebulizer)
7. A4627 (spacer, bag or reservoir, with or without mask, for use with metered dose inhaler)
8. A4614 (peak expiratory flow rate meter, hand held)

Providers must follow the guidelines for coverage in Clinical Coverage Policy #5A, *Durable Medical Equipment*, on DMA's website at http://www.ncdhhs.gov/dma/mp/.

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

## *Attention: CAP/DA Case Managers and CAP/DA Service Providers*

## *Freeze on Participation in the Community Alternatives Program for Disabled Adults*

DMA has been directed by the N.C. General Assembly through the Joint Conference Committee Report on the Continuation, Expansion, and Capital Budgets, Section G, Item 170 of the 2009 Appropriating Act (SL 2009-451) to freeze slots in the Community Alternatives Program for Disabled Adults (CAP/DA) in order to meet the budget reduction goals for State Fiscal Years 2010 and 2011.

In response to this mandate, the maximum number of CAP/DA slots available to each county will be limited to the number of slots each has filled as of September 1, 2009. DMA will continue to evaluate CAP/DA expenditures and the overall Medicaid budget situation to determine if the freeze can be amended to allow additional slot allocations for State Fiscal Years 2010 and 2011.

Please direct questions about the implementation of this freeze to the CAP/DA Unit in the Facility and Community Care Section by calling 919-855-4340 or faxing 919-715-2372.

**Facility and Community Care Section**
**DMA, 919-855-4340**

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

# *Medical Supplies Included as Administrative Costs*

The following table gives examples of items that are considered to be an administrative cost covered in the agency's overhead costs. Items routinely furnished as part of the care provided by the agency are not separately reimbursable. Administrative costs are included when determining reimbursement rates. The list is not all-inclusive but includes the most common items that are covered in administrative costs. These items cannot be billed as separately to Medicaid.

| Dressings and Skin Care | OSHA Requirements and Infection Control | Blood drawing and Testing Supplies | Miscellaneous |
|---|---|---|---|
| Alcohol preps or wipes, betadine swabs, cotton balls | Non-sterile gloves (for employee use) | Vacutainers, needles, collection tubes, tourniquets | Thermometers and covers |
| Tape or adhesive removal pads (exception, for ostomy care) | Sharps containers | Syringes and needles for lab draws | Tongue depressors |
| Band-aids, Steri-strips | Specimen containers | Lancets, test strips, alcohol pads (for employee use) | Minor medical and surgical supplies including non-sterile applicators used by employees |
| Lotions and ointments (ointments requiring a prescription would be covered under the Outpatient Pharmacy Program) | Protective gowns, mask, head gear (for employee use) | Betadine or iodine prep pads or wipes | Blood pressure cuffs |
| Non-sterile applicators | Biohazard collection bags | INR strips (for employee use) | Lubricants |
| Hand cleansers | Wound care disposal bags | | Weights and stretch bands used in physical therapy |

**Facility and Community Care**
**DMA, 919-855-4380**

## *Attention: Dental Providers and Health Department Dental Centers*

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

Effective with date of service November 1, 2009, the following changes will be implemented for the N.C. Medicaid Dental Program. These changes are outlined in the Conference Committee Money Report attached to the budget bill, which refers to dental policy adjustments resulting in program cost savings of approximately $3.7 million in State appropriations.

- Limit panoramic films (D0330) to recipients ages 6 and older.
- Discontinue coverage of **premolar** sealants (D1351) for all recipients.
- Reduce age limits for sealants (D1351) on all permanent molars from under age 21 to under age 16.
- Reduce age limits for sealants (D1351) on primary molars from under age 10 to under age 8.
- Require periodontal charting in addition to radiographs for approval of periodontal scaling and root planing (D4341, D4342).
- Limit periodontal scaling and root planing (D4341, D4342) to no more than two (2) quadrants on the same date of service. This limitation does not apply to recipients treated under general anesthesia in a hospital or ambulatory surgical center.

In addition to the changes listed above, the Medicaid reimbursement for all covered procedure codes will be reduced by 4.52 percent, effective October 1, 2009. The complete Dental Fee Schedule, located on the DMA website at http://www.ncdhhs.gov/dma/fee/, will be updated. Providers are reminded to bill their usual and customary charges rather than the Medicaid rate.

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

For seminar locations and registration information, refer to the Provider Seminar web page at http://www.ncdhhs.gov/dma/provider/seminars.htm.

