Number 11 *November 2006*

North Carolina Medicaid Bulletin

DMA on the Web at: *http://www.dhhs.state.nc.us/dma*

In This Issue.....Page#

In This Issue……...Page#

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

Attention: All Providers

CPT Codes 83900 and 83901, 92630 and 92633 Billing Requirements

The following billing requirements have been implemented for CPT codes **83900 and 83901, 92630 and 92633.**

Code	Description	Effective Date	Requirement
83900	Molecular diagnostics, amplification of patient nucleic acid, multiplex, first two nucleic acid sequences	January 1, 2006	See 83901
83901	Molecular diagnostics, amplification of patient nucleic acid, multiplex, each additional nucleic acid sequence	January 1, 2006	Must be billed in conjunction with CPT code 83900 on the same date of service by the same or a different provider
92630	Auditory rehabilitation; pre-lingual hearing loss	January 1, 2006	92630 is not allowed if 92633 has been billed within the patient's lifetime by the same or a different provider
92633	Auditory rehabilitation; post-lingual hearing loss	January 1, 2006	92633 is not allowed if 92630 has been billed within the patient's lifetime by the same or a different provider

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

Attention: All Providers

Electronic Data Systems (EDS) Provider Services

With the expansion of the Medicaid programs and input from the provider community, Electronic Data Systems (EDS) have added new staff to the EDS Provider Services Call Center. As always, DMA and EDS are working together to provide responsive and efficient customer service to all Medicaid providers. We are optimistic that the increase in staff will provide a higher level of customer satisfaction for our Medicaid providers. EDS Provider Services can be reached at 1-800-688-6696, option 3 between the hours of 8:00a.m. through 4:30p.m. Monday through Friday.

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

Attention: All Providers

Effective Dates for Revised Billing Forms

The National Uniform Claim Committee (NUCC), the National Uniform Billing Committee (NUBC) and the American Dental Association (ADA) have issued revised professional, institutional and dental paper claim formats.

The revised CMS 1500 (08/05) professional claim form will be accepted by Medicaid as of January 1, 2007. In keeping with the NUCC advisory, NC Medicaid will require that any paper CMS 1500 claims received by EDS as of April 1, 2007 be filed using the new claim form. To accommodate a transition period for providers, the Division of Medical Assistance will allow providers the option of submitting either the current CMS 1500 (12/90) form or the new CMS 1500 (08/05) form from January 1, 2007 through March 31, 2007 for Medicaid claims as well as provider-submitted Medicare crossover claims. During this transition period, EDS will process using either claim format; however, claims received on or after April 1, 2007 must be filed on the CMS 1500 (08/05).

The new UB04 claim form released by the NUBC for institutional providers to replace the current UB92 claim form will be accepted by NC Medicaid beginning March 1, 2007. As with the CMS 1500 (08/05), the Division of Medical Assistance will allow a transition period for providers to submit either the UB92 or the UB04 until May 17, 2007. Any paper claims received on or after May 18, 2007 must be filed on the UB04 format.

The revised ADA 2006 claim form released by the ADA for dental providers to replace the current ADA 2002 claim form will be accepted by NC Medicaid beginning March 1, 2007. The Division of Medical Assistance will allow a transition period from March 1, 2007 through May 17, 2007 for providers to submit either the ADA 2002 or the ADA 2006 claim forms. Any paper claims received on or after May 18, 2007 must be filed on the ADA 2006 format.

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

Attention: All Providers

Measles, Mumps, Rubella and Varicella Vaccine (MMRV, ProQuad, CPT Code 90710)—Billing Guidelines

Effective with date of service October 1, 2006, the N.C. Medicaid program recognizes the new measles, mumps, rubella and varicella (MMRV) vaccine (ProQuad), which is being provided through the Universal Childhood Vaccine Distribution Program/Vaccines for Children Program (UCVDP/VFC). These programs provide all vaccines recommended by the Advisory Committee of Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC). UCVDP/VFC covered vaccines are available to children birth through 18 years of age.

