November 2007 Medicaid Bulletin

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

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Attention: All Providers

National Provider Identifier and Address Information Database

In the later part of November 2007, the Division of Medical Assistance (DMA) will implement a searchable National Provider Identifier (NPI) and address database. Providers can access the database by NPI or Medicaid provider number, at http://www.ncdhhs.gov/dma/NPI.htm.

Please access the database as soon as possible to verify your NPI, site address, and billing address. If all information is correct, no action is necessary. To correct typographical errors: print the form, make corrections, and fax to the number on the printable form. To correct more serious (non-typographical) errors, submit a Provider Change Form (http://www.ncdhhs.gov/dma/Forms/changeprovstatus.pdf) and include any other applicable documentation.

If your NPI is not in the database, previously submitted documentation was either not sufficient to update the database or has not been submitted at all. Providers should print the form and submit your NPI with a copy of your National Plan and Provider Enumeration System (NPPES) certification.

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

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

Attention: Pharmacists and Prescribers

National Provider Identifier to Replace Drug Enforcement Administration Number on Claims

Currently, the prescribing provider's Drug Enforcement Administration (DEA) number is used as an identifier on pharmacy claims. Upon National Provider Identifier (NPI) implementation, the NPI will replace the DEA number. Pharmacists are encouraged to begin requesting the NPIs of prescribing providers. Some providers have elected to add their NPIs to their prescription pads. Prescribing providers need to share their NPIs with pharmacies, as it will be required for pharmacy claims processing.

Once the transition takes place in May 2008, if the prescriber's NPI is not on the claim, the pharmacy claim will be denied with EOB 3105, which states, "The NPI submitted for the prescribing provider is missing or invalid." The pharmacy will then need to verify the prescriber's NPI and resubmit the claim.

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

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

Attention: All Providers (Except Pharmacy)

Submit both NPI and Medicaid Provider Number on Claims

Beginning January 1, 2008, with the exception of Pharmacy providers, N.C. Medicaid providers must begin submitting both the NPI and the Medicaid Provider Number on all claims. While claims will not deny at this time if this information is not submitted, not providing this information now may cause your claims to deny once NPI is implementedBoth numbers are needed to ensure that your NPI and Medicaid Provider Number are mapping correctly.

NCECSweb is being modified to allow the submission of both the NPI and the Medicaid Provider Number.

If your software is not updated to submit the NPI number, please contact your clearinghouse or software vendor as soon as possible to obtain the appropriate updates. Please ensure that you keep the capability to submit the Medicaid Provider Number along with the NPI.

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

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

Attention: All Providers

Verify NPI with Clearinghouses and Vendors

It has come to the attention of the Division of Medical Assistance that
Some clearinghouses may be stripping the National Provider Identifier (NPI) off the claim prior to submitting it to Medicaid for claims processing. Clearinghouses may be adding the NPI back on to the Remittance Advice, so that providers are unaware that NPIs are being removed prior to being sent forward.

Some billing services or software vendors are not putting the NPI on the claim, contrary to provider instructions. Some clearinghouses and vendors may be performing their own internal mapping from Medicaid provider number to NPI.

If you are currently submitting your NPI and Medicaid provider number on claims and your claims are filed through a clearinghouse or software vendor, contact them to verify that the NPI is being submitted. Also, confirm that the NPI being submitted on the claim is the same NPI that you reported to N.C. Medicaid for the Medicaid provider number on the claim.

Validation of this information is critical to avoid any potential reimbursement issues upon NPI implementation.

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

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

Attention: All Providers

Clinical Coverage Policies

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

- 1A-23, Physician Fluoride Varnish
- 1F, Chiropractic Services
- 9, Outpatient Pharmacy Program

These policies supersede previously published policies and procedures. Providers may contact EDS at 1-800-688-6696 or 919-851-8888 with billing questions.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

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 payment until the report is received.

A copy of the Medicaid Credit Balance Report form follows this article. 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.

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 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 date fields for each Medicaid 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.

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)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
RECIPIENT'S NAME	MEDICAID NUMBER	FROM DATE OF SERVICE	TO DATE OF SERVICE	DATE MEDICAID PAID	MEDICAID ICN	AMOUNT OF CREDIT BALANCE	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

Attention: All Providers

Payment Error Rate Measurement in North Carolina

In compliance with the Improper Payments Information Act of 2002, the Centers for Medicare and Medicaid Services (CMS) implemented a national Payment Error Rate Measurement (PERM) program to measure improper payments in the Medicaid program and the State Children's Health Insurance Program (SCHIP). North Carolina has been selected as one of 17 states required to participate in PERM reviews of claims paid in Federal fiscal year 2007 (October 1, 2006 – September 30, 2007).

