North Carolina Medicaid Bulletin

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

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Attention: All Providers

General Medicaid Billing Seminars

Seminars on general Medicaid billing guidelines are scheduled for January 2005. Registration information and a list of dates and site locations for the seminars will be published in the December 2004 general Medicaid bulletin.

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

Attention: All Providers

NCLeads Update

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

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

Attention: All Providers

Medicaid Credit Balance Reporting

All providers participating in the Medicaid program are required to submit to the Division of Medical Assistance (DMA), Third Party Recovery Section a quarterly **Credit Balance Report** indicating balances due to Medicaid. Providers must report any **outstanding** credits owed to Medicaid that have not been reported previously on a Medicaid Credit Balance Report. However, hospital and nursing facility providers are required to submit a report every calendar quarter even if there are no credit balances. The report must be submitted no later than 30 days following the end of the calendar quarter (March 31, June 30, September 30, and December 31).

The Medicaid Credit Balance Report is used to monitor and recover "credit balances" owed to the Medicaid program. A credit balance results from an improper or excess payment made to a provider. For example, refunds must be made to Medicaid if a provider is paid twice for the same service (e.g., by Medicaid and a medical insurance policy, by Medicare and Medicaid, by Medicaid and a liability insurance policy, if the patient liability was not reported in the billing process or if computer or billing errors occur).

For the purpose of completing the report, a Medicaid Credit Balance is the amount determined to be refundable to the Medicaid program. When a provider receives an improper or excess payment for a claim, it is reflected in the provider's accounting records (patient accounts receivable) as a "credit." However, credit balances include money due to Medicaid regardless of its classification in a provider's accounting records. If a provider maintains a credit balance account for a stipulated period (e.g., 90 days) and then transfers the account or writes it off to a holding account, this does not relieve the provider of liability to the Medicaid program. The provider is responsible for identifying and repaying all monies owed the Medicaid program.

The Medicaid Credit Balance Report requires specific information on each credit balance on a claim-by-claim basis. The reporting form provides space for 15 claims but may be reproduced as many times as necessary to accommodate all the credit balances being reported. Specific instructions for completing the report are on the reverse side of the reporting form.

Submitting the Medicaid Credit Balance Report does not result in the credit balances automatically being reimbursed to the Medicaid program. A check is the preferred form of satisfying the credit balances; the check must be made payable to EDS and sent to EDS with the required documentation for a refund. If an adjustment is to be made to satisfy the credit balance, an adjustment form must be completed and submitted to EDS with all the supporting documentation for processing.

Submit Medicaid Credit Balance Report Form to:	Submit **refund checks** to:	Submit Medicaid Claim Adjustment Request Form to:
Third Party Recovery Section Division of Medical Assistance 2508 Mail Service Center Raleigh, NC 27699-2508	EDS Refunds P.O. Box 300011 Raleigh, NC 27622-3011	EDS Adjustment Unit P.O. Box 300009 Raleigh, NC 27622-3009

Submit **only** the completed Medicaid Credit Balance Report to DMA. **Do not** send refund checks or adjustment forms to DMA. **Do not** send the Credit Balance Report to EDS. Failure to submit a Medicaid Credit Balance Report will result in the withholding of Medicaid payments until the report is received.

A copy of the Medicaid Credit Balance Report form is available on page 4. Both the Medicaid Claim Adjustment Request form and the Medicaid Credit Balance Report form are also available on DMA's website at http://www.dhhs.state.nc.us/dma/forms.html.

Anita Ray, Third Party Recovery Section
DMA, 919-647-8100

MEDICAID CREDIT BALANCE REPORT

PROVIDER NAME: ____ CONTACT PERSON: ____

PROVIDER NUMBER: ____ TELEPHONE NUMBER: (________) ____

QUARTER ENDING: (Circle one) 3/31 6/30 9/30 12/31 YEAR:____________

(1) RECIPIENT'S NAME	(2) MEDICAID NUMBER	(3) FROM DATE OF SERVICE	(4) TO DATE OF SERVICE	(5) DATE MEDICAID PAID	(6) MEDICAID ICN	(7) AMOUNT OF CREDIT BALANCE	(8) REASON FOR CREDIT BALANCE
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							

Circle one: Refund Adjustment

Return form to: Third Party Recovery
DMA
2508 Mail Service Center
Raleigh, NC 27699-2508

Revised 9/03

Instructions for Completing Medicaid Credit Balance Report

Complete the "Medicaid Credit Balance Report" as follows:

- Full name of facility as it appears on the Medicaid Records
- The facility's **Medicaid** provider number. If the facility has more than one provider number, use a separate sheet for each number. **DO NOT MIX**
- Circle the date of quarter end
- Enter year
- The name and telephone number of the person completing the report. This is needed in the event DMA has any questions regarding some item in the report

Complete the data fields for each Medicaid credit balance by providing the following information:

Column 1 - The last name and first name of the Medicaid recipient (e.g., Doe, Jane)

Column 2 - The individual Medicaid identification (MID) number

Column 3 - The month, day, and year of beginning service (e.g., 12/05/03)

Column 4 - The month, day, and year of ending service (e.g., 12/10/03)

Column 5 - The R/A date of Medicaid payment (not your posting date)

Column 6 - The Medicaid ICN (claim) number

Column 7 - The amount of the credit balance (not the amount your facility billed or the amount Medicaid paid)

Column 8 - The reason for the credit balance by entering: "81" if it is a result of a Medicare payment; "83" if it is the result of a health insurance payment; "84" if it is the result of a casualty insurance/attorney payment or "00" if it is for another reason. Please explain "00" credit balances on the back of the form.

After this report is completed, total column 7 and mail to **Third Party Recovery, DMA, 2508 Mail Service Center, Raleigh, NC 27699-2508**.

Attention: Community Alternatives Program Providers

Reimbursement Rate Increase for Community Alternatives Program Services

Effective with date of service August 16, 2004, the Medicaid maximum reimbursement rate for the following Community Alternatives Program (CAP) services was increased. This was an interim rate increase that will be effective through December 2004. Results from a pending audit of PCS providers may result in a subsequent rate change. Providers are to be notified of any further rate changes in future general Medicaid bulletins.

Procedure Code	Description	Reimbursement Rate
S5125	CAP/C Personal Care	$3.55/15 min unit
S5125	CAP/AIDS In-Home Aide II-Personal Care	$3.55/15 min unit
S5125	CAP/AIDS In-Home Aide III-Personal Care	$3.55/15 min unit
S5125	CAP/DA In-Home Aide II-Personal Care	$3.55/15 min unit
S5125	CAP/DA In-Home Aide III-Personal Care	$3.55/15 min unit
S5125	CAP-MR/DD-Personal Care	$3.55/15 min unit
S5120	CAP-MR/DD In-Home Aide Level I	$3.55/15 min unit
S5150	CAP/C Respite Care In-Home	$3.55/15 min unit
S5150	CAP/AIDS Respite Care In-Home, Aide Level	$3.55/15 min unit
S5150	CAP/DA Respite Care In-Home	$3.55/15 min unit
S5150	CAP-MR/DD Respite Care Community Based	$3.55/15 min unit

In addition, S5150 HQ, CAP-MR/DD Respite Care (group of 2 to 3 clients) has been revised effective October 1, 2004 to $2.74 per 15 minute unit.

Procedure Code	Description	Reimbursement Rate
T1000	CAP/C Nursing Services	$9.11/15 min unit
T1005TD	CAP/AIDS Respite Care – Nursing Level RN	$9.11/15 min unit
T1005TE	CAP/AIDS Respite Care – Nursing Level LPN	$9.11/15 min unit
T1005TD	CAP-MR/DD Respite Care – Nursing Level RN	$9.11/15 min unit
T1005TE	CAP-MR/DD Respite Care – Nursing Level LPN	$9.11/15 min unit

Pat Jeter, Rate Setting
DMA, 919-855-4200

Attention: All Dental Providers Including Health Department Dental Clinics

ADA Code Updates

Effective with date of service October 1, 2004, the following dental procedure codes have been added to the NC Medicaid Dental Program. These additions were published on September 1, 2004 in Special Bulletin VI: Dental Services Coverage Policy and Billing Guidelines.

CDT-4 Code	Description	Reimbursement Rate
D0170	Re-evaluation – limited, problem focused *use as a follow-up exam for a specific problem that has been evaluated previously using D0140 *document in the patient's chart the nature of the emergency and the treatment provided	$20.00
D1204	Topical application of fluoride (prophylaxis not included) – adult *limited to recipients 13 through 20 years old	$15.44
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration) *limited to recipients under age 6 *not allowed for the same tooth on the same date of service as D3220	$150.00
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration) *limited to recipients under age 9 *allowed for primary second molars only *not allowed for the same tooth on the same date of service as D3220	$200.00
D3320	Bicuspid (excluding final restoration) *limited to recipients under age 21 *not allowed for the same tooth on the same date of service as D3220	$259.57

The following procedure codes were end-dated effective with date of service September 30, 2004.

Procedure code	Description
D2910	Recement inlay
D2920	Recement crown
D3110	Pulp cap – direct (excluding final restoration)

In addition, the following changes are effective with date of service October 1, 2004:

- Code D0220 [Intraoral – periapical first film] is now reimbursed at a rate of $14.60 to coincide with a coverage policy revision.
- Code D1203 [Topical application of fluoride (prophylaxis not included) – child]is now covered only for recipients who are between ages 0 and 12 years; the age limit for D1203 covered in the physician fluoride varnish program remains 0 to 2 years.

Providers are reminded to bill their usual and customary charges rather than the Medicaid rate. For coverage criteria and additional billing guidelines, please refer to Clinical Coverage Policy 4A, Dental Services, which is available on the DMA web site at http://www.dhhs.state.nc.us/dma/dental/1dental.pdf.

Dr. Ron Venezie, Dental Director
DMA, 919-855-4280

Attention: Dental Providers Including Health Department Dental Clinics

DMA's Dental Program Website

The Division of Medical Assistance (DMA) has a new website for the NC Medicaid Dental Program located at http://www.dhhs.state.nc.us/dma/dental.htm. This website includes links to the current dental and orthodontic policy manuals as well as the current dental fee schedule. You also will find a list of frequently asked questions, instructions for the Automated Voice Response (AVR) system, and a list of tips for correcting the most common dental claim denials. The Dental Program website also includes links to those Medicaid forms that are most often used by dental providers. Please let us know if you have suggestions for other helpful links that could be included.

Dr. Ron Venezie, Dental Director
DMA, 919-855-4280

Attention: Durable Medical Equipment Providers

HCPCS Code Conversion from A4323 and K0409 to A4217

In order to comply with the Centers for Medicare and Medicaid Services' coding changes, codes A4323, sterile saline, 1000 ml, and K0409, sterile water, 1000 ml, will be end-dated on November 30, 2004. They will be replaced with code A4217, sterile water/saline, 500 ml.

Effective with date of service December 1, 2004, providers must bill for sterile water/saline with code A4217. The maximum reimbursement rate will be $2.66. Prior approval is not required. However, a Certificate of Medical Necessity and Prior Approval form must be completed regardless of the requirement for prior approval.

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

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

HCPCS Code Changes for Home Health Supplies

Reimbursement Rate Increase for Private Duty Nursing Services

Effective with date of service October 1, 2004, the Medicaid maximum reimbursement rate for In-Home Private Duty Nursing is being changed to $9.11 per 15 minute unit. This is an annual rate increase per the State Plan.

Effective with date of service November 30, 2004, the following HCPCS codes will be end-dated to comply with the national standard codes mandated by the Health Insurance Portability and Accountability Act (HIPAA). The new codes will become effective December 1, 2004.