Since June 2006, ACIP has recommended a second dose of varicella vaccine for children 12 months through 12 years of age, effectively making a second dose of varicella vaccine recommended for all children 12 months through 18 years of age. All children under 13 years of age should be routinely administered two doses of varicella-containing vaccine, with the first dose administered at 12 through 15 months of age and the second dose at 4 through 6 years of age (that is, before a child enters kindergarten or first grade). The second dose can be administered at an earlier age, provided the interval between the first and second dose is at least three months. However, if the second dose is administered at least 28 days following the first dose, the second dose does not need to be repeated. The ACIP provisional recommendations for prevention of varicella are online at http://www.cdc.gov/nip/vaccine/varicella/varicella_acip_recs_prov_june_2006.pdf.

ProQuad is licensed for use in children 12 months through 12 years of age. Effective October 1, 2006, UCVDP began offering MMRV (ProQuad**)** vaccine as an option that may be administered only during the routine 12-through-15-months and 4-through-6-year schedules. UCVDP will continue to provide single-antigen varicella vaccine as well as measles, mumps and rubella (MMR) vaccine for children who fall outside these two age groups.

Due to limited funding, UCVDP state-supplied MMRV vaccine will be available only for patients within these two age groups. However, children seen for late-up-to-date visits may be administered state-supplied MMRV through six years of age.

Billing Guidelines:

- The procedure code for billing MMRV is 90710.
- Due to the availability of the UCVDP/VFC vaccines, Medicaid does not reimburse for vaccines that are covered under that program (for recipients 12 months through six years of age who receive the VFC vaccine); however, an administration fee may be billed to Medicaid, if appropriate.
- Medicaid will not reimburse for the MMRV vaccine for recipients over six years of age.
- Diagnosis code V06.8 should be used when billing for MMRV, if applicable. Providers should refer to the April 2006 Special Bulletin I, *Health Check Billing Guide 2006,* for additional information on billing Medicaid for vaccines.

- Private providers may bill for the administration of MMRV vaccine by either CPT procedure code 90471 or 90471 and 90472 with the EP modifier. If provider counseling is performed for children under the age of 8 years, bill using CPT code 90465 or 90465 and 90466 with the EP modifier.
- Local health departments may bill CPT code 90471 or 90465 as appropriate with the EP modifier for any visit other than a Health Check screening. Rural Health Clinics and Federally Qualified Health Centers, using the C suffix, may bill 90471 or 90465 if the immunization administration is during a Health Check visit.

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

Attention: All Providers

National Provider Identifier (NPI) Collection Form

The National Provider Identifier (NPI) Form is now available on the Division of Medical Assistance's (DMA) Website at http://www.dhhs.state.nc.us/dma/npi.htm.

The North Carolina Medicaid is collecting the NPI numbers from currently enrolled Medicaid providers. The form can be returned by fax or mail to the address listed on the form. Providers must also include with the NPI form a copy of the notification letter from the National Plan and Provider Enumeration System (NPPES). Please provide this information to DMA no later than March 31, 2007.

DMA is pursuing options for e-mail, web-based and electronic batch file submission. Details will be provided in future bulletins.

Provider Services
DMA, 919-855-4050

Attention: All Providers

Medicaid Crossover Claims

In accordance with Centers for Medicare & Medicaid Services (CMS) directive, the North Carolina Medicaid program implemented the Coordination of Benefits Agreement (COBA) program effective August 1, 2006. The COBA program consolidated Medicare Claims Crossover processing from multiple intermediaries to a single Coordination of Benefits Contractor (COBC). Group Health Incorporated (GHI) was selected by CMS as the national COBC.

To facilitate the transition during the month of August, crossover claims were accepted in both the traditional method (from multiple intermediaries) and from the COBC in the American National Standards Institute (ANSI) X12N 837 format.