**Dental Program**
**DMA, 919-855-4280**

## *Attention: Dental Providers and Health Department Dental Centers*

## *Overrides for 10-year Limitation on Complete or Partial Dentures*

All dental providers requesting an override of the 10-year policy limitation on complete and partial dentures are reminded that supporting documentation, **including medical necessity,** will be accepted from a recipient's medical provider only if it is signed by a physician or surgeon. Requests for time limit overrides signed by nurse practitioners, physician assistants, case workers, and other non-physicians are not acceptable. Narratives received without a physician's signature will be returned to the requesting dental provider to arrange for the recipient's physician to sign and confirm the medical need for replacement of the complete and/or partial dentures.

**Dental Program**
**DMA, 919-855-4280**

## *Attention: Hospice Providers*

## *Core Based Statistical Area Code Pricing Structure for Revenue Codes RC651, RC652, RC655, and RC656*

Effective with date of service October 1, 2009, CMS updated the payment for hospice care using Core Based Statistical Area (CBSA) codes. The N.C. Medicaid Program is mandated by the Social Security Act to follow Medicare's lead regarding pricing of hospice claims. DMA has priced hospice claims accordingly for the four prospectively determined rate categories (routine home care, continuous home care, inpatient respite care, and general inpatient care). Hospice providers should expect that their claims will price based on the location of the delivered service.

For further information, please refer to Clinical Coverage Policy 3D, *Hospice Services*, on DMA's website at http://www.ncdhhs.gov/dma/mp/ and the Hospice Fee Schedule at http://www.ncdhhs.gov/dma/fee/.

**Finance Management**
**DMA, 919-855-4190**

## *Attention: Federally Qualified Health Centers and Rural Health Clinics*

## *Core Services Policy*

Clinical Coverage Policy 1D-4, *Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics*, effective October 1, 2009, is now available on DMA's website (http://www.ncdhhs.gov/dma/mp/). This policy describes the package of face-to-face services (commonly referred to as core services) that may be reimbursed to a rural health clinic (RHC) or federally qualified health center (FQHC).

Please note the following billing changes:

1. Bill T1015 for a regular core service visit.
2. Bill T1015 with the HI modifier for "other health" visit, such as a behavioral health visit.
3. Bill T1015 with the SC modifier for a visit subsequent to the regular core visit, in which the recipient appears with, presents with, or suffers illness or injury requiring additional diagnosis.

A total of three visits per day can be billed as long as only one of each of the types of visits described above occurs.

Billing for recipients with Family Planning Waiver (MAFD) has not changed. Please refer to the May 2006 Special Bulletin, *Family Planning Waiver, Be Smart* (http://www.ncdhhs.gov/dma/bulletin/), for instructions on how to properly bill for services for this Medicaid coverage category.

Every FQHC and RHC provider is encouraged to read the new policy.

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

# *Attention: Federally Qualified Health Centers and Rural Health Clinics*

# *Seminars for Federally Qualified Health Centers and Rural Health Clinics*

Seminars for federally qualified health centers (FQHCs) and rural health clinics (RHCs) are scheduled for the month of November 2009. Information on FQHC/RHC clinical coverage guidelines and billing procedures will be presented at these seminars.

The seminars are scheduled at the locations listed below. **Pre-registration is required.** Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

Providers may register for the FQHC/RHC seminars online at http://www.ncdhhs.gov/dma/provider/seminars.htm. Sessions will begin at 9:00 a.m. and 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.**

| Date | Location |
|---|---|
| Monday, November 2, 2009 | Raleigh – Hilton North Raleigh<br>3415 Wake Forest Road<br>Raleigh NC 27609-7330 |
| Tuesday, November 3, 2009 | Morganton – Western Piedmont Community College<br>Moore Hall Building<br>1001 Burkemont Avenue<br>Morganton NC 28655 |
| Tuesday, November 10, 2009 | Greenville – Hilton Greenville<br>207 SW Greenville Boulevard<br>Greenville NC 27834 |

## Directions to the FQHC/RHC Seminars

**GREENVILLE**
***Hilton Greenville***
Take US 64 East to US 264 East to Greenville. Turn right at the 2nd traffic light as you come into the city onto Allen Road/US Alternate 264. Travel approximately 2 miles. Allen Road becomes Greenville Boulevard/Alternate 264. Follow Greenville Boulevard for 2.5 miles. The Hilton Greenville is located on the right.

**MORGANTON**
***Western Piedmont Community College, Moore Hall Auditorium***
**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, 1 block beyond I-40.