HCPCS Code List

Current HCPCS Code	New HCPCS Code	Description	Billing Unit	Maximum Reimbursement Rate
A4214	A4216	Sterile /saline or water, 10ml	10ml	$ .40
A4323 K0409	A4217	Sterile /saline or water, 500ml	500ml	2.66
A4621	A7525	Tracheostomy mask each	Each	2.07
	A7526	Tracheostomy tube, collar and holder	Each	3.37
A4622	A7520	Tracheostomy/laryngectomy tube, non-cuffed, polyvinylchloride (pvc), silicone or equal each	Each	47.48
	A7521	Tracheostomy/laryngectomy tube, cuffed polyvinylchloride (pvc), sil1cone or equal each.	Each	47.05
	A7522	Tracheostomy/laryngectomy tube, stainless steel or equal (sterilizable or reusable), each	Each	45.16
A6422	A6443	Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to three inches and less than 5 inches, per yard	Per yard	.29
A6424	A6444	Conforming bandage, non-elastic, knitted/woven, nonsterile greater than or equal to five inches per yard.	Per yard	.56
A6426	A6446	Conforming bandage, nonelastic, knitted/woven, sterile, width greater than or equal to three inches and less than 5 inches, per yard	Per yard	.41
A6428	A6447	Conforming bandage, nonelastic, knitted/woven, sterile, greater than or equal to five inches per yard	Per yard	.67
A6430	A6449	Light compression bandage, elastic, knitted/woven, width greater than or equal to three inches and less than 5 inches, per yard	Per yard	1.75
A6432	A6450	Light compression bandage, elastic, knitted/woven, width greater than or equal to 5 inches, per yard	Per yard	1.00
A6440	A6456	Zinc paste impregnated bandage, nonelastic, knit/woven, width greater than or equal to 3 inches and less than 5 inches, per yard	Per yard	1.28
B4084	B4086	Gastrostomy/jejunostomy tube any type	Each	17.09
K0621	A6407	Packing strips, non-impregnatal, up to 2 inched wide	Each	1.88
S8181	See A7526 Above	Tracheostomy tube, collar and holder	Each	3.37
W4651	Use current code A4253	Blood glucose test strips	50/pkg	33.22

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

Attention: Home Health Providers

Revision to Rates for Home Health Agencies

The Home Health Fee Schedule has been updated to reflect the following rates for all home health visits. The update is effective for dates of service July 1, 2004. EDS will generate automated adjustments for claims processed and paid at the old rate. Providers do not need to submit adjustment requests.

Revenue Code	Home Health Services Description	Billing Unit	Maximum Rate Reimbursement
420	Physical Therapy	1 visit	$99.94
424	Physical Therapy - Evaluation	1visit	99.94
430	Occupational Therapy	1 visit	99.94
434	Occupational Therapy - Evaluation	1visit	99.94
440	Speech Therapy	1 visit	99.94
444	Speech Therapy - Evaluation	1visit	99.94
550	Observation/Evaluation of stable patient	1 visit	101.41
551	Skilled Nursing Visit Prefilling insulin syringes	1 visit	101.41
559	Skilled Nursing Visit for Prefilling medicine planners	1 visit	101.41
570	Home Health Aide	1 visit	46.39
580	Skilled Nursing Visit for Venipuncture	1 visit	101.41
581	Skilled Nursing Visit for Denied by Medicare for dually-eligible patient	1 visit	101.41
589	Skilled Nursing Visit meeting Medicare criteria	1 visit	101.41
590	Skilled Nursing Visit/Not Otherwise Classified	1 visit	101.41

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

Attention: Hospitals and Physicians

Outpatient Observation Charges for Hysterectomies

The N.C. Medicaid program does not routinely cover observation charges for hysterectomies. These charges are covered only in situations where a patient exhibits an uncommon or unusual reaction or other postoperative complications that require monitoring or treatment beyond the usual provided in the immediate post operative period. When observation charges are billed and no records are included with the claim, the claim will be denied for medical records to substantiate necessity for the service. Providers will receive the denial EOB 1396 "Observation is not routinely allowed. Submit records to review for medical necessity, include: History and Physical, Operative records, Pathology report and Discharge summary."

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

Attention: Independent Practitioner Program Providers

Revision to Rates for Independent Practitioner Program Services

Effective with date of service September 17, 2004, the rates for some services provided by the Independent Practitioners Program were changed. Below is a list of the changes.

Refer to Clinical Policy #10B (previously numbered as #8G) on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm for additional information and for a complete list of billing codes.

Note: Not all rates are changing at this time. Please refer to future bulletin articles for further information. Providers should continue to bill their usual and customary charges.

Procedure Code	Maximum Reimbursement Rate
29075	$ 69.79
29085	74.33
29105	72.68
29125	55.15
29126	68.14
29130	33.91
29131	44.49
29240	54.90
29260	45.37
29280	45.93
29405	72.21
29425	78.52
29505	63.99
29515	55.72
29530	47.73
29540	32.73
31502	73.36
31720	87.02
92065	31.39
92510	123.43
92526	74.77
92551	9.69
92552	15.41
92567	18.49
92569	14.09
92571	13.43
92572	3.19

Procedure Code	Maximum Reimbursement Rate
92576	$ 15.63
92583	31.14
92587	52.81
92588	70.00
92590	39.94
92591	59.99
92592	17.56
92593	26.31
92594	18.98
92595	28.82
92610	115.35
94010	28.81
94060	49.52
94150	18.77
94200	19.09
94240	32.00
94375	31.80
94657	63.34
95831	21.38
95832	18.76
95833	31.75
95834	38.23
97010	4.00
97012	13.71
97016	12.88
97018	5.98
97020	4.33

Procedure Code	Maximum Reimbursement Rate
97022	$ 13.51
97024	5.32
97026	4.33
97028	5.37
97032	14.37
97033	18.91
97034	12.95
97035	11.30
97036	21.05
97110	26.09
97112	26.31
97116	22.55
97124	20.23
97140	24.28
97504	27.74
97520	25.65
97530	26.61
97533	23.75
97535	27.30
97542	25.43
97601	35.01
97602	15.77
97703	22.85
97750	26.31

Laurie Edwards, Financial Management
DMA, 919-855-4200

Attention: Local Education Agencies

Revision to Rates for Local Education Agency Services

Effective with date of service September 17, 2004, the rates for some services provided by Local Education Agencies (LEAs) were changed. Below is a list of the changes. This table replaces information published in the April 2004 general Medicaid bulletin.

The below are maximum reimbursement rates; however, providers must bill their usual and customary charges. Schools that bill Medicaid are only paid the federal share of the Medicaid reimbursement rate listed below. Reimbursement rates will change as the Federal Financial Participation (FFP) percentage changes.

Refer to the Clinical Coverage Policy #10C (previously numbered at 8H) on DMA's website at http://www.dhhs.state.nc.state.us/dma/mp/mpindex.htm for additional information on billing for LEA services and a complete list of billing codes.

Note: Not all rates are changing at this time. Please refer to future bulletin articles for further information.

Procedure Code	Maximum Reimbursement Rate
29075	$ 69.79
29085	74.33
29105	72.68
29125	55.15
29126	68.14
29130	33.91
29131	44.49
29240	54.90
29260	45.37
29280	45.93
29405	72.21
29505	63.99
29515	55.72
29530	47.73
29540	32.73
90801	139.49
90802	148.15
90804	59.98
90806	90.19
90808	134.73
90810	64.21
90812	97.28

Procedure Code	Maximum Reimbursement Rate
90814	$ 141.27
90846	87.47
90853	29.40
92065	31.39
92510	123.43
92526	74.77
92551	9.69
92552	15.41
92567	18.49
92569	14.09
92572	3.19
92576	15.63
92583	31.14
92585	89.93
92587	52.81
92588	70.00
92590	39.94
92591	59.99
92592	17.56
92593	26.31
92594	18.98
92595	28.82

Procedure Code	Maximum Reimbursement Rate
95831	$ 21.38
95832	18.76
95833	31.75
95834	38.23
96100	62.40
96110	10.22
96111	131.50
96115	62.40
96117	62.40
97110	26.09
97112	26.31
97116	22.55
97140	24.28
97504	27.74
97520	25.65
97530	26.61
97533	23.75
97535	27.30
97542	25.43
97703	22.85
97750	26.31

Laurie Edwards, Financial Management
DMA, 919-855-4200

Attention: Licensed or Certified Psychologists, Licensed Clinical Social Workers, Certified Clinical Nurse Specialists in Psychiatric Mental Health Advanced Practice, Nurse Practitioners Certified as Clinical Nurse Specialists in Psychiatric Mental Health Advanced Practice, Licensed Psychological Associates, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Clinical Addictions Specialists, and Certified Clinical Supervisors

Seminar Schedule for the Expansion of Provider Types for Outpatient Behavioral Health Services

Seminars for the expansion of provider types for Outpatient Behavioral Health Services are scheduled for December 2004. This seminar will focus on the expansion of access to services for Medicaid eligible recipients by increasing the provider community and the age group that they serve.

Providers are encouraged to arrive 30 minutes before the seminar begins to complete registration. Unregistered providers are welcome to attend if space is available. No food or drinks will be provided.

Providers may register for the seminars by completing and submitting the registration form on the next page or by registering online at http://www.dhhs.state.nc.us/dma/provsem.htm.

The December 2004 Special Bulletin VII, *Outpatient Behavioral Health Services Provided by Direct Enrolled Providers*, will be used as the primary training document for the seminar. The special bulletin will be available on DMA's website beginning December 2004 at http://www.dhhs.state.nc.us/dma/bulletin.htm. **Please print the special bulletin and bring it to the seminar.**

Tuesday, December 7, 2004
(9:00 am – 12:00 pm)
Park Inn
909 Highway 70 SW
Hickory, N.C.

Wednesday, December 8, 2004
(9:00 am – 12:00 pm)
Blue Ridge Community College
Bo Thomas Auditorium
Flat Rock, N.C.

Thursday, December 9, 2004
(9:00 am – 12:00 pm)
Greenville Hilton
207 Greenville Blvd. SW
Greenville, N.C.

Friday, December 10, 2004
(12:30 pm – 3:30 pm)
WakeMed
Andrews Conference Center
3000 New Bern Ave.
Raleigh, N.C.

Directions to the Expansion of Provider Types for Outpatient Behavioral Health Services Seminars:

Park Inn Gateway Conference Center – Hickory, North Carolina
Take I-40 to exit 123. Follow signs to Highway 321 North. Take the first exit (Hickory exit) and follow the ramp to the stoplight. Turn right at the light onto Highway 70. The Gateway Conference Center is on the right.

Blue Ridge Community College, Bo Thomas Auditorium – Flat Rock, North Carolina
Take I-40 to Asheville. Travel east on I-26 to exit 22. Turn right and then take the next right. Follow the signs to Blue Ridge Community College. Turn left at the large Blue Ridge Community College sign. The college is located on the right. Take the first right-hand turn into the parking lot for the Bo Thomas Auditorium.

Greenville Hilton – Greenville, North Carolina
Take Highway 264 east to Greenville. Turn right onto Allen Road in Greenville. Travel approximately 2 miles. Allen Road becomes Greenville Boulevard/Alternate 264. Follow Greenville Boulevard for 2½ miles to the Hilton Greenville, which is located on the right.

WakeMed Andrews Conference Center – Raleigh, North Carolina
Take the I-440 Raleigh Beltline to exit 13A, New Bern Avenue.

Paid parking ($3.00 maximum per day) is available on the **top two levels** of parking deck P3. To reach the parking deck, turn left at the fourth stoplight on New Bern Avenue, and then turn left at the first stop sign. Parking for oversized vehicles is available in the overflow lot for parking deck P3. Handicapped accessible parking is available in parking lot P4, directly in front of the conference center.

To enter the Andrews Conference Center, follow the sidewalk toward New Bern Avenue past the Medical Office Building to entrance E2 of the William F. Andrews Center for Medical Education. A map of the WakeMed campus is available online at http://www.wakemed.org/maps/.

Illegally parked vehicles will be towed. Parking is **not** permitted at East Square Medical Plaza, Wake County Human Services or in parking lot P4 (except for handicapped accessible parking).