During this transition period NC Medicaid recognized that the overall volume of crossover claims had dropped from the normal submission volumes. The NC Medicaid program worked with the COBC to address this issue and bring the volume back in line with historical averages. During the week of October 9, 2006 all outstanding claims from August 2006 to current were submitted for adjudication during the weekly check write. The provider community should find these claims adjudicated on the RA date of October 17, 2006.

NC Medicaid is continuing to monitor the overall volume of claims crossed over by the COBC and have found a consistent upward trend in this volume. However, as we continue through this transition period, if providers identify any instances where their claims have not crossed they should contact EDS Provider Services with the specific examples so that they can be researched and resolved.

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

Attention: All Providers Who Submit Claims Electronically

National Provider Identifier (NPI) 837 Filing Requirements

With the implementation of the NPI, Medicaid will begin using additional data from the 837 Health Care Claim to identify the providers within our system. The additional information from the 837 that will be used is as follows:

- Billing/Rendering Provider Taxonomy Codes
- Billing Provider/Service Facility Location Zip Codes

Although North Carolina Medicaid will not be implementing NPI until 2007, we encourage providers to begin sending these additional data elements as soon as possible.

Follow the rules of the 837 Implementation Guides and the Medicaid Companion Guides to populate this information on your transactions.

Providers who have received their NPIs can begin submitting them on all transactions with your Medicaid Provider number.

Currently these changes apply to the 837 transactions changes. Changes to the NCECSWeb application will be made at a later date.

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

Attention: All Providers

Required Fields on New Provider Enrollment Applications and Provider Change Form

Effective January 1, 2007, to facilitate NPI implementation, the Division of Medical Assistance (DMA) will no longer accept enrollment applications or change forms without the following information:

- National Provider Identifier (NPI)
- Zip Code plus Four
- Taxonomies

Federally mandated requirements for NPI implementation is May 23, 2007. This information is required. If this information is not provided, your new application or change forms will be returned.

If you have not enumerated, please check our Website at http://www.dhhs.state.nc.us/dma/NPI.htm for information or enumerate at NPI at https://nppes.cms.hhs.gov/NPPES/Welcome.do.
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Provider Services
DMA, 919-855-4050

Attention: All Providers

Tax Identification Information

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

How to Verify Tax Information

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

How to Correct Tax Information

All providers are required to complete a W-9 form for each provider for whom incorrect information is on file. Please go to http://www.irs.gov/pub/irs-pdf/fw9.pdf to obtain a copy of a W-9 form. Correct information must be received by December 01, 2006. The procedure for submitting corrected tax information to the Medicaid program is outlined below:

All providers who identify incorrect tax information must submit a completed and signed W-9 form, along with a completed and signed Medicaid Provider Change form or Carolina ACCESS Provider Information Change Form, to the address listed below:

Division of Medical Assistance
Provider Services
2501 Mail Service Center
Raleigh NC 27699-2501

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

Attention: All Providers

2007 Checkwrite Schedule

Beginning February 2007, the cutoff day for electronic claims submission will change from Friday to Thursday due to anticipated increased processing time for the NPI implementation. It is important that you make any required system changes to accommodate this cutoff day. Following is the 2007 checkwrite schedule.

Month	Electronic Cut-Off	Checkwrite Date
January	01/05/07	01/09/07
	01/12/07	01/17/07
	01/19/07	01/25/07
February	02/02/07	02/06/07
	02/08/07	02/13/07
	02/15/07	02/20/07
	02/22/07	02/28/07
March	03/01/07	03/06/07
	03/08/07	03/13/07
	03/15/07	03/20/07
	03/22/07	03/29/07
April	04/05/07	04/10/07
	04/12/07	04/17/07
	04/19/07	04/26/07
May	05/03/07	05/08/07
	05/10/07	05/15/07
	05/17/07	05/22/07
	05/24/07	05/31/07