**RALEIGH**

***Hilton North Raleigh***

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

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

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

**FQHC/RHC Workshops**
**November 2009 Seminar Registration Form**
*(No Fee)*

Provider Name _____

Medicaid Provider Number _____ NPI Number _____

Mailing Address _____

City, Zip Code _____ County _____

Contact Person _____ E-mail _____

Telephone Number (_____) _____ Fax Number _____

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

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

## *Attention: Health Departments, Hospitals, OB/GYN Providers, and Physicians*

# *Sterilization Consent Forms and Hysterectomy and Abortion Statements*

Effective with date of processing October 2, 2009, the N.C. Medicaid Program will require all providers to submit claims electronically. To assist with the electronic claim submission requirement, the process for submitting sterilization consent forms and hysterectomy and abortion statements has been modified. Providers can now submit their federal forms **prior to** submitting the claim. To confirm sterilization consent and hysterectomy statement approval, providers may use the Automated Voice Response (AVR) System, transaction 7. Please review the instructions pertaining to the specific type of procedure. The sterilization and hysterectomy statement review process is completed and results are available in the AVR System within 10 business days from the date of receipt of the form.

### Sterilization

When submitting sterilization consents separately from the claim, follow the instructions below:

- **Write the recipient's Medicaid identification (MID) number** in the upper right corner of the consent form. Medicaid's fiscal agent must have the MID to enter the form into the system.
- **Verify** that all the information on the form is correct.
- **Mail the consent to**: EDS<br>PO Box 300012<br>Raleigh, NC 27622
- **Send only** sterilization consents (no claims) to PO Box 300012. Upon receipt, Medicaid's fiscal agent will review the statement to ensure adherence to federally mandated guidelines. Review results will be entered into the EDS system.
- Submit an **electronic claim** for processing.

### Hysterectomy

When submitting hysterectomy statements separately from the claim, follow the instructions below:

- **Write the recipient's MID number** in the upper right corner of the statement form. Medicaid's fiscal agent must have the MID to enter the form into the system.
- **Verify** that all the information on the form is correct.
- **Mail the statement to**: EDS<br>PO Box 300012<br>Raleigh, NC 27622
- **Send only** hysterectomy statements (no claims) and attachments to PO Box 300012. Upon receipt, Medicaid's fiscal agent will review the statement to ensure adherence to federally mandated guidelines. Review results will be entered into the EDS system.
- Submit an **electronic claim** for processing.

### Abortion

Abortion statements are not required to be reviewed prior to claim submission. Some abortion procedures must be billed on paper with all appropriate documentation attached. Refer to the ECS exceptions list on DMA's website at http://www.ncdhhs.gov/dma/provider/ECSExceptions.htm for a list of abortion procedure codes that must be billed on paper.

If the claim is submitted electronically and it is denied requesting additional information, providers may submit an adjustment request. Include requested medical records, a copy of the Remittance and Status Report, and a paper claim with the adjustment request.

For additional information on federal form instructions, refer to the OB/GYN Services page on DMA's webpage at http://www.ncdhhs.gov/dma/services/obgyn.htm and to the October 2005 Special Bulletin, *OB/GYN Billing Guide*, http://www.ncdhhs.gov/dma/bulletin/.

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

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

# *Changes to Outpatient Specialized Therapies*

Effective with dates of service December 1, 2009, prior authorization (PA) for outpatient specialized therapies (occupational therapy, physical therapy, speech therapy, respiratory therapy, and audiology services) will once again be required for recipients under 21 years of age. Effective with date of service January 1, 2010, PA for outpatient specialized therapies will also be required for recipients 21 years of age and older. Prior authorization will be required for all therapy treatments regardless of the setting. As soon as DMA identifies a vendor, information will be published on the DMA website at http://www.ncdhhs.gov/dma/provider/budgetinitiatives.htm and Clinical Coverage Policy 10A, *Outpatient Specialized Therapies*, will be updated. Specific details will be published in the November 2009 Medicaid bulletin.

Prior authorization is not required for dually eligible Medicaid/Medicare recipients. For Local Education Agencies (LEAs), the prior authorization is deemed met by the IEP process.

Once the new vendor is identified and their website is available, providers will need to register and obtain password information to access these secure pages. Please check on the availability of the new website daily during the month of October. Once the website is available, you can begin registering and submitting requests. Online provider training will be available.

**Nora Poisella,**
**DMA, 919-855-4310**

## *Attention: Dialysis Providers, Nurse Practitioners, and Physicians*

# *Ferumoxytol Injection (Feraheme, HCPCS Procedure Code J3490): Billing Guidelines*

Effective with date of service August 18, 2009, the N.C. Medicaid program covers ferumoxytol (Feraheme) injection for use in the Physician's Drug Program when billed with HCPCS procedure code J3490 (unclassified biologics). Feraheme is indicated for the treatment of iron deficiency anemia in adult patients with chronic kidney disease (CKD). It is available as single-use vials containing 510 mg of elemental iron in 17 ml (30 mg/ml).