Outpatient Behavioral Health Provider Expansion Seminar Registration Form
(No Fee)

Provider Name ______________________________ Provider Number ________________________
Address ____
City, Zip Code ______________________________ County ______________________________
Contact Person ______________________________ E-mail Address ________________________
Telephone Number ___________________________ Fax Number ___________________________
1 or **2** (circle one) person(s) will attend the seminar at ____________________ on ________________
(location) (date)

Return to: Provider Services
EDS
P.O. Box 300009
Raleigh, NC 27622

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

Attention: Nursing Facility Providers

Medical Data Sets Validation Program for Nursing Facilities

On October 1, 2004, the Division of Medical Assistance (DMA) will begin a new Medical Data Sets (MDS) Validation Program as a component of the Medicaid Case Mix Reimbursement System. All facilities participating in the Medicaid Case Mix Reimbursement System are required to participate in the MDS Validation Program. The overall goal of the Case Mix Reimbursement System is to align payments with the level of care needed by the residents in the facility. Completion of the MDS reports is a very important function of the nursing facility staff and ensures that the nursing facility receives accurate payments from the N.C. Medicaid program.

The MDS Validation Program provides DMA and the nursing facility with assurance that the Medicaid payments are accurately based on the recorded medical and functional needs of the nursing facility resident as documented in the medical record. The MDS Validation Program replaces the FL2 and FL12 utilization review program performed by the facility staff and contract physicians, which was discontinued as of September 30, 2003.

DMA has contracted with Myers and Stauffer, LLP, to provide registered nurse reviewers to conduct onsite MDS reviews of each nursing facility in North Carolina. The reviews were scheduled to begin on October 1, 2004. All of the reviews will be completed by September 30, 2005. This first year (October 1, 2004 through September 30, 2005) of reviews are considered as **educational** reviews and are intended to assist facility staff in understanding the process and the requirements for MDS supportive documentation.

Important Definitions for the MDS Validation Program

RUG-III Reimbursement System – Medicaid uses the RUG III system to assign the facility Case Mix Index (CMI) rate. RUG III groups classify residents into 34 groups that use similar quantities of resources defined as nursing time, therapy time, and nursing assistant time. There are 108 MDS 2.0 elements that determine the RUG III classification system.

Case Mix – refers to a combination of different individual resident profiles seen in a specific setting or facility.

Case Mix Index (CMI) – each RUG-III group is assigned a weight, or numeric score, which reflects the relative resources predicted to provide care to the resident. The higher the case mix index, the greater the resource requirement for the resident.

Resident Roster – identifies all non-discharged residents and includes information on the MDS RUG-III elements transmitted on the sample set of assessments. In addition, it provides a summary of the number of MDS records in each RUG-III category.

Supportive Documentation Guidelines

DMA uses the Supportive Documentation Guidelines approved by the Centers for Medicare and Medicaid Services (CMS) to define the supporting documentation necessary to verify a RUG-III item during an MDS review.

MDS Validation Program Protocols

1. The list of residents or resident roster is produced on a Case Mix Index Report (CMI Report) every quarter on the "snapshot date" and sent to the facility. The "snapshot dates" are March 31, June 30, September 30, and December 31. For a facility review occurring in October 2004, the review sample will be drawn from the CMI Report dated June 30, 2004. For a facility review, occurring in February 2005, the review sample will be drawn from the CMI Report of residents in the facility dated September 30, 2004.

2. The sample will be drawn from all residents listed on the final CMI report regardless of payer source.

3. Both the primary and expanded samples shall include a minimum of 80 percent Medicaid recipients.

4. In the second year of case mix reviews, facilities will experience an expanded review when the primary assessment sample results in an unsupported percent are equal to or greater than the state threshold. This expanded review will include an additional 10 percent of the residents on the final CMI report or an additional 10 assessments, whichever is greater.

5. The results of the MDS Validation Program may result in re-rugging and a change in the case mix index rate for the nursing facility, as defined below.

MDS Review Process

1. Nursing facilities will be notified by the contract nurse reviewers both by phone and by fax three (3) business days prior to the visit.

2. An entrance conference will be held with the nursing facility administrator, the MDS coordinator, and any other facility personnel the administrator selects to discuss the overall objectives of the review and to allow the facility personnel to ask questions.

3. The nurse reviewer will prepare a list of the MDS's and resident records selected for review and ask the facility personnel to pull the records. If possible, the primary sample will include at least one assessment from each of the seven RUG-III classification groups.

4. The review begins immediately after the entrance conference. The reviewers will use the MDS documentation guidelines as issued by CMS (http://www.cms.hhs.gov/medicaid).

5. The reviewer will verify the MDS items and determine if the RUG-III category reported on the Final Case Mix Report is supported with documentation in the medical record.

6. Documentation for the activities of daily living (ADL's) must reflect 24/7 of the observation periods to verify the submitted values on the MDS.

7. Immediately following the review of the MDS assessments, the medical records, and other supportive documentation, the nurse reviewers will hold an exit interview with the facility staff to review preliminary results. Any unresolved issues or trends will be identified and discussed.

8. No supporting documentation will be accepted after the close of the exit conference.

9. A case mix review summary letter will be mailed to the provider by the nurse reviewers from Myers and Stauffer indicating the results of the review.

10. DMA reserves the right to conduct follow-up reviews as needed. These reviews would occur no earlier than 120 days following the exit interview.

Delinquent MDS Assessment:
Any assessment with an R2b date greater than 121 days from the previous R2b date will be deemed delinquent and assigned a RUG-III code of BC1, which is the lowest possible case mix index.

Unsupported MDS Assessment
The MDS is unsupported when the MDS nurse reviewers do not find adequate documentation for the RUG-III Classification level in the patient record. An unsupported MDS assessment can result in a different RUG-III classification from the one submitted by the facility.

Effect of Unsupported Thresholds
1. First year of program (October 2004 through September 2005) – No penalties for unsupported MDS values.

2. Second year of program (October 2005 through September 2006) – 40 percent unsupported MDS values will result in re-rugging of all unsupported MDS assessments and a recalculation of the direct rate. May also result in a retrospective rate adjustment.

3. Third year of the program (October 2006 through September 2007) – 35 percent unsupported MDS values will result in re-rugging of all unsupported MDS assessments and a recalculation of the direct rate. May also result in a retrospective rate adjustment.

4. Fourth and succeeding years of program (October 2007 through September 2008) – 25 percent unsupported will result in the recalculation as above.

The following resources are available to facility staff for questions related to the MDS and MDS Validation Program

MDS State Contact – For all questions related to coding.
Cindy DePorter, Division of Facility Services
919-715-1872, ext. 214

MDS Help Desk
919-715-1872
QUIESHELPDESK@ncmail.net

Myers and Stauffer's Help Desk – For questions other than coding issues.
Documentation Guidelines
1-800-763-2278

MDS Validation Program Oversight and Administration
Margaret Comin, RN, Facility Unit Manager
DMA, 919-855-4350

Attention: Physicians

Physician's Drug Program List Update

The following table lists the FDA-approved-drugs currently covered by the N.C. Medicaid program when the drugs are provided in a physician's office for the FDA-approved indications. This list replaces all previously published lists. Rates are effective with the April 1, 2004 date of service and reflect a change to 90 percent AWP. Since the effect is both increases and decreases to the rates, systematic adjustments will be made to align paid claims with these fees retroactive to April 1, 2004 for claims paid between April 1, 2004 and implementation of these rates.

Physicians will continue to bill on the CMS-1500 claim form using the appropriate drug code and indicating the specified number of units administered. Providers must bill their usual and customary charges.

An asterisk (*) indicates that an invoice must be submitted with the CMS-1500 claim form. **An invoice must be submitted with each claim.** The paper invoice must indicate the name of the recipient, the recipient's Medicaid identification number, the name of the medication, the dosage given, the National Drug Code (NDC) number from the vial(s) used, the number of vials used, and the **cost per dose**. Providers must indicate the number of units given in block 24G on the CMS-1500 claim form. Payment is based in accordance with Medicaid's State Plan for reimbursement. Providers will be reimbursed the lower of the invoice price or maximum allowable fee on file.

Injectable Drug List

Invoice Required	Procedure Code	Description	Maximum Reimbursement Rate
	J0130	Abciximab 10 mg	$486.02
	J1120	Acetazolamide Sodium, up to 500 mg (Diamox)	19.44
	J0150	Adenosine I.V., 6 mg (Adenocard)	36.85
	J0152	Adenosine, 30 mg (Adenoscan)	72.40

Injectable Drug List, continued

Invoice Required	Procedure Code	Description	Maximum Reimbursement Rate
	J0170	Adrenalin, Epinephrine, up to 1 ml ampule	$2.22
*	J3490	Agalsidase Beta, 1mg (Fabrazyme)	4500.00
	P9047	Albumin (human), 25%, 50 ml	52.20
	P9041	Albumin (human), 5%, 50 ml	13.78
	J9015	Aldesleukin, per single use vial (Proleukin, IL-2, Interleukin) 22 million I.U.	695.81
	J0215	Alefacept 0.5 mg, injection (Amevive)	29.85
	J0205	Alglucerase, per 10 units (Ceredase)	35.56
	J0256	Alpha 1 Proteinase Inhibitor Human A, 10 mg (Prolastin)	2.52
	J2997	Alteplase recombinant, 1 mg	34.77
	J0207	Amifostine 500 mg (Ethyol)	429.13
	S0072	Amikacin Sulfate (100 mg)	14.06
	S0016	Amikacin Sulfate 500 mg (Amikin)	16.88
	J0280	Aminophyllin, up to 250 mg	1.00
	J1320	Amitriptyline HCL, up to 20 mg (Elavil, Enovil)	2.28
	J0300	Amobarbital, up to 125 mg (Amytal)	2.52
	J0288	Amphotericin B cholesteryl sulfate complex, 10 mg	14.40
	J0287	Amphotericin B lipid complex, 10 mg	20.70
	J0289	Amphotericin B liposome, 10 mg	33.91
	J0285	Amphotericin B, 50 mg (Amphocin, Fungizone IV)	10.48
	J0295	Ampicillin Sodium/Sulbactam Sodium, per 1.5 gm (Unasyn)	7.03
	J0290	Ampicillin, up to 500 mg (Omnipen-N, Totacillin-N)	1.57
	J0350	Anistreplase, per 30 units (Eminase)	2552.02
	J7197	Antithrombin II (human) per I.U. (Throbate III)	1.19
	J0395	Arbutamine HCL, 1 mg (GenESA)	172.80
	J9017	Arsenic Trioxide 1mg (Trisenox)	35.10
	J9020	Asparaginase, 10,000 units (Elspar)	59.32
	J0460	Atropine Sulfate, up to 0.3 mg	0.78
	J2910	Aurothioglucose, up to 50 mg (Solganal)	16.40
	J0456	Azithromycin, 500 mg. (Zithromax)	24.20