Month	Electronic Cut-Off	Checkwrite Date
June	05/31/07	06/05/07
	06/07/07	06/12/07
	06/14/07	06/21/07
July	06/28/07	07/03/07
	07/05/07	07/10/07
	07/12/07	07/17/07
	07/19/07	07/26/07
August	08/02/07	08/07/07
	08/09/07	08/14/07
	08/16/07	08/23/07
September	08/30/07	09/05/07
	09/06/07	09/11/07
	09/13/07	09/18/07
	09/20/07	09/27/07
October	10/04/07	10/09/07
	10/11/07	10/16/07
	10/18/07	10/23/07
	10/25/07	10/31/07
November	11/01/07	11/06/07
	11/08/07	11/14/07
	11/15/07	11/21/07
December	11/29/07	12/04/07
	12/06/07	12/11/07
	12/13/06	12/20/07

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

Attention: Durable Medical Equipment Providers

Revised Continuous Positive Airway Pressure (CPAP) Device and Respiratory Assist Device (RAD) Clinical Coverage Policies

Durable Medical Equipment (DME) providers are reminded that revised clinical coverage policies for CPAP and RAD went into effect September 1, 2006. There are several significant changes from the old policies. Please refer to Clinical Coverage Policy #5A, Durable Medical Equipment, on DMA's Web site for coverage details. Section 9.0 of that policy lists the changes that were made by effective date.

Clinical Policy
DMA, 919-855-4316

Attention: Personal Care Service (PCS) and Personal Care Service Plus (PCS PLUS) Providers

PCS Provider Training Session II

The Carolinas Centers for Medical Excellence (CCME), formerly Medical Review of North Carolina (MRNC), under contract with the Division of Medical Assistance (DMA), will continue quarterly PCS training sessions statewide.

The training will be for registered nurses, agency administrators and agency owners.

The agenda topics are as follows:

1. Spotlight on Physician's Authorization for Care and Treatment (PACT)
    a. Issues
    b. Trouble spots
    c. Trends seen in 1st quarter reviews
2. Application
    a. PACT assessment
    b. Scoring
    c. Instrumental Activities of Daily Living (IADLs)
3. Plan of Care and Aide Log trouble spots with application
4. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and age-appropriate ADL scoring for the under-21 population

Please choose the training session that is most convenient for you from the list below.

December 1, 2006
Charlotte
Hilton Charlotte Executive Park
5624 Westpark Drive
Charlotte NC 28217
704-527-8000
http://www.hilton.com/en/hi/hotels/index.jhtml;jsessionid=O0HUORJ5IHTNKCSGBIXM22QKIYFCVUUC?ctyhocn=CLTEPHF

December 4, 2006
Winston-Salem
Benton Convention Center
301West Fifth Street
Winston-Salem NC 27101
336-727-2976
http://www.twincityquarter.com/index.html

December 5, 2006
Cary
Embassy Suites/RTP
201 Harrison Oaks Boulevard
Cary NC 27513
919-677-1840
http://embassysuites.hilton.com

December 7, 2006
Wilmington
Shell Island Resort
2700 North Lumina Avenue
Wrightsville Beach NC 28480
910-256-8696
http://www.shellisland.com

December 8, 2006
New Bern
Sheraton Hotel
One Bicentennial Park
New Bern NC 28560
252-638-3585
http://www.starwoodhotels.com/sheraton/property/overview/index.html?propertyID=18 (**Note: The Sheraton Web site gives this address as 100 Middle Street.)**

Pre-registration is required. Space is limited to the first 200 participants at each site. To register online, go to http://www.mrnc.org/mrnc_web/mrnc/medicaid.aspx?ID=Registration and follow the instructions for registration. A computer-generated confirmation number will confirm your registration.

To register via fax, complete the attached registration form and fax it to the attention of Jennifer Manning at 919-380-9457. A member of the PCS team will call you with a confirmation number.

Registration is currently open for all sites and will close Friday, November 17, 2006. If you need to cancel at any time, please contact Jennifer Manning at 919-380-9860, x2018.