Treatment with Feraheme consists of an initial 510-mg intravenous (IV) infusion followed by a second 510-mg IV injection 3 to 8 days later. The hematologic response should be evaluated at least one month following the second Feraheme injection. The recommended Feraheme dose may be readministered to patients with persistent or recurrent iron deficiency anemia.

Dialysis treatment facilities may bill for Feraheme in addition to the dialysis composite rate. Administration supply costs are included in the dialysis composite rate.

### Providers of Chronic Kidney Disease Treatment Who Bill on the CMS-1500 or the 837P Transaction

- The ICD-9-CM diagnosis codes required for billing Feraheme are
  - **280.9** (iron deficiency anemia) **plus one** of the following diagnosis codes:
  - **585.1 through 585.5** (chronic kidney disease)
- Providers must bill Feraheme with HCPCS procedure code J3490 (unclassified biologics).
- One Medicaid unit of coverage is 510 mg/17 ml – one single-use vial. The maximum reimbursement rate, per vial, is $446.38. An entire single-use vial may be billed.
- Indicate the number of HCPCS units billed.
- Providers must bill 11-digit National Drug Codes (NDCs) codes with appropriate NDC units. The NDC units must be reported in "units." For example, if billing for the entire single-use vial, report the NDC units as "UN1." If a drug was purchased under the 340B Drug Pricing Program, place a "UD" modifier on the drug detail.

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

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

### Billing Requirements for Dialysis Treatment Centers Billing on the UB-04 or the 837I Transaction

- Enter revenue code 250 in form locator 42.
- Enter the description of the drug in form locator 43.
- Enter HCPCS procedure code J3490 (unclassified biologics) in form locator 44.
- Enter the date of service in form locator 45.

- Enter the units given in form locator 46 (510 mg/17 ml = 1 unit).
- Enter the total charges in form locator 47.
- Enter one of the following diagnosis codes in form locator 67.
  - ♦ **585.6** (end stage renal disease)

  **OR**

  - ♦ **585.9** (chronic kidney disease, unspecified)
- Enter diagnosis code **280.9** in form locator 68:
- Follow the guidelines for billing NDC units indicated above, using the UD modifier as appropriate.

**Example:**

| 42<br>Rev Code | 43<br>Description | 44<br>HCPCS/Rate | 45<br>Serv Date | 46<br>Serv Units | 47<br>Total Charges |
|---|---|---|---|---|---|
| 250 | Feraheme 510 mg/17 ml | J3490 | 08242009 | xx | $ |

| 67<br>Principal Diagnosis Code | 68<br>Code | 69<br>Code | 70<br>Code | 71<br>Code | 72<br>Code | 73<br>Code | 74<br>Code | 75<br>Code |
|---|---|---|---|---|---|---|---|---|
| 585.6 | 280.9 | | | | | | | |

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

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

## *Attention: Pharmacists and Prescribers*

## *New Prior Authorization Requirements for Short-acting Inhaled Beta Agonists*

Effective with date of service of September 21, 2009, the N.C. Outpatient Pharmacy Program began requiring prior authorization for short acting inhaled beta agonists. Prescribers can request prior authorization by contacting ACS at 866-246-8505 (telephone) or 866-246-8507 (fax). The criteria and prior authorization request form for these medications are available on the N.C. Medicaid Enhanced Pharmacy Program website at http://www.ncmedicaidpbm.com. Proventil HFA, Ventolin HFA, and generic albuterol do not require prior authorization.

N. C. pharmacists are allowed to substitute equivalent drug products when such substitution is authorized by the prescriber. Please refer to G.S. 90-85.28 through G.S. 90-85.31 for the North Carolina law that defines an equivalent drug product.

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

## *Attention: Pharmacists*

# *State Maximum Allowable Cost Change*

N.C. Medicaid utilizes a State maximum allowable cost (SMAC) list for reimbursement of drugs under the outpatient pharmacy program. The SMAC list contains products with A-rated equivalents and, in the great majority of cases, products marketed by at least two labelers. The reimbursement has been based on 150 percent of the lowest priced generic prior to October 5, 2009. Effective with dates of service October 5, 2009, the reimbursement methodology will change so that the reimbursement will be based on 190 percent of the lowest priced generic in order to encourage generic utilization.

In cases where 190 percent results in a price less than the cost of the second lowest generic product, at least an additional ten percent margin is added to the cost of the second lowest drug to establish the SMAC price. The additional margin is variable due to the wide range of differences in cost from product to product. For established generic drugs with only one supplier, the SMAC price is established between the actual acquisition cost and average wholesale price of the generic drug. A minimum reimbursement of 20 percent above actual acquisition is guaranteed for these drugs. In most cases, SMAC pricing is substantially higher than this 20 percent, which allows the state and pharmacies to share in the cost savings of using the generic product.