Injectable Drug List, continued

Invoice Required	Procedure Code	Description	Maximum Reimbursement Rate
	Q0144	Azithromycin, oral suspension 1 unit = 1 gm packet (Zithromax), only oral drug on list	$23.02
	J0476	Baclofen, for intrathecal trial, 50 mcg (Lioresal for intrathecal trial)	75.60
	J0475	Baclofen, Kit 1*20 ml. Amp. (10 mg/20ml. 500 meg/ml.)	221.40
*	J3490	Baclofen, Kit 2*5 ml. Amp. (10 mg./5 ml. 2000 meg/ml.)	464.40
*	J3490	Baclofen, Kit 4*5 ml. Amp. (10 mg./5ml. 2000 meg/ml.)	815.40
	J9031	BCG live (intravesical) per installation (Tice, TheraCys)	151.70
	J0702	Betamethasone Acetate and Betamethasone Sodium Phosphate, per 3 mg	4.72
	J0704	Betamethasone Sodium Phosphate, per 4 mg	1.02
	J0520	Bethanechol Chloride, mytonachol or urecholine, up to 5 mg (Urecholine)	5.06
	J9040	Bleomycin Sulfate, 15 units (Blenoxane)	172.80
	S0115	Bortezomib 3.5 mg (Velcade)	1076.63
	J0585	Botulinum toxin type A, per unit (Botox)	4.69
	J0945	Brompheniramine Maleate, 10mg	0.90
	J0595	Butorphanol Tartrate, 1mg (Stadol)	4.17
	J0636	Calcitriol, 0.1 mcg (Calcijex)	1.31
	J0610	Calcium Gluconate, per 10 ml (Kaleinate)	0.96
	J0620	Calcium Glycerophosphate and Calcium Lactate, per 10 ml (Calphosan)	6.08
	J9045	Carboplatin, 50 mg (Paraplatin)	140.92
	J9050	Carmustine, 100 mg (BiCNU)	129.01
	J0690	Cefazolin Sodium, 500 mg (Ancef, Kefzol, Zolicef)	2.13
	J0692	Cefepime HCL, 500 mg (Maxiprene)	7.70
	J0698	Cefotaxime Sodium, per gm (Claforan)	9.90
	J0694	Cefoxitin Sodium, 1 gm (Mefoxin)	10.13
	J0713	Ceftazidime per 500 mg (Fortaz, Tazidime)	6.40
	J0715	Ceftizoxime Sodium, per 500 mg (Cefizox)	4.70
	J0696	Ceftriaxone Sodium, per 250 mg (Rocephin)	14.14
	J0697	Cefuroxime Sodium, per 750 mg (Kefurox, Zinacef)	6.08
	J1890	Cephalothin Sodium, up to 1 gm (Keflin)	9.72
	J0710	Cephapirin Sodium, up to 1 gm (Cefadyl)	1.33

Injectable Drug List, continued

Invoice Required	Procedure Code	Description	Maximum Reimbursement Rate
	J0720	Chloramphenicol Sodium Succinate, up to 1 gm	$6.84
	J1990	Chlordiazepoxide HCL, up to 100 mg (Librium)	23.68
	J0390	Chloroquine HCL, up to 250 mg (Aralen)	18.65
	J1205	Chlorothiazide Sodium, 500 mg (Diuril Sodium)	9.94
	J2400	Chlorprocaine HCL 30 ml (Nesacaine, Nesacaine-MPF)	6.06
	J3230	Chlorpromazine HCL up to 50 mg (Thorazine)	4.17
	J0725	Chorionic Gonadotropin, per 1,000 USP units	2.93
	J0740	Cidofovir 375 mg (Vistide)	799.20
	J0743	Cilastatin Sodium Imipenem, per 250 mg (Primaxin IM, Primaxin IV)	15.04
	S0023	Cimetadine HCL, 300 mg (Tagamet)	1.34
	J0744	Ciprofloxacin for IV infusion, 200 mg (Cipro)	12.97
	J9062	Cisplatin, 50 mg (Platinol AQ)	75.60
	J9060	Cisplatin, powder or solution, per 10 mg (Platinol, Plantinol AQ)	15.12
	J9065	Cladribine, per 1 mg (Leustatin)	48.60
	J0735	Clonidine Hydrochloride, 1 mg	52.25
	J0745	Codeine Phosphate, per 30 mg	0.48
	J0760	Colchicine, 1 mg	6.70
	J0770	Colistimethate Sodium, up to 150 mg (Coly-Mycin M)	51.30
	J0800	Corticotropin, up to 40 units (Acthar, ACTH)	88.05
	J0835	Cosyntropin, per 0.25 mg (Cortrosyn)	17.28
	J3420	Cyanocobalamin, vitamin B 12, 1000 mcg	0.13
	J9096	Cyclophosphamide Lyophilized 1 gm (Cytoxan Lyophilized)	46.29
	J9093	Cyclophosphamide Lyophilized, 100 mg (Cytoxan Lyophilized)	5.29
	J9097	Cyclophosphamide Lyophilized, 2gm	92.60
	J9091	Cyclophosphamide, 1.0 gm (Cytoxan, Neosar)	43.33
	J9070	Cyclophosphamide, 100 mg (Cytoxan, Neosar)	5.43
	J9092	Cyclophosphamide, 2.0 gm (Cytoxan, Neosar)	86.63

Injectable Drug List, continued

Invoice Required	Procedure Code	Description	Maximum Reimbursement Rate
	J9080	Cyclophosphamide, 200 mg (Cytoxan, Neosar)	$10.31
	J9090	Cyclophosphamide, 500 mg (Cytoxan, Neosar)	21.65
	J9094	Cyclophosphamide, Lyophilized, 200 mg (Cytoxan Lyophilized)	10.58
	J9095	Cyclophosphamide, Lyophilized, 500 mg (Cytoxan Lyophilized)	23.14
	J9100	Cytarabine 100 mg (Cytosar-U)	3.02
	J9110	Cytarbine, 500 mg (Cytosar-U)	8.10
	J7070	D5W, 1000 cc	10.40
	J9130	Dacarbazine 100 mg (DTIC-Dome)	12.02
	J9140	Dacarbazine 200 mg (DTIC-Dome)	20.90
	J7513	Daclizumab, 25 mg (Zenapax)	402.73
	J9120	Dactinomycin, .5 mg (Cosmegen)	13.14
	J1645	Dalteparin, per 2500 I.U. (Fragmin)	14.87
	J0880	Darbepoetin Alfa, 5 mcg (Aranesp)	22.45
	J9151	Daunorubicin Citrate Liposomal, 10 mg (DaunoXome)	61.20
	J9150	Daunorubicin HCL, 10 mg (Cerubidine)	70.33
	J0895	Deferoxamine Mesylate, 500 mg (Desferal)	14.81
	J9160	Denileukin Diftitox, 300mcg (Ontak)	1260.90
	J1000	Depoestradiol Cypionate, up to 5 mg	1.80
	J7340	Dermal and epidermal tissue of human origin, with or without bioengineered or	27.76
	J2597	Desmopression Acetate per 1 mcg (DDAVP)	3.27
	J1094	Dexamethasone Acetate 1 mg	0.68
	J1100	Dexamethosone Sodium Phosphate, 1 mg (Cortastat, Dalalone)	0.10
	J1190	Dexrazoxane HCL, 250 mg (Zinecard)	221.65
	J7110	Dextran 75, 500 ml	13.46
	J7042	Dextrose 5%/Normal Saline (500 ml = 1 unit)	8.95
	J7060	Dextrose 5%/Water (500 ml = 1 unit)	8.57
	J3360	Diazepam, up to 5 mg (Valium, Zetran)	0.82
	J1730	Diazoxide, up to 300 mg (Hyperstat IV)	116.48
	J0500	Dicyclomine HCL, up to 20 mg (Bentyl, Dilomine, Antispas)	16.16
	J9165	Diethylstilbestrol Diphosphate, 250 mg (Stilphostrol)	13.65
	J1160	Digoxin, up to 0.5 mg (Lanoxin)	1.69
	J1110	Dihydroergotamine Mesylate, up to 1 mg	38.16
	J1240	Dimenhydrinate, up to 50 mg	0.36

Injectable Drug List, continued

Invoice Required	Procedure Code	Description	Maximum Reimbursement Rate
	J0470	Dimercaprol, per 100 mg	$22.43
	J1200	Diphenhydramine HCL, up to 50 mg (Benadryl)	1.52
	J1245	Dipyridamole, per 10 mg (Persantine IV)	5.40
	J1212	DMSO, Dimethyl Sulfoxide, 50%, 50 ml	42.26
	J1250	Dobutamine HCL, 250 mg (Dobutrex)	4.49
	J9170	Docetaxel, 20 mg (Taxotere)	339.08
	J1260	Dolasetron Mesylate, 10 mg (Anzemet)	15.59
	J1270	Doxercalciferol, 1 mg (Hectorol)	5.21
	J1810	Droperidol and Fentanyl Citrate, up to 2 ml ampule (Innovar)	8.95
	J1790	Droperidol, up to 5 mg (Inapsine)	2.66
	J1180	Dyphylline, up to 500 mg (Lufyllin, Dilor)	8.54
	J0600	Edetate Calcium Disodium up to 1000 mg	41.78
	J1650	Enoxaparin Sodium, 10 mg (Lovenox)	6.13
	J9178	Epirubicin HCl, 2 mg (Ellence)	26.18
	Q9920	EPO, per 1000 units, Patient HCT 20 or less	12.02
	Q9921	EPO, per 1000 units, Patient HCT 21	12.02
	Q9922	EPO, per 1000 units, Patient HCT 22	12.02
	Q9923	EPO, per 1000 units, Patient HCT 23	12.02
	Q9924	EPO, per 1000 units, Patient HCT 24	12.02
	Q9925	EPO, per 1000 units, Patient HCT 25	12.02
	Q9926	EPO, per 1000 units, Patient HCT 26	12.02
	Q9927	EPO, per 1000 units, Patient HCT 27	12.02
	Q9928	EPO, per 1000 units, Patient HCT 28	12.02
	Q9929	EPO, per 1000 units, Patient HCT 29	12.02
	Q9930	EPO, per 1000 units, Patient HCT 30	12.02
	Q9931	EPO, per 1000 units, Patient HCT 31	12.02
	Q9932	EPO, per 1000 units, Patient HCT 32	12.02
	Q9933	EPO, per 1000 units, Patient HCT 33	12.02
	Q9934	EPO, per 1000 units, Patient HCT 34	12.02
	Q9935	EPO, per 1000 units, Patient HCT 35	12.02
	Q9936	EPO, per 1000 units, Patient HCT 36	12.02
	Q9937	EPO, per 1000 units, Patient HCT 37	12.02
	Q9938	EPO, per 1000 units, Patient HCT 38	12.02
	Q9939	EPO, per 1000 units, Patient HCT 39	12.02
	Q9940	EPO, per 1000 units, Patient HCT 40	12.02

Injectable Drug List, continued

Invoice Required	Procedure Code	Description	Maximum Reimbursement Rate
	Q0136	Epoetin Alpha (for non ESRD use) per 1000 units (Epogen)	$12.02
	J1325	Epoprostenol 0.5 mg	17.11
	J1330	Ergonovine Maleate, up to 0.2 mg	4.45
	J1364	Erythromycin Lactobionate, per 500 mg (Erythrocin)	3.32
	J1380	Estradiol Valerate, up to 10 mg	0.50
	J1390	Estradiol Valerate, up to 20 mg	1.00
	J0970	Estradiol Valerate, up to 40 mg (Delestrogen)	1.54
	J1410	Estrogen Conjugated per 25 mg(Premarin intravenous)	58.28
	J1435	Estrone, per 1 mg (Estone Aqueous, Estronol, etc.)	0.54
	J1436	Etidronate Disodium, per 300 mg (Didronel)	72.9
	J9181	Etoposide, 10 mg (VePesid)	1.62
	J9182	Etoposide, 100 mg (VePesid)	16.20
	J7193	Factor IX (Antihemophilic Factor, Purified, non-recombinant) – per I.U.	1.06
	J7195	Factor IX(Antihemophilic Factor recombinant)per I.U.	1.06
	J7194	Factor IX complex, per I.U.	0.35
	Q0187	Factor VIIa (Coagulation Factor, recombinant) per 1.2 mg (Novoseven)	15.93
	J7190	Factor VIII (anti-hemophilic factor, human) per I.U.	0.83
	J7191	Factor VIII (anti-hemophilic factor, porcine) per I.U.	1.94
	J7192	Factor VIII(anti-hemophilic factor recombinant)per I.U.	1.20
	J3010	Fentanyl Citrate, 0.1 mg (2 ml) (Sublimaze)	0.88
	J1440	Filgrastim , 300 mcg/1ml (Neupogen)	176.11
	J1441	Filgrastim , 480 mcg/1.6ml (Neupogen)	297.54
	J9200	Floxuridine, 500 mg (FUDR)	129.6
	J9185	Fludarabine Phosphate, 50 mg (Fludara)	337.33
	J9190	Fluorouracil, 500 mg (Adrucil)	1.96
	J2680	Fluphenazine Decanoate up to 25mg(Prolixin Decanoate)	8.93
	J1455	Foscarnet Sodium, per 1000 mg (Foscavir)	12.38
	J9395	Fulvestrant, 25 mg (Faslodex)	82.98