Check-in for each session begins at 8:30a.m.; the trainings are scheduled from 9:00 a.m. to 4:00 p.m. Lunch will be on your own.

CCME Training Session III Coming January 2007! Watch for site schedule and agenda in the December general Medicaid bulletin.

CCME PCS Provider Training Session II for December 2006 Registration form

Location Requested: _____ Location Date: _____

If you are registering for the Shell Island/Wilmington session, will you be purchasing a deli buffet lunch at the hotel for $9.95? (cash or check, no credit cards)

Circle one: Yes No

First Name: _____
Last Name: _____
Credentials: _____
Position: _____
Organization: _____
Facility: _____
Address: _____
City: _____ NC Zip: _____
County: _____
UPIN/Provider #: _____
Phone #: _____ Ext: _____
Fax #: _____
E-mail: _____

Referred by/How did you hear about this event?
_____

_____

Please fax completed form to the attention of Jennifer Manning at 919-380-9457

May we send you e-mail updates on new information, features, and tools on the CCME

Web site?

Circle one: Yes No

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

Attention: Physicians

Ranibizumab, 0.5 mg injectable (Lucentis, HCPCS Procedure Code J3590)—Billing Guidelines

Effective with date of service October 1, 2006, the N.C. Medicaid program covers ranibizumab (Lucentis) for use in the Physician Drug Program when billed with HCPCS procedure code J3590 (unclassified biologics). Lucentis is indicated for neovascular (wet) age-related macular degeneration. Lucentis is an antibody fragment to vascular endothelial growth factor (VEGF), which is involved in the formation of new blood vessels (angiogenesis). Lucentis binds and thereby inhibits VEGF. Lucentis is administered by ophthalmic intravitreal injection. Intravitreal injections have been associated with endo-ophthalmic and retinal detachments, and Lucentis is contraindicated in patients with ocular or periocular infection.

Lucentis is administered as a 0.5-mg (0.05-ml) intravitreal injection once a month.

For Medicaid Billing:

- The ICD-9-CM diagnosis code 362.52 (exudative senile macular degeneration) is required when billing for Lucentis.
- Providers must bill Lucentis with HCPCS procedure code J3590 (unclassified biologics), with the original invoice or copy of the original invoice attached to the CMS-1500 claim form. **An invoice must be submitted with each claim.** The paper invoice must include the recipient's name and Medicaid identification number, the name of the medication, the dosage given, the National Drug Code (NDC) number from the vial(s) used, the number of vials used and the cost per dose.
- Providers must indicate the number of units given in block 24G on the CMS-1500 claim form.
- Providers must bill their usual and customary charge.
- CPT code 67028—Intravitreal injection of a pharmacologic agent (separate procedure) with the appropriate modifier must be included with the billing of Lucentis.

For Medicaid billing, one unit of coverage is 0.5 mg. The maximum reimbursement rate per unit is $2,193.75. Claims denied for dates of service October 1, 2006, and after may be resubmitted.

The new fee schedule for the Physician Drug Program is available on DMA's Web site at http://www.dhhs.state.nc.us/dma/fee/fee.htm.

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

Attention: Physicians and Nurse Practitioners

Pegylated Interferon Alfa-2b, 10 mcg (PEG-Intron, HCPCS Procedure Code J3590)—Billing Guidelines

Effective with date of service May 1, 2006, the N.C. Medicaid program will cover pegylated interferon alfa-2b (PEG-Intron) for use in the Physician Drug Program. PEG-Intron is a covalent conjugate of recombinant alfa-2b interferon with monomethoxy polyethylene glycol (PEG). It has been approved by the FDA as a once-weekly monotherapy for the treatment of chronic hepatitis C in adult patients. PEG-Intron is indicated for use alone or in combination with Rebetol (Ribavirin) for patients who are at least 18 years of age, who have compensated liver disease, and who have not been previously treated with alpha interferon. PEG-Intron is supplied in both vials and the Redipen for subcutaneous use (Redipen is a dual-chamber glass cartridge containing PEG-Intron in the sterile chamber and a second chamber containing sterile water for injection).