Drugs subjected to SMAC pricing must be in adequate supply. Drug shortage information is verified through national pharmacy websites as well as through information provided by national drug wholesalers. The lowest price at any given time will be the current reimbursement for a N.C. Medicaid claim.

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

## *Attention: Pharmacists*

# *Pharmacy Reimbursement Changes*

Effective October 5, 2009, the reimbursement methodology for pharmacy claims will change. The Average Wholesale Price (AWP) minus 10 percent pricing methodology will change to Wholesale Acquisition Cost (WAC) plus 7 percent. The cost of a drug will continue to be calculated from the lowest of the costs on file (currently utilizing First Data Bank). The pricing methodologies that will be available include the following: WAC plus 7 percent, the federal upper limit, the state maximum allowable cost, the enhanced specialty discount or the usual and customary charge. The enhanced specialty discount drug list will continue to use Average Wholesale Price as the basis for reimbursement.

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

## *Attention: Pharmacy Providers Who are Also Enrolled as Durable Medical Equipment Providers*

## *Suppliers of Medicare Durable Medical Equipment*

Medicaid requires that durable medical equipment (DME) providers be enrolled with Medicare. Suppliers of Medicare DME must meet the DME accreditation standards by September 30, 2009, are required to obtain a surety bond by October 2, 2009, and should amend their CMS-855S application in order to retain the ability to continue to bill Medicaid. Suppliers not meeting these requirements risk having their Medicare and Medicaid billing privileges revoked (some exceptions to the accreditation requirement for pharmacies are listed below).

As a pharmacy, you may choose to provide DME drugs that do not require accreditation (such as those items listed below) and other Part B drugs that are covered by Medicare Part B. In these instances, accreditation is **NOT** required but a pharmacy will still need to possess a **surety bond.** This applies to the following covered drugs under Medicare Part B (that only require a surety bond):

1. Epoetin
2. Immunosuppressants
3. Infusion drugs
4. Nebulizer drugs
5. Oral anticancer drugs
6. Oral antiemetic drugs (replacement for IV antiemetics)

To continue to bill Medicare for these Part B medications **without accreditation,** as a pharmacy, you will need to update your status by submitting an **amended CMS-855S application** to the NSC. Therefore, if you choose to forgo accreditation, you must still obtain a surety bond, and the CMS-855S application must be amended in order to bill Medicare properly.

For more information on **accreditation,** refer to the Medicare Learning Network article SE0903 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0903.pdf.

For more information on **surety bonds**, refer to the Medicare Learning Network article MM6392 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6392.pdf and to CMS Publication 100-08, Medicare Program Integrity, Transmittal 287, at http://www.cms.hhs.gov/transmittals/downloads/R287PI.pdf.

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

## *Attention: All Providers*

# *2010 Checkwrite Schedule*

Please refer to the following table for the 2010 Checkwrite Schedule.

| Month | Electronic Cut-off Date | Checkwrite Date |
|---|---|---|
| January | 1/7/10 | 1/12/10 |
| | 1/14/10 | 1/20/10 |
| | 1/21/10 | 1/28/10 |
| February | 1/28/10 | 2/2/10 |
| | 2/4/10 | 2/9/10 |
| | 2/11/10 | 2/17/10 |
| | 2/18/10 | 2/25/10 |
| March | 2/25/10 | 3/2/10 |
| | 3/4/10 | 3/9/10 |
| | 3/11/10 | 3/16/10 |
| | 3/18/10 | 3/25/10 |
| April | 4/1/10 | 4/6/10 |
| | 4/8/10 | 4/13/10 |
| | 4/15/10 | 4/22/10 |
| May | 4/29/10 | 5/4/10 |
| | 5/6/10 | 5/11/10 |
| | 5/13/10 | 5/18/10 |
| | 5/20/10 | 5/27/10 |
| June | 6/3/10 | 6/8/10 |
| | 6/10/10 | 6/15/10 |
| | 6/17/10 | 6/24/10 |
| July | 7/1/10 | 7/7/10 |
| | 7/8/10 | 7/13/10 |
| | 7/15/10 | 7/22/10 |
| August | 7/29/10 | 8/3/10 |
| | 8/5/10 | 8/10/10 |
| | 8/12/10 | 8/17/10 |
| | 8/19/10 | 8/26/10 |
| September | 9/2/10 | 9/8/10 |
| | 9/9/10 | 9/14/10 |
| | 9/16/10 | 9/23/10 |
| October | 9/30/10 | 10/5/10 |
| | 10/7/10 | 10/13/10 |
| | 10/14/10 | 10/19/10 |
| | 10/21/10 | 10/28/10 |
| November | 10/28/10 | 11/2/10 |
| | 11/4/10 | 11/9/10 |
| | 11/10/10 | 11/18/10 |
| December | 11/24/10 | 12/1/10 |
| | 12/2/10 | 12/7/10 |
| | 12/9/10 | 12/14/10 |
| | 12/16/10 | 12/22/10 |

**Note:** There are 42 scheduled checkwrite cycles; 21 in the first six months and 21 in the second six months of the year.