CMS is using three national contractors to measure improper payments. One of the contractors, Livanta LLC (Livanta), will be communicating directly with providers and requesting medical record documentation associated with the sampled claims (approximately 800 - 1200 claims for North Carolina). Providers will be required to furnish the records requested by Livanta, within a timeframe indicated by Livanta.

It is anticipated that Livanta will begin requesting medical records for the NC sampled claims this month. Providers are urged to respond to these requests promptly with timely submission of the requested documentation.

Providers are reminded of the requirement in Section 1902(a)(27) of the Social Security Act and Federal Regulation 42 CFR Part 431.107 to retain any records necessary to disclose the extent of services provided to individuals and, upon request, furnish information regarding any payments claimed by the provider for rendering services.

Program Integrity
DMA, 919-647-8000

Attention: All Providers

Reaching Compliance with HIPAA Privacy Regulations

The information sent through the North Carolina Medicaid e-mail system is considered public information and is not encrypted. The security of patient information sent by e-mail cannot be guaranteed. If it is necessary to send patient specific information to an "ncmail.net" or “eds.com” e-mail address, please send the information in a password-protected attachment to the e-mail. Telephone the e-mail recipient with the password; do not send it by e-mail.

Examples of information that should be protected include any protected health information (PHI), as defined by the HIPAA Privacy Rule [such as the patient's full name, Medicaid ID Number (MID), Internal Control Number (ICN), Prior Approval Number (PA#)]. When the need to reference particular claims and/or other items arises, we recommend the use of the last four digits of the ICN and the billed amount, or the billed amount and the recipient's initials, and similar tactics. This will allow DMA and/or its fiscal agent to determine which claim is being referenced without explicitly using PHI to do so. See http://www.ncdhhs.gov/dma/hipaa/submitpatientinfo.html for additional information.

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

Attention: All Providers

State Fiscal Year 2007-08 Rate Updates

The legislature removed the rate freeze for state fiscal year 2007-08. The following providers will have annual rate updates effective in the first four months of the state fiscal year:

PROVIDER DESCRIPTION	RATE EFFECTIVE DATE
Durable Medical Equipment	August 1, 2007
Home Infusion Therapy	September 1, 2007
Home Health	September 1, 2007
Community Alternative Programs – Choice, Children, Disabled Adults & Mentally Retarded/Developmentally Disabled	September 1, 2007
Private Duty Nursing	September 1, 2007
ICF-MR	July 1, 2007
Hospice	October 1, 2007
Swing Nursing Beds	October 1, 2007
Vent Nursing Beds	October 1, 2007
Inpatient Hospital Rates	October 1, 2007

The claims payment system will not be updated for most of these rate increases until after the effective date of the rate changes. Therefore, providers should check for changes to the maximum allowable rates on the fee schedules at http://www.dhhs.gov/dma/fee/fee.htm. Providers with individual accommodation rates will receive an official notification letter from DMA. Providers should continue to bill their usual and customary charges. As each provider type is updated in the claims payment system, DMA will request EDS to review and recalculate affected claims filed prior to the update. Providers should not file adjustment claims. Any additional reimbursement will be reflected in future payments and indicated on the RA as an adjustment.

Rate Setting
DMA, 919-855-4200

Attention: Ambulatory Surgical Center Providers

Rate Change

Effective with date of service October 1, 2007, rates have been adjusted for the Ambulatory Surgical Center pricing groups in accordance with the State Plan.

For current pricing on these codes, refer to the Division of Medical Assistance Web site at http://www.ncdhhs.gov/dma/fee/fee.htm. For all billings, providers are reminded to bill their usual and customary rates.

Financial Management
DMA, 919-855-4200

Attention: Dental Providers and Health Department Dental Centers

Effective November 15, 2007, the 2002 ADA Claim Form Will No Longer Be Accepted (Reprint from October 2007 Bulletin)

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

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

Providers who receive EOB 189 will need to resubmit their claims on the 2006 ADA Claim Form. Claim forms can be ordered directly from the ADA. Listed below are the web address, toll-free telephone number, and mailing address.

http://www.ada.org/ada/prod/catalog/index.asp
1-800-947-4746
American Dental Association
Attn: Salable Materials Office
211 E. Chicago Avenue
Chicago, IL 60611-2678

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

Attention: Enhanced Mental Health and Substance Abuse Service Providers

Community Support Services – Billing

The General Assembly enacted Session Law 2007-323, Section 10.49 (ee) that requires an additional modifier to identify units of service provided by the Qualified Professional (QP) and Non-Qualified Professional (non-QP) staff persons for Community Support services. This is effective with date of service December 1, 2007. Community Intervention Services (CIS) providers billing for community support will be required to bill a secondary modifier on the claim submission for:

- H0036 HA – Community Support Child
- H0036 HB – Community Support Adult
- H0036 HQ – Community Support Group

The identified modifiers for use are as follows:

- Modifier U3 will be used as a secondary modifier to identify a service rendered by a Qualified Professional (QP)

- Modifier U4 will be used as a secondary modifier to identify a service rendered by a non-Qualified Professional (non QP)

Each submission will require the total of the two modifiers to be processed for payment.