Dosage and administration:
The volume of PEG-Intron to be injected depends on the strength of the PEG-Intron and the patient's weight**.**

- **PEG-Intron Monotherapy**: The recommended dose of PEG-Intron regimen is 1.0 mcg/kg/wk subcutaneously for one year, with doses administered on the same day of the week, each week.
- **PEG-Intron Combination Therapy**: When administered in combination with Rebetol (Ribavirin), the recommended dose of PEG-Intron is 1.5 mcg/kg/wk.

Billing Guidelines:
- Providers must bill HCPCS procedure code J3590 for PEG-Intron.
- ICD-9-CM diagnosis code 070.44 (chronic hepatitis C with hepatic coma) or 070.54 (chronic hepatitis C without mention of hepatic coma) is required when billing PEG-Intron.
- Providers must submit the original invoice or copy of the original invoice with each claim. **An invoice must be submitted with each claim.** The paper invoice must indicate the recipient's name and Medicaid identification number, the name of the medication, the dosage given, the National Drug Code (NDC) number from the vial(s) used, the number of vials used and the cost per dose.
- Providers must indicate the number of units given in block 24G on the CMS-1500 claim form. For billing purposes, each Medicaid unit is 10 mcg.
- Bill the usual and customary charge.
- Claims that have been denied for dates of service on or after May 1, 2006, may be resubmitted.

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

Attention: Physicians and Nurse Practitioners

Levetiracetam, 500-mg/5-ml injection (Keppra, HCPCS Procedure Code J3490)—Billing Guidelines

Effective with date of service October 1, 2006, the N.C. Medicaid program covers levetiracetam (Keppra) injection for use in the Physician Drug Program when billed with HCPCS procedure code J3490 (unclassified drug code). Keppra injection is indicated for adjunctive therapy in the treatment of partial onset seizures in adults 18 and older with epilepsy when oral administration is temporarily not feasible.

Keppra 500-mg/5-ml solution is diluted in 100 ml of a compatible diluent and administered by intravenous infusion over 15 minutes. Treatment should be initiated with a daily dose of 1000 mg/day, given as twice-daily dosing (500 mg twice a day). Additional dosing increments may be given (1000 mg/day additional every 2 weeks) to a maximum recommended daily dose of 3000 mg.

For Medicaid Billing:

- An ICD-9-CM diagnosis code in the range of 345.0 through 345.9 (epilepsy) is required when billing for Keppra.
- Bill Keppra only for Medicaid recipients 18 years of age or older.
- Bill Keppra with HCPCS procedure code J3490 (unclassified drug code).
- Submit an original invoice or copy of the original invoice with the CMS-1500 claim form. **An invoice must be submitted with each claim.** The paper invoice must include the recipient's name and Medicaid identification number, the name of the medication, the dosage given, the National Drug Code (NDC) number from the vial(s) used, the number of vials used and the cost per dose.
- Indicate the number of units given in block 24G on the CMS-1500 claim form.
- Bill the usual and customary charge.

For Medicaid billing, one unit of coverage is a 500-mg/5-ml vial. The maximum reimbursement rate per unit is $33.75 per vial.

The new fee schedule for the Physician Drug Program is available on DMA's Web site at http://www.dhhs.state.nc.us/dma/fee/fee.htm.

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

Attention: Physicians and Nurse Practitioners

Etonogesterel, 68-mg implant (Implanon, HCPCS Procedure Code J3490)—Billing Guidelines

Effective with date of service October 1, 2006, the N.C. Medicaid program covers etonogesterel implants (Implanon) for use in the Physician Drug Program when billed with HCPCS procedure code J3490 (unclassified drug code). Implanon is a long-acting (3 years), reversible method of contraception for women. Implanon is a 4-cm rod that is administered as a subdermal implant and must be removed after three years. Implanon is indicated for prevention of pregnancy. All warnings and contraindications that apply to other progestin-only contraceptives apply to Implanon, including, but not limited to, ectopic pregnancies, bleeding irregularities, ovarian cysts, thrombosis, cigarette smoking, increased blood pressure, etc.