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

## *Attention: All Providers*

# *Reimbursement Rate Update*

Due to legislated budget reductions, effective July 1, 2009, there was no annual inflationary adjustment in reimbursement rates for Medicaid participating providers. Rates effective with date of service July 1, 2009, were held at existing rates as of June 30, 2009, except Medicaid rates were adjusted downward in accordance with the current year's downward adjustments to the Medicare fee schedule.

Effective with date of service October 1, 2009, rate reductions (annualized over nine months) that are delineated below will be applied to all public and private Medicaid providers except for federally qualified health centers, rural health clinics, school-based and school-linked health centers, State institutions, hospital outpatient, pharmacy, hospice, and the non-inflationary components of the case-mix reimbursement system for skilled nursing facilities. Critical access hospitals will continue to have their inpatient and outpatient Medicaid costs settled at 100 percent.

The annualized reductions resulted in overall program reduction percentage that differs from the actual rate reduction percent applied. In some programs, the rates reduction percentage was not applied uniformly. Additional reimbursement reductions in the areas of nursing home and personal care service providers will be implemented as mandated by the North Carolina General Assembly. With regard to hospital providers, DMA plans to implement Diagnostic Related Grouper Version 26 for discharges occurring on and after October 1, 2009.

At this time, DMA continues to work on the establishment of the DRG weights and rates in addition to the development of the crosswalk for the new ICD-9-CM diagnosis codes. Hospitals will continue to receive claim payment utilizing Version 25. Any claim submitted with a new diagnosis code will be denied and the hospital will have to rebill the claim once the new grouper and crosswalk are implemented. Once the rates and weights are finalized for DRG Version 26, hospitals will receive new rate letters and a recoup/repay will be initiated.

Updated fee schedules have been published for all current rates on the DMA website at http://www.ncdhhs.gov/dma/fee/. Providers are reminded to bill their usual and customary rates when submitting claims to N.C. Medicaid.

The overall program and rate reduction percentages are listed below with additional explanatory information detailed.

| Program | Program Reduction % | Over All Rate Reduction % |
|---|---|---|
| Waivers: CAP MR/DD, CAP DA, CAPCHOICE, CAP CHILD | * | * |
| PCS - ACH | -5.02% | |
| Nursing Home Rate Reduction | -6.30% | |
| Nursing Home Direct Ceiling Reduction to 102.6%^ | | |
| Vent Services | -4.70% | |
| Head Injury Services | -4.70% | |
| Geropsych Services | -4.54% | |
| Swing Bed Services | -5.65% | |
| ICFMR | -5.00% | |
| Home Health, PDN | -5.73% | |
| PCS Basic/PCS Plus | -4.96% | |
| Dental Services | -5.79% ^ | -4.52% |
| Home Infusion Therapy | -4.12% | -5.66% |

| Program | Program Reduction % | Over All Rate Reduction % |
|---|---|---|
| Physician, Independent Laboratory, Radiology, Local Heal Departments, Health Check, Anesthesia, CRNA, Chiropractor, Optical Supplies, Optometrist, Podiatry, Multi-Specialty Independent Professional Practitioners, Occupational Therapy, Physical Therapy, Respiratory Therapy, Speech Therapy, Nurse Midwife, | -4.90% | -9.00% *** |
| Ambulatory Surgical Centers. | -5.46% | -5.46% |
| Rehabilitative Services | -4.68% | Various**** |
| Psychiatric Residential Treatment Facilities | -4.28% | -8.05% |
| Durable Medical Equipment | -4.16% | Various |
| Case Management / Targeted Case Management | -14.48% | Various** |
| Extended Services for Pregnant Women | -7.32% | -9.76% |
| Orthotics and Prosthetics | -4.15% | -5.60% |
| Physician Drug Program | -2.70% | -3.60% |
| Local Education Authorities | -6.14% | -9.00% |
| Hearing | -6.32% | -9.76% |
| Hospital (In-Patient) | -6.32% | |

^The difference in the Dental percentage impact is due to the additional policy change on sealants.

*Rates for waiver services vary due to parity between State Plan rates and the waivers.