Injectable, Drug List, continued

Invoice Required	Procedure Code	Description	Maximum Reimbursement Rate
	J1940	Furosemide, up to 20 mg (Lasix, Furomide M.D.)	$0.93
	J1570	Ganciclovir Sodium, 500 mg (Cytovene)	33.40
	J7310	Ganciclovir, Long-acting Implant, 4.5 mg (Vitrasert)	4500.00
	J9201	Gemcitabine HCl. 200 mg (Gemzar)	114.64
	J1580	Gentamicin (Garamycin Sulfate) up to 80 mg (Gentamicin Sulfate, Jenamicin)	1.80
	J1610	Glucagon Hydrochloride, per 1 mg	43.20
	J1600	Gold Sodium Thiomaleate, up to 50 mg (Myochrysine)	12.81
	J1620	Gonadorelin Hydrochloride, per 100 mcg (Factrel)	191.35
	J9202	Goserelin Acetate Implant, per 3.6 mg (Zoladex)	422.99
	J1626	Granisetron Hydrochloride, 100 mcg (Kytril)	17.57
	J1631	Haloperidol Decanoate, per 50 mg (Haldol Decanoate – 50)	8.64
	J1630	Haloperidol Lactate, up to 5 mg (Haldol)	6.47
	J1642	Heparin Sodium, per 10 units (Heparin Lock Flush)	0.05
	J1644	Heparin Sodium, per 1000 units	0.38
	J3470	Hyaluronidase, up to 150 units (Wydase)	19.50
	J0360	Hydralazine HCL, up to 20 mg (Apresoline)	15.19
	J1700	Hydrocortisone Acetate, up to 25 mg	0.32
	J1710	Hydrocortisone Sodium Phosphate, up to 50 mg	5.27
	J1720	Hydrocortisone Sodium Succinate, up to 100 mg	2.36
	J1170	Hydromorphone, up to 4 mg (Dilaudid)	1.47
	J3410	Hydroxyzine HCL, up to 25 mg (Vistaril, Vistaject-25, Hyzine-50)	1.14
	J7320	Hylan G-F 20, 16 mg, for intra-arterial injection (Synvisc)	220.87
	J1980	Hyoscyamine Sulfate, up to 0.25 mg (Levsin)	8.11
	J7130	Hypertonic Saline Solution, 50 or 100 mEq, 20 cc vial)	0.50
	J1742	Ibutilide Fumarate 1 mg. (Corvert)	238.12
	J9211	Idarubicin Hydrochloride, 5 mg (Idamycin)	397.84
	J9208	Ifosfamide, 1 gm (Ifex)	142.46
	J1785	Imiglucerase, per unit (Cerezyme)	3.56
	J1745	Infliximab, 10 mg (Remicade)	62.24

Injectable Drug List, continued

Invoice Required	Procedure Code	Description	Maximum Reimbursement Rate
	J1815	Insulin, up to 100 units (Regular, NPH, Lente, or Ultralente))	$0.10
	J9213	Interferon, Alfa-2A, Recombinant, 3 million units (Roferon-A)	33.05
	J9214	Interferon, Alfa-2B, Recombinant, 1 million units (Intron A)	14.09
	J9212	Interferon, Alfacon-1, Recombinant, 1 mcg (Infergen)	3.88
	J9215	Interferon, Alfa-N3, (human leukocyte derived) 250,000 IU (Alferon N)	7.74
	J9216	Interferon, Gamma 1-B, 3 million units (Actimmune)	198.21
	J9206	Irinotecan, 20 mg (Camptosar)	138.07
	J1750	Iron Dextran, 50 mg (Infed)	16.97
	J1756	Iron Sucrose injection, 1mg (Venofer)	0.62
	J1840	Kanamycin Sulfate, up to 500 mg (Kantrex, Klebcil)	3.11
	J1850	Kanamycin Sulfate, up to 75 mg (Kantrex, Klebcil)	0.47
	J1850	Kanamycin Sulfate, up to 75 mg (Kantrex, Klebcil)	0.47
	J1885	Ketorolac Tromethamine, per 15 mg (Toradol)	3.38
	J3490	Kutapressin, 1 ml	7.65
*	J3490	Laronidase, 2.9 mg/5 ml (Aldurazyme)	699.75
	J0640	Leucovorin Calcium , per 50 mg (Wellcovorin)	3.52
	J9219	Leuprolide Acetate Implant, 65 mg (Viadur)	5115.60
*	J3490	Leuprolide Acetate, 11.25 mg (Lupron Depot Pediatric)	1166.26
*	J3490	Leuprolide Acetate, 15 mg (Lupron, for Depot Pediatric)	1284.51
	J1950	Leuprolide Acetate, 3.5 mg (Lupron, for Depot Suspension)	490.10
*	J3490	Leuprolide Acetate, 7.5 mg (Lupron, for Depot Pediatric)	642.39
	J9217	Leuprolide Acetate, 7.5 mg (Lupron, for Depot Suspension)	579.38
	J9218	Leuprolide Acetate, per 1 mg (Lupron)	66.58
	J1955	Levocarnitine, per 1 gm (Carnitor)	32.40
	J1956	Levofloxacin, 250 mg (Levaquin)	19.72
	J1960	Levorphanol tartrate, up to 2 mg (Levo-Dromoran)	3.56

Injectable Drug List, continued

Invoice Required	Procedure Code	Description	Maximum Reimbursement Rate
	J2001	Lidocaine HCL, 10 mg IV (Xylocaine)	$0.93
	J2010	Lincomycin HCL, up to 300 mg (Lincocin)	3.02
	J2060	Lorazepam, 2 mg (Ativan)	2.98
	J3475	Magnesium Sulfate, 500 mg.	0.25
	J2150	Mannitol, 25% in 50 ml	3.10
	J9230	Mechlorethamine Hydrochloride (Nitrogen Mustard), 10mg	11.38
	J1055	Medroxyprogesterone Acetate for Contraceptive Use, 150 mg (Depo-Provera)	53.06
	J1051	Medroxyprogesterone Acetate, 50 mg (Depo-Provera)	4.78
	J1056	Medroxyprogesterone Acetate/Estradiol Cypionate 5 mg/25 mg (Lunelle)	23.32
	J9245	Melphalan Hydrochloride, 50 mg, (Alkeran)	397.99
	J2180	Meperidine and Promethazine HCL, up to 50 mg (Mepergan Injection)	4.47
	J2175	Meperidine Hydrochloride, per 100 mg (Demerol HCL)	0.53
	J0670	Mepivacaine, per 10 ml (Carbocaine)	2.03
	J9209	Mesna, 200 mg (Mesnex)	34.56
	J0380	Metaraminol Bitartrate, 10 mg (Aramine)	1.21
	J1230	Methadone HCL, up to 10 mg (Dolophine)	0.71
	J2800	Methocarbamol, up to 10 ml (Robaxin)	14.00
	J9250	Methotrexate Sodium, 5 mg	0.37
	J9260	Methotrexate Sodium, 50 mg	4.50
	J0210	Methyldopate HCL, up to 250 mg (Aldomet)	11.26
	J2210	Methylergonovine Maleate, up to 0.2 mg (Methergine)	3.89
	J1020	Methylprednisolone Acetate, 20 mg (Depo Medrol)	2.54
	J1030	Methylprednisolone Acetate, 40 mg	3.92
	J1040	Methylprednisolone Acetate, 80 mg	7.84
	J2930	Methylprednisolone Sodium Succinate, up to 125 mg (Solu-Medrol, A-methaPred)	3.07
	J2920	Methylprednisolone Sodium Succinate, up to 40 mg (Solu-Medrol, A-Metha Pred)	1.85
	J2765	Metoclopramide HCL, up to 10 mg (Reglan)	1.88

Injectable Drug List, continued

Invoice Required	Procedure Code	Description	Maximum Reimbursement Rate
	J2250	Midazolam HCL, per 1 mg (Versed)	$1.22
	J2260	Milrinone Lactate, 5 mg per 5 ml (Primacor)	48.86
	J9290	Mitomycin, 20 mg (Mutamycin)	196.56
	J9291	Mitomycin, 40 mg (Mutamycin)	270.00
	J9280	Mitomycin, 5 mg (Mutamycin)	60.48
	J9293	Mitoxantrone HCL, per 5 mg (Novantrone)	340.43
	J2271	Morphine Sulfate (100 mg)	10.49
	J2275	Morphine Sulfate (preservative-free sterile solution), per 10 mg (Astramorph PF, Duramorph)	2.26
	J2270	Morphine Sulfate, up to 10 mg	0.73
	J2310	Nalaxone HCL, per 1 mg (Narcan)	2.24
	J2300	Nalbuphine Hydrochloride, 10 mg	1.43
	J2321	Nandrolone Decanoate, up to 100 mg	7.26
	J2322	Nandrolone Decanoate, up to 200 mg	14.91
	J2320	Nandrolone Decanoate, up to 50 mg	3.64
	J2710	Neostigmine Methylsulfate, up to 0.5 mg (Prostigmin)	0.64
	J7030	Normal Saline Solution, 1000 cc, infusion	10.21
	J7050	Normal Saline Solution, 250 cc, infusion	2.56
	J7040	Normal Saline Solution, Sterile (500 ml=1 unit), infusion	5.10
*	J2353	Octreotide Acetate, 1 mg (Sandostatin LAR Depot), Pricing Based on 10 mg	146.32
*	J2353	Octreotide Acetate, 1 mg (Sandostatin LAR Depot), Pricing Based on 20 mg	84.02
*	J2353	Octreotide Acetate, 1 mg (Sandostatin LAR Depot), Pricing Based on 30 mg	75.30
	J2354	Octreotide Acetate, 25 mcg, non-depot, SC or IV	4.03
	S0107	Omalizumab 25mg (Xolair)	81.19
	J2405	Ondansetron Hydrochloride, per 1 mg (Zofran)	5.77
	J2355	Oprelvekin, 5 mg (Newmega)	253.80
	J2360	Orphenadrine Citrate, up to 60 mg (Norflex, etc.)	5.14
	J2700	Oxacillin Sodium, up to 250 mg (Bactocile, Prostaphlin)	0.76
	J9263	Oxaliplatin, 0.5 mg (Eloxatin)	8.95
	J2410	Oxymorphone HCL, up to 1 mg (Numorphan)	2.80

Injectable Drug List, continued

Invoice Required	Procedure Code	Description	Maximum Reimbursement Rate
	J2460	Oxytetracycline HCL, up to 50 mg (Terramycin IM)	$0.96
	J2590	Oxytocin, up to 10 units (Pitocin, Syntocinon)	1.63
	J9265	Paclitaxel, 30 mg (Taxol)	155.45
	J2430	Pamidronate Disodium, per 30 mg (Aredia)	251.87
	J2440	Papaverine HCL, up to 60 mg	3.38
	J9266	Pegaspargase Single Dose vial, (5 ml) (Oncaspar)	1462.50
	J2505	Pegfilgrastim, 6 mg (Neulasta)	2655.00
	J0540	Penicillin G Benzathine and Penicillin G Procaine, up to 1,200,000 units (Bicillin C-R)	22.17
	J0550	Penicillin G Benzathine and Penicillin G Procaine, up to 2,400,000 units (Bicillin C-R)	47.48
	J0530	Penicillin G Benzathine and Penicillin G procaine, up to 600,000 units (Bicillin C-R)	11.30
	J0570	Penicillin G Benzathine, up to 1,200,000 units (Bicillin L-A, Permapen)	18.74
	J0580	Penicillin G Benzathine, up to 2,400,000 units (Bicillin L-A, Permapen)	37.48
	J0560	Penicillin G Benzathine, up to 600,000 units (Bicillin L-A, Permapen)	9.37
	J2540	Penicillin G Potassium, up to 600,000 units (Pfizerpen)	0.28
	J2510	Penicillin G Procaine, Aqueous, up to 600,000 units (Wycillin, etc.)	9.10
	J2545	Pentamidine Isethionate, inhalation solution, per 300 mg (Pentam 300, NebuPent, PentacaRinat)	48.10
	S0080	Pentamidine Isethionate, IV, IM, per 300 mg	42.48
	J3070	Pentazocine HCL, up to 30 mg (Talwin)	4.96
	J2515	Pentobarbital Sodium (Nembutal Sodium Solution), per 50 mg	1.25
	J9268	Pentostatin, per 10 mg (Nipent)	1825.20
	J3310	Perphenazine, up to 5 mg (Trilafon)	6.76
	J2560	Phenobarbital Sodium, up to 120 mg	1.54
	J2760	Phentolamine Mesylate, up to 5 mg (Regitine)	30.24
	J2370	Phenylephrine HCL, up to 1 ml (NeoSynephrine)	1.22
	J1165	Phenytoin Sodium, per 50 mg (Dilantin)	0.82
	J2543	Piperacillin Sodium/Tazobactam Sodium 1gm/0.125 gm (1.125gm) (Zosyn)	4.62
	J9270	Plicamycin, 2.5 mg (Mithracin)	88.87