Implanon is administered as one 68-mg subdermal implant every three years, with removal of implant no later than three years after implantation.

For Medicaid Billing:

- ICD-9-CM diagnosis code V25.5 (insertion of implantable subdermal contraceptive) is required when billing for the insertion of Implanon. Diagnosis code V25.43 should be billed for surveillance (checking, reinsertion or removal) of the previously implanted Implanon.
- Bill Implanon with HCPCS procedure code J3490 (unclassified drug code). The FP modifier (family planning) must be appended to the HCPCS code.
- Submit the original invoice or copy of the original invoice with the CMS-1500 claim form. **An invoice must be submitted with each claim.** The paper invoice must include the recipient's name and Medicaid identification number, the name of the medication, the dosage given, the National Drug Code (NDC) number from the implant used and the cost per dose.
- Indicate one unit implanted in block 24G on the CMS-1500 claim form.
- Bill CPT procedure code 11981, 11982, or 11983 for the insertion, removal or removal with reinsertion of the non-biodegradable drug delivery implant. The FP modifier (family planning) must be appended to the CPT procedure code.
- Bill the usual and customary charge.
- Do not bill for more than one unit of Implanon in a 3-year period.
- Do not bill other forms of birth control such as IUDs (Paragard, Mirena), Depo-Provera or Lunelle if Implanon has been or is being billed.
- Claims denied for dates of service on or aftern October 1, 2006, may be resubmitted.

One unit of coverage is one 68-mg implant. The maximum reimbursement rate per unit is $588.38.

The new fee schedule for the Physician Drug Program is available on DMA's Web site at http://www.dhhs.state.nc.us/dma/fee/fee.htm.

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

Attention: Physicians and Nurse Practitioners

Injection, Ertapenem Sodium, 500 mg (Invanz, HCPCS Procedure Code J1335)—Billing Guidelines

Effective with date of service November 1, 2006, the N.C. Medicaid program covers Invanz for use in the Physician Drug Program. Invanz is indicated for the treatment of

1. complicated intra-abdominal infections;
2. complicated skin and skin structure infections;
3. community acquired pneumonia;
4. complicated urinary tract infections, including pyelonephritis; and
5. acute pelvic infections, including postpartum endomyometritis, septic abortion and post-surgical gynecologic infections.

The dosage of Invanz for patients 13 years of age or older is 1 gram given once a day. The dosage of Invanz for patients 3 months to 12 years of age is 15 mg/kg twice daily, not to exceed 1 gram per day. Invanz may be administered by intravenous infusion for up to 14 days or intramuscular injection for up to 7 days. When administered intravenously, Invanz should be infused over a period of 30 minutes.

Billing Reminders:

- Use the CMS-1500 claim form or bill electronically on the 837 transaction set.
- Use HCPCS procedure code J1335 to bill for Invanz.
- Enter the appropriate diagnosis in block 21.
- Enter the date of service in block 24A.
- Enter the place of service in block 24B.
- Enter HCPCS procedure code J1335 in block 24D.
- Enter the usual and customary charge in block 24F.
- Enter the units given in block 24G (500 mg = 1 unit).
- Bill the usual and customary charge.

Example

21 Diagnosis	**24A Date(s) of Service**	**24B Place of Service**	**24D Procedures, Services or Supplies**	**24F Charges**	**24G Days or Units**
	11032006	11	J1335	$	2

For Medicaid billing, 1 unit of coverage is 500 mg. The maximum reimbursement rate per unit is $23.14.