**Case Management: The following procedure codes and rates are applicable for all providers in all Medicaid Waivers and Programs except as specifically noted for At-Risk Case Management and HIV Case Management:

| Procedure Code | Description | Old Rate | New Rate | Effective Date |
|---|---|---|---|---|
| S9445 | Patient Education, Not Otherwise Classified, Non-Physician Provider (1unit=15min.) | $16.50 | $14.43 | 10/01/2009 |
| T1016 | Case Management, Each 15 Minutes | $15.25 and $21.74 | $14.43 | 10/01/2009 |
| T2041 | Supports Brokerage, Self-Directed, Waiver; Per 15 Minutes | $15.25 | $14.43 | 10/01/2009 |
| T1017 | Targeted Case Management (One Unit = 15 Minutes) | $29.30 | $17.76 | 10/01/2009 |
| T1017 HI | Targeted Case Management (One Unit = 15 Minutes) | $18.75 and $29.30 | $17.67 | 10/01/2009 |
| T1017 | Targeted Case Management (One Unit = 15 Minutes) for **At-Risk Case Management and HIV Case Management** | $13.82 | $13.22 | 10/01/2009 |

*** **Primary Care Physicians** codes for *Physician Evaluation and Management Services* can be billed by other providers. The rates for these services were not reduced and are held at the Jan 1, 2009 rate. The -9.00% rate reduction was applied to all of the other Physician Services Procedure codes rendering the -4.90% over all program reduction.

| Code | Description |
|---|---|
| 99201 – 99205 | New Patient office visit codes |
| 99211 – 99215 | Established Patient office visit codes |
| 99217 | Observation care discharge |
| 99218 – 99220 | Initial observation care |
| 99221 – 99223 | Initial hospital care |
| 99231 – 99233 | Subsequent hospital care |
| 99234 – 99236 | Observation or inpatient care services (admission and discharge on the same day |
| 99238 – 99239 | Hospital discharge day management |
| 99291 – 99292 | Critical care |
| 99304 – 99306 | Initial nursing facility care |
| 99307 – 99310 | Subsequent nursing facility care |
| 99315 – 99316 | Nursing facility discharge services |
| 99318 | Evaluation and management of a patient involving an annual nursing facility assessment |
| 99324 – 99328 | Domiciliary, rest home (e.g., boarding home), or custodial care services new patient |
| 99334 – 99337 | Domiciliary, rest home (e.g., boarding home), or custodial care services established patient |
| 99341 – 99345 | Home visit for the evaluation and management of a new patient |
| 99347 – 99350 | Home visit for the evaluation and management of an established patient |
| 99354 – 99355 | Prolonged physician service in the office or other outpatient setting |
| 99356 – 99357 | Prolonged physician service in the inpatient setting |
| 99367 | Medical team conference with interdisciplinary team; participation by physician<br>(DMA limits to use for case conference for sexually abused children. See Clinical Coverage Policy 1A-5) |
| 99375 | Physician supervision of a patient under care of home health agency requiring complex and multidisciplinary care modalities within a calendar month; 30 minutes or more |
| 99378 | Physician supervision of a hospice patient requiring complex and multidisciplinary care modalities within a calendar month; 30 minutes or more |
| 99381 – 99387 | New patient initial comprehensive preventive medicine E/M |
| 99391 – 99397 | Established patient periodic comprehensive preventive medicine E/M |
| 99406 – 99407 | Smoking and tobacco use cessation counseling visit |
| 99408 – 99409 | Alcohol and/or substance abuse structured screening and brief intervention (SBI) services |
| 99420 | Administration and interpretation of health risk assessment instrument |
| 99460 – 99463 | Newborn care services |

**** The Rehabilitative services are comprised of the Mental Health Independent Professional Practitioners, the Residential Treatment program, and the Enhanced Mental Health services.

The program change information is listed in the tables below:

| Program | Service | Program Reduction % | Rate Reduction % |
|---|---|---|---|
| IPP | All CPT | -2.93% | various |
| IPP | All H - Codes | -6.10% | -8.14% |
| Residential Treatment | HRI Level I<br>HRI Level II – TFC<br>HRI Level II – Group Homes | -3.94 | -5.25% |
| Residential Treatment | HRI Level III<br>HRI Level IV | -4.38 | -5.85% |
| Enhanced Mental Health | All procedure codes with the exception of the four services held harmless [1] | -4.79% | -9.62% |

The services listed below are not part of the rate reduction for Rehabilitative Services and their rates remain at the current rate.

| Code | Description | Current Rate |
|---|---|---|
| H2011 | Mobile Crisis Management | $ 34.37 |
| H2022 | Intensive In-Home Services | 258.20 |
| H2033 | Multi-systemic Therapy | 37.32 |
| ACTT | Assertive Community Treatment Team | 301.35 |