Injectable Drug List, continued

Invoice Required	Procedure Code	Description	Maximum Reimbursement Rate
	J9600	Porfimer Sodium, 75 mg (Photofin)	$2466.64
	J3480	Potassium Chloride, per 2 mEq.	0.07
	J2730	Pralidoxime Chloride, up to 1 gm (Protopam Chloride)	97.54
	J2650	Prednisolone Acetate, up to 1 ml	0.30
	J2690	Procainamide HCL, up to 1 gm (Pronestyl)	1.36
	J0780	Prochlorperazine Edisylate 10 mg (Compazine, Cotranzine, Compa-Z, Ultrazine-10)	3.96
	J2675	Progesterone, per 50 mg	3.49
	J2950	Promazine HCL, up to 25 mg (Sparine, Prozine-50)	0.43
	J2550	Promethazine HCL, up to 50 mg (Phenergan, Phenazine)	2.70
	J1800	Propranolol HCL, up to 1 mg (Inderal)	11.02
	J2720	Protamine Sulfate, per 10 mg	0.72
	J2725	Protirelin, per 250 mcg (Relefact TRH, Thypinone)	23.11
	J2780	Rantidine HCL, 25 mg (Zantac)	1.36
	J2993	Retaplase, 18.1 mg (Retavase)	1292.63
	J7120	Ringers Lactate Infusion, up to 1000 cc	11.80
*	J3490	Risperidone 25mg (Risperdal Consta)	249.84
*	J3490	Risperidone 37.5mg (Risperdal Consta)	374.77
*	J3490	Risperidone 50mg (Risperdal Consta)	499.69
	J9310	Rituximab (Rituxan) 100 mg (Rituxan)	474.76
	J2820	Sargramostim (GM-CSF), 50 mcg (Leukine, Prokine)	27.53
	J3490	Sodium Bicarbonate 7.5% up to 50 ml	3.20
	J2912	Sodium Chloride, 0.9% per 2 ml	0.47
	J2916	Sodium Ferric Gluconate Complex in Sucrose, 12.5mg (Ferrlecit)	7.74
	J7317	Sodium Hyaluronate, per 20-25 mg. for intra-articular injection (Biolon, Provisc, Vitrax, Hyalgan)	131.41
	J3320	Spectinomycin Dihydrochloride, up to 2 gm (Trobicin)	26.78
	J7051	Sterile Saline or Water (up to 5 cc)	0.72
	J2995	Streptokinase, per 250,000 IU (Streptase)	84.38

Injectable Drug List, continued

Invoice Required	Procedure Code	Description	Maximum Reimbursement Rate
	J3000	Streptomycin, up to 1 gm (Streptomycin Sulfate)	$6.01
	J9320	Streptozocin, 1 gm (Zanosar)	134.03
	J0330	Succinycholine Chloride, up to 20 mg (Anectine, Quelicin, Surostrin)	0.19
	J3105	Terbutaline Sulfate, up to 1 mg (Brethine, Bricanyl Subcutaneous)	27.85
	J1060	Testosterone Cypionate and Estradiol Cypionate, up to 1 ml	4.40
	J1070	Testosterone Cypionate, up to 100 mg	4.69
	J0900	Testosterone Enanthate and Estradiol Valerate up to 1 cc (Deladumone, etc.)	1.55
	J3120	Testosterone Enanthate, up to 100 mg (Evarone, Delatestryl, etc.)	8.51
	J3130	Testosterone Enanthate, up to 200 mg, (Evarone, Delatestryl, Andro L.A. 200, etc.)	17.02
	J1080	Testosterone Estradiol Cypionate, 1 cc, 200 mg	8.94
	J3150	Testosterone Propionate, up to 100 mg (Testex)	1.62
	J3140	Testosterone Suspension, up to 50 mg (Andronaq 50, Testosterone Aqueous, etc.)	0.38
	J0120	Tetracycline, up to 250 mg (Achromycin, Panmycin, Sumycin)	0.23
	J3280	Thiethylperazine Maleate, up to 10 mg (Norzine, Torecan)	5.36
	J9340	Thiotepa, 15 mg (Thioplex)	110.82
	J3240	Thyrotropin Alfa, 0.9 mg (Thyrogen)	585.00
	J3260	Tobramycin Sulfate, up to 80 mg (Nebcin)	4.22
	J2670	Tolazoline HCL, up to 25 mg (Priscoline HCL)	3.72
	J9350	Topotecan, 4 mg (Hycamtin)	756.61
	J3265	Torsemide, 10 mg/ml (Demadex)	1.48
	J9355	Trastuzumab, 10 mg (Herceptin)	55.07
	J3301	Triamcinolone Acetonide, per 10 mg (Kenalog-10, Kenalog-40, Tri-Kort, etc.)	1.51
	J3302	Triamcinolone Diacetate, per 5 mg (Aristocort Intralesional, Aristocort Forte, Amcort, etc.)	0.32
	J3303	Triamcinolone Hexacetonide, per 5 mg (Aristospan Intralesional, Aristospan Intra-articular)	0.95
	J3400	Triflupromazine HCL, up to 20 mg (Vesprin)	11.70

Injectable Drug List, continued

Invoice Required	Procedure Code	Description	Maximum Reimbursement Rate
	J3250	Trimethobenzamide HCL, up to 200 mg (Tigan, Ticon, Tiject-20, Arrestin)	$1.47
	J3305	Trimetrexate Glucoronate, per 25 mg (Neutrexin)	135.00
	J3350	Urea, up to 40 gm (Ureaphil)	80.00
	J3365	Urokinase, 250,000 I.U. Vial (Abbokinase)	484.58
	J3364	Urokinase, 5000 I.U. vial (Abbokinase Open-Cath)	9.69
	J9357	Valrubicin, intravesical, 200 mg (Valstar)	498.96
	J3370	Vancomycin HCL, 500 mg (Varcocin, Vancoled)	6.66
	J9360	Vinblastine Sulfate, 1 mg (Velban)	3.89
	J9370	Vincristine Sulfate, 1 mg (Oncovin,)	32.19
	J9375	Vincristine Sulfate, 2 mg (Oncovin)	64.39
	J9380	Vincristine Sulfate, 5 mg (Oncovin,)	151.92
	J9390	Vinorelbine Tartrate, per 10 mg (Navelbine)	84.65
	J3430	Vitamin K, Phytonadione 1 mg/0.5ml	2.30
	J2501	Zemplar (Paricalcitol) 1 mcg	4.75
	J3487	Zoledronic Acid (Zometa), 1 mg	205.98

Note: The following list of drugs has been added since April 2004 bulletin or the code number and/or fee has changed since April 2004. The fees listed for these drugs are current as of the date of this publication.

Invoice Required	Procedure Code	Description	Maximum Reimbursement Rate
*	J9999	Azacitidine (Vidaza) 25 mg	$107.40
	S0159	Agalsidase Beta, 35mg(Fabrazyme)	4500.00
	S0116	Bevacizumab (Avastin) 100 mg	618.75
*	J9999	Cetuximab (Erbitux) 100 mg/50 ml vial	489.60
	J9300	Gemtuzumab ozogamicin (Mylotarg) 5 mg	1953.94
	S0158	Laronidase (Aldurazyme) .58 mg	139.95
*	J9999	Pemetrexed (Alimta) 500 mg	2071.88
	S0163	Risperidone, long acting (Risperdal Consta) 12.5 mg	124.92
	J3395	Verteporfin (Visudyne) 15 mg	1404.26

Immune Globulins

Invoice Required	Procedure Code	Description	Maximum Reimbursement Rate
	90291	Cytomegalovirus immune globulin (CMV-IgIV), human, for intravenous use, 1 ml	$13.49
	J1460	Gamma Globulin, Intramuscular, 1 cc (Gammar)	11.53
	J1470	Gamma Globulin, Intramuscular, 2 cc	23.07
	J1480	Gamma Globulin, Intramuscular, 3 cc	34.63
	J1490	Gamma Globulin, Intramuscular, 4 cc	46.13
	J1500	Gamma Globulin, Intramuscular, 5 cc	57.66
	J1510	Gamma Globulin, Intramuscular, 6 cc	69.05
	J1520	Gamma Globulin, Intramuscular, 7 cc	80.64
	J1530	Gamma Globulin, Intramuscular, 8 cc	92.26
	J1540	Gamma Globulin, Intramuscular, 9 cc	103.89
	J1550	Gamma Globulin, Intramuscular, 10 cc	115.32
	J1560	Gamma Globulin, Intramuscular, over 10 cc (use correct combinations of above codes)	^^
	90371	Hepatitis B immune globulin (HBIg), human, for intramuscular use, 0.5 ml	615.6
	J1563	Immune Globulin, Intravenous, 1 gm (Sandoglobulin)	82.24
	J1564	Immune Globulin, Intravenous, 10 mg (Sandoglobulin)	0.82
	90375	Rabies immune globulin (RIg), human, for intramuscular and/or subcutaneous use, 2 ml	69.01
	90376	Rabies immune globulin, heat-treated (RIg-HT), human, for intramuscular and/or subcutaneous use, 2 ml	74.00
	90379	Respiratory syncytial virus immune globulin (RSV-IgIV), human, for intravenous use, 1 ml	17.17
	90384	Rho(D) immune globulin (RhIg), human, full-dose, for intramuscular use, 1500 IU/300 mcg	95.04
	90385	Rho(D) immune globulin (RhIg), human, mini-dose, for intramuscular use, 120 IU/50 mcg	32.94
	90386	Rho(D) immune globulin (RhIglV), human, for intravenous use, 100 IU	20.10
	90389	Tetanus immune globulin (TIg), human, for intramuscular use, 250 u/1 ml	118.13
	90396	Varicella-zoster immune globulin, human, for intramuscular use, 125 u/1.25 ml	112.50

(^ ^) Designates special pricing.

Vaccines/Toxoids

Medicaid reimburses for vaccines in accordance with the guidelines from the Advisory Committee on Immunization Practices (ACIP). Information regarding the risk categories pertinent to vaccines may be found at http://www.cdc.gov/nip/publications/ACIP/default.htm.

Medicaid does not reimburse for vaccines provided to recipients ages birth through 18 years that are available through the Universal Childhood Vaccine Distribution Program (UCVDP)/Vaccines for Children (VFC) Program. For Medicaid-eligible recipients ages 19 through 20 who are not age-eligible for the VFC program vaccines, Medicaid will reimburse providers for Medicaid-covered vaccines.