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

Attention: Residential Child Care Treatment Facilities

Full License Requirement

All Residential Services (Level II, III and IV) providers were required to submit their Attestation letter and Provisional license to DMA by September 6, 2006. You are required to send a copy of your full license to DMA as soon as you receive it from the Division of Facility Services (DFS) to maintain Medicaid enrollment and thus to prevent claim denials for a terminated Medicaid provider number. DMA must receive a copy of your full license prior to your Provisional license's expiration date.

For renewal of your Medicaid enrollment, all Residential Services (Level II, III and IV) providers will now be required to send DMA a copy of your renewed license and a copy of your local management entity's endorsement letter.

Provider Services
DMA, 919-855-4070

Attention: CAP-MR/DD Providers, MH/SA Providers, Local Management Entities,Targeted Case Managers for CAP-MR/DD and MH/SA

Transportation Included in the Provider Rate

This is to clarify recent inquiries regarding Medicaid transportation assistance for certain CAP-MR/DD and Community Intervention Enhanced Benefits services. Transportation is included as an element of the provider's reimbursement fee for the services below. Since transportation costs are part of the Medicaid reimbursement rate, providers must arrange and provide transportation to and from the participant's primary residence when providing these services. The county dss cannot pay for transportation costs to these services.

The departments of social services have been notified that State and Federal reimbursement cannot be claimed for Medicaid transportation when transportation has been included in the Medicaid provider's fee. The Administrative Letter to the counties can be viewed on the DMA website, http://info.dhhs.state.nc.us/olm/manuals/dma/abd/adm/. The services that include transportation in the fee and CPT codes are as follows:

CAP-MR/DD SERVICE	**CPT CODE**
Day Supports – Individual	T2021
Day Supports – Group	T2021HQ
Supported Employment – Individual	H2025
Supported Employment – Group	H2025HQ
COMMUNITY INTERVENTION SERVICES - ENHANCED BENEFITS SERVICE	**CPT CODE**
Community Supports Service – Adult	H0036HB
Community Supports Services – Child	H0036HA
Community Supports Services – Group – Adult or Child	H0036HQ
Community Support Treatment Team (CST)	H2015HT
Assertive Community Treatment Team (ACTT)	H0040
Child and Adolescent Day Treatment	H2012HA
Diagnostic Assessment	T1023
Intensive In-Home Services	H2022
Mobile Crisis	H2011
Multi-systemic Therapy (MST)	H2033
Partial Hospital	H0035
Professional Treatment Services in Facility-Based Crisis Program	S9484
Psychosocial Rehabilitation	H2017
Substance Abuse Comprehensive Outpatient Treatment	H2035
Substance Abuse Intensive Outpatient Program	H0015
Substance Abuse Medically Monitored Residential Treatment	H0013
Substance Abuse Non-Medical Community Residential Treatment	H0012HB
Ambulatory Detoxification	H0014
Medically Supervised Detoxification/Crisis Stabilization	H2036
Non-Hospital Medical Detoxification	H0010
Outpatient Opioid Treatment	H0020

When providing these services, do not refer participants requesting transportation assistance to the county department of social services (dss).

Medicaid Eligibility
DMA, 919-855-4000

NCLeads Update

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

Provider Relations
Office of MMIS Services
919-647-8315

Proposed Clinical Coverage Policies

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

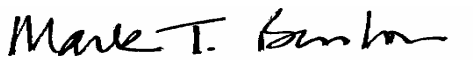
Gina Rutherford
Division of Medical Assistance
Clinical Policy Section
2501 Mail Service Center
Raleigh, NC 27699-2501

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.

2006 Checkwrite Schedule

November	11/03/06	11/07/06
(g)	11/09/06	11/14/06
(h)	11/17/06	11/21/06
December	12/01/06	12/05/06
	12/08/06	12/12/06
	12/15/06	12/21/06

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.



Mark T. Benton, Senior Deputy Director and
Chief Operating Officer
Division of Medical Assistance
Department of Health and Human Services

Cheryll Collier
Executive Director
EDS