***** Specific **Durable Medical Equipment Program** reductions were applied to the Services listed below. All other DME services were reduced by .76%.

| Code and Modifier | Description | Current Rate | New Rate |
|---|---|---|---|
| A4253NU | Blood Glucose Test Strips Or Reagent Strips For Home Glucose Moni | $ 33.94 | $ 30.06 |
| A4259NU | Lancets, Per Box Of 100 | 12.06 | 10.91 |
| B4035NU | Enteral Feeding Supply Kit, Pump Fed - Daily | $12.40 | 11.30 |
| E0260RR | Hospi Bed W/Any Type Rails Semi Elect Head/Foot Ad | 137.14 | 127.12 |
| E0260NU | Hospi Bed W/Any Type Rails Semi Elect Head/Foot Ad | 1,371.42 | 1,271.20 |
| E0260UE | Hospi Bed W/Any Type Rails Semi Elect Head/Foot Ad | 1,028.57 | 953.40 |
| E0431RR | Portable Gaseous 02 System, Rental, Includes Regulator, Flowmeter | 31.79 | 28.77 |
| E0434NU | Portable Liquid Oxygen System, Rental; Inc. Portable Container, Flowmeter, Tubin | 31.79 | 28.77 |
| E0470RR | Respiratory Assist Device, Bilevel Pressure Capability, W/O Back Up Rate Feature | 256.60 | 232.22 |
| E0470NU | Respiratory Assist Device, Bilevel Pressure Capability, W/O Back Up Rate Feature | 2,566.00 | 2322.20 |

| Code and Modifier | Description | Current Rate | New Rate |
|---|---|---|---|
| E0470UE | Respiratory Assist Device, Bilevel Pressure Capability, W/O Back Up Rate Feature | 1,924.50 | 1741.50 |
| E0471RR | Respiratory Assist Device, Bilevel Pressure Capability W/Back Up Rate Feature | 642.17 | 581.16 |
| E0562RR | Humidifier, Heated, Used With Positive Airway Pressure Device | 30.11 | 27.26 |
| E0562NU | Humidifier, Heated, Used With Positive Airway Pressure Device | 301.22 | 272.60 |
| E0562UE | Humidifier, Heated, Used With Positive Airway Pressure Device | 225.91 | 204.45 |
| E0570RR | Nebulizer With Compressor E.G. Devilbliss Pulmo-Ad | 16.11 | 14.00 |
| E0570NU | Nebulizer With Compressor E.G. Devilbliss Pulmo-Ad | 161.10 | 140.00 |
| E0570UE | Nebulizer With Compressor E.G. Devilbliss Pulmo-Ad | 120.83 | 105.00 |
| E0601RR | Nasal Continuous Airway Pressure (CPAP) Device | 107.33 | 101.00 |
| E0601NU | Nasal Continuous Airway Pressure (CPAP) Device | 1,073.34 | 1,010.00 |
| E0601UE | Nasal Continuous Airway Pressure (CPAP) Device | 805.00 | 757.50 |
| E1390RR | Oxygen Concentrator, Capable Of Delivering 85% Oxygen Concentration | 199.28 | 175.79 |
| E2402RR | Negative Pressure Wound Therapy Electrical Pump, Stationary Or Portable | 1,800.70 | 1,553.40 |
| S8490NU | Insulin Syringes (100 Syringes, Any Size) | 33.46 | 30.11 |

Please refer to the published fee schedules for all current rates on the DMA website at http://www.ncdhhs.gov/dma/fee/. Providers are reminded to bill their usual and customary rates when submitting claims to NC Medicaid.

Please direct any questions to Roger Barnes, Assistant Director, DMA Finance Management, at 919-855-4183.

**Finance Management**
**DMA, 919-855-4180**

## *Early and Periodic Screening, Diagnosis and Treatment and Applicability to Medicaid Services and Providers*

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

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

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

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

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

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

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

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

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

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

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

## *Proposed Clinical Coverage Policies*

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

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

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

## *2009 Checkwrite Schedule*

| Month | Electronic Cut-off Date | Checkwrite Date |
|---|---|---|
| October | 10/1/09 | 10/6/09 |
| | 10/8/09 | 10/14/09 |
| | 10/15/09 | 10/20/09 |
| | 10/22/09 | 10/29/09 |
| | 10/29/09 | 11/3/09 |
| November | 11/5/09 | 11/10/09 |
| | 11/12/09 | 11/19/09 |
| | 11/25/09 | 12/1/09 |

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

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

**Melissa Robinson**
**Executive Director**
**EDS, an HP Company**