Vaccines/Toxoids Drug List

Invoice Required	Procedure Code	Description	Maximum Reimbursement Rate
	90585	Bacillus Calmette-Guerin vaccine (BCG), for tuberculosis, live, for percutaneous use, per vial	$151.70
	90721	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DtaP-Hib), for intramuscular use	46.27
	90647	Hemophilus influenza b vaccine (Hib) PRP-OMP conjugate (3 Dose schedule), for intramuscular use, 0.5 ml	21.52
	90648	Hemophilus influenza b vaccine (Hib) PRP-T conjugate (4 dose schedule), for intramuscular use, 0.5 ml	22.86
	90632	Hepatitis A vaccine, adult dosage, for intramuscular use, 1ml	66.65
	90633	Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule, for intramuscular use, 0.5 ml	28.22
	90746	Hepatitis B vaccine, adult dosage, for intramuscular use, 1 ml	52.54
	90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use, 40 mcg/2ml per dose	105.08
	90658	Influenza virus vaccine, split virus, 3 years and above dosage, for intramuscular or jet injection use, 0.5 ml	9.42
	90705	Measles virus vaccine, live, for subcutaneous or jet injection use, 0.5 ml	14.24
	90707	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous or jet injection use	36.98
	90733	Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous or jet injection use, 0.05 mg	62.11

Vaccines/Toxoids Drug List, continued

Invoice Required	Procedure Code	Description	Maximum Reimbursement Rate
	90704	Mumps virus vaccine, live, for subcutaneous or jet injection use	$18.41
	90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use, 0.5 ml	17.64
	90713	Poliovirus vaccine, inactivated, (IPV), for subcutaneous use	24.35
	90675	Rabies vaccine, for intramuscular use, 2 ml	129.00
	90680	Rotavirus vaccine, tetravalent, live, for oral use	17.37
	90706	Rubella virus vaccine, live, for subcutaneous or jet injection use, 0.5 ml	15.85
	90718	Tetanus and diphtheria toxoids (Td) adsorbed for use in individuals seven years or older, for intramuscular or jet injection, 0.5 ml	10.92
	90703	Tetanus toxoid adsorbed, for intramuscular or jet injection use, 0.5 ml	13.62
	90716	Varicella virus vaccine, live, for subcutaneous use, 0.5 ml	61.26

Aydlett Hunike, Financial Management
DMA, 919-855-4200

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

New Guidelines for Enrollment

Effective January 1, 2005, physician-type providers will enroll directly with the Division of Medical Assistance to participate in the Medicaid program. Blue Cross Blue Shield of North Carolina has processed enrollment for these practitioners for many years, but will no longer do so after December 31, 2004.

By December 1, 2004, applications, agreements, change forms and instructions will be available on the DMA website at http://www.dhhs.state.nc.us/dma. Physician-type providers will be able to download these forms to enroll in the Medicaid program. They will also be able to change their existing enrollment information, including addresses, by downloading and completing DMA enrollment change forms from the DMA website.

If you have questions about this change in procedure, please contact DMA Provider Services.

Angela Floyd, Provider Services
DMA, 919-855-4050

Attention: Prescribers and Pharmacists

Discontinuation of Coverage for Anorexia, Weight Loss, and Weight Gain Products and Medications

Legislation was passed July 1, 2004 removing anorexia, weight loss and weight gain products from the N.C. Medicaid Pharmacy Program. On September 28, 2004, all weight loss products were end-dated to non-coverage status, with an effective date of July 1, 2004 (claims previously paid will not be recouped). N.C. Medicaid will deny claims for weight loss drugs: (J8A - Anorexic Agents, D5A - Fat Absorption Decreasing Agents) including Meridia and Xenical.

Sharman Leinwand, Pharmacy Manager
DMA, 919-855-4260

Attention: Prescribers and Pharmacists

Discontinuation of Coverage for Vioxx

Due to the voluntary withdrawl of Vioxx from the U.S. and worldwide market by Merck & Co., Inc., effective with date of service October 1, 2004, the N.C. Medicaid program end-dated coverage for all forms of Vioxx.

Prior approval overrides will not be issued by the N.C. Medicaid program for Vioxx. Individual prescribers must prescribe an alternative medication for their patients.

Sharman Leinwand, Pharmacy Manager
DMA, 919-855-4260

Attention: Prescribers and Pharmacists

Medical Necessity Criteria for Approval of Oxycontin

Effective with date of service August 24, 2004, the medical necessity criteria for the approval of Oxycontin was revised to address the following situations.

Criteria for Cancer or Patients with Other Terminal Illnesses

1. Patient must have failed therapy with generic products (oxycodone or similar narcotic analgesics).
2. A maximum of six tablets per day may be authorized.
3. Length of therapy may be approved for up to one year.

Criteria for Chronic, Nonmalignant Pain

1. Patient must have failed therapy with generic products (oxycodone or similar narcotic analgesics).
2. Patient must have a diagnosis of chronic pain syndrome of at least four weeks duration.
3. Patient must have a pain agreement on file at the physician's office.
4. A copy of this form may be requested by the Division of Medical Assistance.
5. A maximum of four tablets per day may be authorized.
6. Length of therapy may be approved for up to one year.

Additional information, including prior authorization criteria, frequently asked questions, and prior authorization forms is available online at http://www.ncmedicaidpbm.com.

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

Attention: Prescribers and Pharmacists

Medical Necessity Criteria for Approval of Provigil

Effective with date of service August 24, 2004, the medical necessity criteria for the approval of modafinil (Provigil) was revised.

Approval of Provigil is considered as a treatment to improve wakefulness for patients who:

- Are at least 16 years old and have a diagnosis of narcolepsy.
- Are at least 16 years old and have excessive sleepiness associated with shift work sleep disorder.
- Require adjunct treatment for a diagnosis of obstructive sleep apnea/hypopnea syndrome (OSAHS) with concurrent use of continuous positive airway pressure (CPAP) if CPAP is the treatment of choice.

The maximum daily dose should be two tablets per day for all strengths.

Additional information, including prior authorization criteria, frequently asked questions, and prior authorization forms is available online at http://www.ncmedicaidpbm.com.

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

Attention: Prescribers and Pharmacists

Removal of Smoking Cessation Medications and Products from the Prior Authorization Drug List

Effective with date of service August 25, 2004, the following smoking cessation medications and products no longer require prior authorization from Medicaid:

- Zyban (buproprion)
- Nicotrol NS (nicotine patch)
- Nicotrol Cartridge Inhaler

There is no limit to the number of times a recipient can receive these medications and products.

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

Attention: Prescribers and Pharmacists

Revised Criteria 1a through 1d Synagis Form

The Criteria 1a-1d form for Synagis has been revised to correct an error in the date of birth requirement for patients with Hemodynamically Significant Heart Disease. The date of birth for this group of patients must be on or after **October 15, 2002**, which will allow receipt of Synagis for patients **24 months or younger**. This change is consistent with the Red Book 2003 guidelines as follows:

"Children who are 24 months of age or younger with hemodynamically significant cyanotic and acyanotic congenital heart disease will benefit from 5 monthly intramuscular injections of palivizumab (15mg/kg). Decisions regarding prophylaxis with palivizumab in children with congenital heart disease should be made on the basis of the degree of physiologic cardiovascular compromise. Infants younger than 12 months of age with congenital heart disease who are most likely to benefit from immunoprophylaxis include:

- Infants who are receiving medication to control congestive heart failure
- Infants with moderate to severe pulmonary hypertension
- Infants with cyanotic heart disease"

Also, there has been some confusion regarding requirements for prematurity in criteria 1a. Chronic Lung Disease is the same as Bronchopulmonary Dysplasia (BPD) which is generally a lung disease of prematurity. This is not asthma.

The Synagis policies and procedures for the RSV season 2004-2005, along with request forms are available on the Divison of Medical Assistance's website at http://www.dhhs.state.nc.us/dma/forms.html.

Sharman Leinwand, Pharmacy Manager
DMA, 919-855-4260

Attention: Physician and Hospital Providers

Stem Cell Transplants-Prior Approval Effective Dates

Prior approval for stem cell transplants will only be effective for a six month period, from the date the prior approval is granted. If services extend beyond the six month period, providers will need to notify the hospital consultant, and a new request, along with additional clinical information may be requested.

Debbie Garrett, RNC, Hospital Consultant
Clinical Policy and Programs
DMA, 919-857-4020

Attention: Community Alternative Providers

Proposed CAP-MR/DD Rates

The **proposed** CAP-MR/DD rates and service changes to be effective April 1, 2005, have been published on the following web sites as of October 19, 2004:

- DMA web site: **http://www.dhhs.state.nc.us/dma/fee/mhfee.htm**
- DMH/DD/SAS web site: **http://www.dhhs.state.nc.us/mhddsas/**

These rates are based on the service definitions contained within the CAP-MR/DD waiver posted on the DMH/DD/SAS web site: **http://www.dhhs.state.nc.us/mhddsas/**

In arriving at the proposed CAP-MR/DD Medicaid rates, there were some new services added as well as other services being eliminated based on the new waiver. Service rates were updated for increases which had occurred across all specialties regarding personal care and nurse visits. Additionally, multiple cost models for the new services were developed that factored in direct labor costs, supervisory labor costs, supply costs, and other administrative costs. Subject matter experts were consulted and asked for input into the calculations of the cost models. Once all of this data was collected, the rate setting staff of DMA and the DMH/DD/SAS jointly reviewed the forecasted volume of service costs and the cost models and agreed on rates and anticipated utilizations to arrive at the proposed CAP-MR/DD Medicaid rates.

The Department of Health and Human Services is appreciative of and welcomes input regarding these proposed rates prior to finalization. In order to effectively address and respond to concerns regarding these rates, it is necessary for DMA, DMH/DD/SAS and the Controller's Office to focus on issues brought to us from a representative sample of actual service providers. For consideration of any discussion of the new proposed rates, DMA, DMH/DD/SAS, and Controller's Office rate setting staff will seek data and analyses from at least three providers for each service for comparison. This data must include the assumptions and the calculations to arrive at cost figures from financial statements which need to accompany the cost data.

The selection of providers to submit cost data will be performed in a new manner. The selection of providers will come from a provider database being developed by DMH/DD/SAS. DMH/DD/SAS and DMA will select a representative sample of providers from the providers currently listed in the provider database in addition to specific provider recommendations from various provider organizations in order to review the attached proposed rates for implementation April 1, 2005. The process will bring together the providers with DMA, DMH/DD/SAS and Controller's Office staff to walk through the new services and rates. If providers disagree with any of the proposed rates, they will have the opportunity to submit data to DMA, DMH/DD/SAS and the Controller's Office, as described above, for the purpose of rate reconsideration. The participating providers will have until November 19, 2004 to submit their cost data. The providers selected for this review process will be listed on each Division's web page. Following this review, final rates will be presented to the DHHS Rate Review Board for approval and implementation.

In the future, it is our intent for the provider database to become more comprehensive. The database will consist of providers who have expressed a willingness to participate with DHHS staff in future meetings around rate and policy issues. This database will be developed as follows:

1. DMH/DD/SAS and DMA will send out a communication to providers, provider organizations, LMEs, etc., prior to November 1, 2004, informing them of the provider database and indicating how providers can express their willingness to participate;
2. DMH/DD/SAS will set up the database on its public web page through which providers can indicate their willingness to participate by entering the required provider information such as, services

provided, agency budget, sources of revenues, incorporation status of the provider, number of consumers served, etc.

DMA and DMH/DD/SAS will make development of the provider listing an open and widely publicized process to ensure that all providers who are willing to participate have the opportunity to sign up. By rotating provider participation around subsequent rate and policy issues, DHHS will seek to broaden provider representation and input into the various rate and policy issues which impact MH/DD/SA service development and operation. Rotation of provider representation will also help ensure that providers with relevant experience are involved in related rate and policy issues.

Jamie Christensen, Rate Setting
DMA, 919-855-4200

Attention: Mental Health Providers

Proposed Enhanced Benefits and Existing Mental Health Rates

The **proposed** Enhanced Benefits and existing Mental Health Service rates to be effective July 1, 2005, have been published on the following web sites as of October 19, 2004 on:

- DMA web site: **http://www.dhhs.state.nc.us/dma/fee/mhfee.htm**
- DMH/DD/SAS web site: **http://www.dhhs.state.nc.us/mhddsas/**

The rates are based on the service definitions posted on:

- DMHDDSAS web site: **http://www.dhhs.state.nc.us/mhddsas/stateplanimplementation/servicedefinitions10-15-04.pdf**

In arriving at the proposed FY 2006 Medicaid rates, there were many factors that were considered in the calculation methodologies. The first factor was taking historical actual claims paid in FY 2003 multiplied by the rate in place for FY 2004 to give a real expended figure for projection into the new service definitions established jointly by DMA and DMH/DD/SAS. This volume of service costs was cross walked into the new service definitions with an anticipated utilization developed by DMH/DD/SAS. In addition to referencing rate information provided by TAC, multiple cost models were developed that factored in direct labor costs, supervisory labor costs, supply costs, and other administrative costs. Subject matter experts in all areas of service delivery were polled and asked for input into the calculations of the numerous cost models. Once all of this data was collected, the rate setting staff of DMA and the DMH/DD/SAS jointly reviewed the forecasted volume of service costs and the cost models and agreed on rates and anticipated utilizations to arrive at the proposed FY 2006 Medicaid rates.

The Department of Health and Human Services is appreciative of and welcomes input regarding these proposed rates prior to finalization. In order to effectively address and respond to concerns regarding these rates, it is necessary for DMA, DMH/DD/SAS and the Controller's Office to focus on issues brought to us from a representative sample of actual service providers. For consideration of any discussion of the new proposed rates, DMA, DMH/DD/SAS and the Controller's Office rate setting staff will seek data and analyses from at least three providers for each service for comparison. This data must include the assumptions and the calculations to arrive at cost figures from financial statements which must accompany the cost data.

The selection of providers to submit cost data will be performed in a new manner. The selection of providers will come from a provider database being developed by DMH/DD/SAS. We find this is necessary since many providers currently bill for services through area programs; thus they are not visible to the State. DMH/DD/SAS and DMA will select a representative sample of providers from the providers currently listed in the provider database in addition to specific provider recommendations from various provider organizations in order to review the attached proposed rates for implementation July 1, 2005. The process will bring together the providers with DMA, DMH/DD/SAS and the Controller's Office staff to walk through the new services and rates. If providers disagree with any of the proposed rates, they will have the opportunity to submit data to DMA, DMH/DD/SAS and the Controller's Office, as described above, for the purpose of rate reconsideration. The participating providers will have until November 19, 2004 to submit their cost data. The providers selected for this review process will be listed on each Division's web page. Following this review, final rates will be presented to the DHHS Rate Review Board for approval and implementation.

In the future, it is our intent for the provider database to become more comprehensive. The database will consist of providers who have expressed a willingness to participate with DHHS staff in future meetings around rate and policy issues. This database will be developed as follows:

1. DMH/DD/SAS and DMA will send out a communication to providers, provider organizations, LMEs, etc., prior to November 1, 2004, informing them of the provider database and indicating how providers can express their willingness to participate;
2. DMH/DD/SAS will set up the database on its public web page through which providers can indicate their willingness to participate by entering the required provider information such as, services provided, agency budget, sources of revenues, incorporation status of the provider, number of consumers served, etc.

DMA and DMH/DD/SAS will make development of the provider listing an open and widely publicized process to ensure that all providers who are willing to participate have the opportunity to sign up. By rotating provider participation around subsequent rate and policy issues, DHHS will seek to broaden provider representation and input into the various rate and policy issues which impact MH/DD/SA service development and operation. Rotation of provider representation will also help ensure that providers with relevant experience are involved in related rate and policy issues.

In addition this bulletin, the same communications were sent on October 19, 2004, to Area/County MHDDSAS Directors, and various providers, stakeholders and professional organizations.

Bill Connelly, Rate Setting
DMA, 919-855-4200

Attention: Outpatient Mental Health Providers
ValueOptions

Effective immediately, ValueOptions has revised their Outpatient Treatment Report. This form will reflect utilization of H codes and CPT codes. Providers can access these forms on the web at http://www.ValueOptions.com.

Carolyn Wiser, Behavioral Health Services
DMA, 919-855-4290

Attention: Hospice Providers

Medicaid Reimbursement Rates for Hospice Services

Effective with date of service October 1, 2004, the maximum allowable rate for the following hospice services are outlined below:

			Routine Home Care	Continuous Home Care	Inpatient Respite Care	General Inpatient Care
Metropolitan Statistical Area	**SC**	**MSA**	**RC 651 Daily**	**RC 652 Hourly**	**RC 655 Daily**	**RC 656 Daily**
Asheville	39	480	125.16	30.41	135.41	555.11
Charlotte/Gastonia/Rock Hill	41	1520	125.51	30.49	135.71	556.57
Fayetteville	42	2560	118.59	28.81	129.78	527.92
Greensboro/Winston-Salem/High Point	43	3120	120.20	29.20	131.16	534.59
Hickory/Morganton/Lenoir	44	3290	120.88	29.37	131.74	537.40
Jacksonville	45	3605	114.64	27.85	126.39	511.56
Raleigh/Durham/Chapel Hill	46	6640	127.29	30.93	137.23	563.94
Wilmington	47	9200	123.75	30.07	134.20	549.28
Rural Counties	53	9934	113.87	27.67	125.74	508.40
Goldsboro	105	2980	115.33	28.02	126.99	514.44
Greenville	106	3150	119.60	29.06	130.64	532.09
Norfolk (Currituck County)	107	5720	115.31	28.02	126.97	514.34
Rocky Mount	108	6895	119.40	29.01	130.47	531.25

At this time, the rate for RC 659 is still reimbursed at $131.14

Key to the Hospice Rate Table

SC	Specialty Code
RC	**Revenue Code**

1. A minimum of eight hours of continuous home care per day must be provided.
2. There is a maximum of five consecutive days including the date of admission but not the date of discharge for inpatient respite care. Bill for the sixth day and any subsequent days at the routine home care rate.
3. When a Medicare/Medicaid recipient is in a nursing facility, Medicare is billed for routine or continuous home care, as appropriate, and Medicaid is billed for the appropriate long-term care rate. When a Medicaid only hospice recipient is in a nursing facility, the hospice may bill for the appropriate long-term care rate in addition to the home care rate provided in RC 651 or RC 652.
4. The hospice refunds any overpayments to the Medicaid program.
5. Date of Discharge: For the day of discharge from an inpatient unit, the appropriate home care rate must be billed instead of the inpatient care rate unless the recipient expires while inpatient. When the recipient is discharged as deceased, the inpatient care rate (general or respite) is billed for the discharge date.
6. Providers are expected to bill their usual and customary charges. Adjustments will not be accepted for rate changes.

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

Attention: All Providers

Influenza Vaccine Coverage

North Carolina faces a shortage of influenza vaccine this year due to the loss of approximately one half of the United States supply of trivalent inactivated vaccine for the 2004-2005 influenza season. As a result of this shortage, the N.C. Medicaid program and the N.C. Division of Public Health are following the CDC's recommendations for prioritizing the use of the remaining vaccine supplies.

CDC urges vaccination of the following priority groups:

- all children aged 6-23 months,
- adults aged > 65 years,
- persons aged 2-64 years with underlying chronic medical conditions,
- all women who will be pregnant during influenza season,
- residents of nursing homes and long-term care facilities,
- children 6 months-18 years of age on chronic aspirin therapy,
- health-care workers providing direct patient care, and
- out-of-home caregivers and household contacts of children aged <6 months

Information regarding the risk categories pertinent to influenza vaccine can be accessed online at http://www.cdc.gov/nip/ACIP/default.htm.

FluMist Nasal Vaccine
The N.C. Medicaid program is also responding to the vaccine shortage by covering the FluMist nasal vaccine for healthy recipient's ages 5 years through 49 years who are household contacts of medically high-risk Medicaid recipients. The coverage is effective with date of service October 1, 2004. FluMist is **only** covered when it is dispensed at the local health department according to the guidelines from the Advisory Committee on Immunization Practices. This policy will remain in effect through March 31, 2005.

The inactivated influenza vaccine is preferred over LAIV, known commercially as FluMist, for household members, health-care workers, and others who have close contact with severely immunosupressed persons (e.g., patients with hepatopoietic stem cell transplants) during those periods when the person requires care in a protective environment.

No preference exists, however, for inactivated influenza vaccine use by some members of the last two high-risk groups mentioned above. Health-care workers providing direct patient care, and out-of-home caregivers and household contacts of children aged <6 months may be candidates for the FluMist vaccine.

The following people **should not receive** the intranasal influenza vaccine (FluMist).

- People less than 5 years of age.
- People 50 years of age and over.
- People with a medical condition that places them at high risk for complications from influenza, including those with chronic heart or lung disease, such as asthma or reactive airways disease; people with medical conditions such as diabetes or kidney failure; or people with illnesses that weaken the immune system, or who take medications that can weaken the immune system.
- Children or adolescents receiving aspirin.

- People with a history of Guillain-Barré syndrome, a rare disorder of the nervous system.
- Pregnant women.
- People with a history of allergy to any of the components of LAIV or to eggs.

Reimbursement Guidelines

Reimbursement for the Injectable Vaccine for Recipients through Age 18

The Immunization Branch distributes childhood vaccines to local health departments, hospitals, and private providers to be used in accordance with the N.C. Universal Childhood Vaccine Distribution Program/Vaccine for Children (UCVDP/VFC) coverage criteria and state law/administrative code. The N.C. Medicaid program does not routinely reimburse for vaccines that are supplied through UCVDP/VFC for recipients through 18 years of age. However, due to the shortage of the influenza vaccine for the 2004-2005 flu season, Medicaid **will** reimburse providers who have purchased a supply of the injectable vaccine because the supply of free vaccine has been exhausted when it is used for recipients through 18 years of age. Reimbursement for purchased vaccine will be made for dates of service October 1, 2004 through March 31, 2005.

Changes are underway to allow for processing of claims for the purchased injectable vaccine. **Providers should watch future bulletins for notification that the system is prepared to accept claims.**

Reimbursement for the Injectable Vaccine for Recipients 19 Years of Age and Older

Providers may bill Medicaid for influenza vaccine for high-risk adults 19 and 20 years of age using CPT code 90658. Refer to the 2004 Health Check Special Bulletin, page 7, for billing guidelines.

All providers may bill Medicaid for influenza vaccine for high-risk adults ≥ 19 years of age using CPT code 90658 and for the administration fee using CPT code 90471. 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.

Reimbursement for FluMist Vaccine

Changes are underway to allow for processing of Local Health Department claims for FluMist. An administration fee will not be reimbursed in addition to the cost of the vaccine. **Providers should watch future Medicaid bulletins for notification that the system is prepared to accept claims.** FluMist will be reimbursed only when administered at the Local Health Department.

Billing Reminders for Vaccine Supplied Through VFC

Medicaid does not reimburse for influenza vaccine that is supplied through UCVDP/VFC for recipients through 18 years of age. Report CPT code 90655 or 90657 for children ≤ 6 months through 35 months of age and CPT code 90658 for children ≥ 3 years of age through 18 years of age.

Providers may bill for an administration fee using CPT code 90471 or 90471 and 90472, as appropriate. Local health departments, however, may only bill CPT code 90471 with the EP modifier for any visit other than a Health Check screening. Refer to the 2004 Health Check Special Bulletin, page 7, for billing guidelines.

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

Proposed Clinical Coverage Policies

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

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

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

Holiday Closing

The Division of Medical Assistance (DMA) and EDS will be closed on Thursday, November 11, 2004 in observance of Veteran's Day and on Thursday, November 25, 2004 and Friday, November 26, 2004 in observance of Thanksgiving.

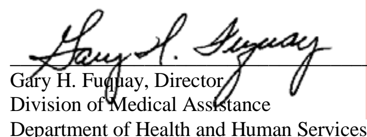
Checkwrite Schedule

November 2, 2004	December 7, 2004
November 9, 2004	December 14, 2004
November 16, 2004	December 22, 2004
November 24, 2004	

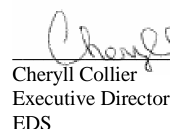
Electronic Cut-Off Schedule

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

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



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



Cheryll Collier
Executive Director
EDS