Primary modifiers HA, HB, or HQ must be placed in the first modifier field on the corresponding claim detail line.

Secondary modifiers U3 or U4 must be placed in the second modifier field on the corresponding claim detail line.

CMS-1500 Claim Examples:
These examples are for illustration purposes only. Actual codes billed should reflect who rendered the services.

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER		E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1																1D	555555B
	12	01	07	12	01	07	11		H0036	HA	U3		256.40	20		NPI	NPI Number

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER		E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1																1D	555555B
	12	01	07	12	01	07	11		H0036	HA	U4		256.40	20		NPI	NPI Number

Note: No rounding is allowed for billable services, only round down when time does not reach a complete 15 minutes per individual staff rendering the service.

Behavioral Health Services
DMA, 919-855-4290

Attention: Local Education Agencies

Revised Medicaid Administrative Claiming / School-Based Services Time Study

Effective with the October-December 2007 claiming quarter, all Local Education Agencies (LEAs) in North Carolina seeking Medicaid reimbursement for both the Medicaid Administrative Claiming (MAC) and Fee for Service (FFS) programs will be required to conduct or participate in a Centers for Medicare and Medicaid Services (CMS) approved time study. While participating in a time study has always been a requirement for the MAC program, it is now a CMS requirement in order to participate in the FFS program. Effective with the October-December 2007 claiming quarter, the Division of Medical Assistance (DMA) will move from the Traditional One-Week Time Study conducted in the past for LEAs participating in the MAC program, to a Random Moment Time Study (RMTS).

The purpose of the RMTS will be to measure the amount of time spent by eligible staff on MAC and FFS activities. The RMTS results will be used to calculate MAC claims and set FFS rates going forward. Even if an LEA chooses not to participate in the MAC program, the LEA is still required to participate in the RMTS time study in order to bill FFS.

While RMTS has not received CMS approval at this time, CMS has indicated that prior approval is not necessary in order for North Carolina to implement the time study and begin capturing results for claiming purposes**. Once CMS deems the time study to be approvable, DMA and CMS will use the approved time study to address any prior period costs/claims. DMA will notify LEAs once the time study has been approved by CMS.**

If you have questions or require technical assistance, please contact Sandy Frederick with the Division of Medical Assistance. You may reach Sandy at the following email address: Sandy.Frederick@ncmail.net or by phone at 919-855-4153.

Sandy Frederick
DMA, 919-855-4153

Attention: Nursing Facilities, Hospitals and Home Care Providers

Upcoming Transfer of Asset Changes for Medicaid Eligibility

Effective November 1, 2007, DMA will implement changes mandated by several legislative actions. The Deficit Reduction Act of 2005 (DRA), the 2006 NC State Appropriations Act, and a bill passed by the 2007 NC General Assembly have resulted in several changes regarding the assets of persons requesting assistance for institutional services or certain non-institutional services. Institutional services include services provided in a nursing facility (NF), intermediate care facility for the mentally retarded (ICF-MR), swing bed or inappropriate level of care bed or services provided through the Community Alternatives Program (CAP) or a Program of All-inclusive Care for the Elderly (PACE). Non-institutional services that may be sanctioned are in-home health services and supplies after the individual has been sanctioned for institutional services.

The DRA imposed the following changes: a home equity limitation of $500,000, the lookback period will be from 36 to 60 months in determining if an asset was transferred for less than fair market value, and the beginning date for a sanction period changes to the date the applicant or recipient both receives institutional services and is otherwise eligible for Medicaid. State law changes were to look at excluded assets in determining if they were transferred for less than fair market value and to provide a procedure for the applicant or recipient, their representative, or the nursing home facility where they reside to request an undue hardship waiver prior to imposition of a sanction period.

When an individual disposes of assets for less than fair market value he is subject to a sanction period, also known as a penalty period. During the penalty period the individual is ineligible for Medicaid payment for institutional services. Because Medicaid is not paying for the individual's institutional services during a penalty period, the individual is responsible for paying for that care. Once the penalty period expires, the individual may become eligible for Medicaid payment for the institutional services. Contact the EDS automated voice response system (AVRS) at 1-800-723-4337, transaction #6, for verification of Medicaid eligibility.

Medicaid Eligibility Unit
DMA, 919-855-4000

Attention: Personal Care Services and Personal Care Services–Plus

Personal Care Services Provider Training Sessions

The Carolinas Center for Medical Excellence (CCME; www.thecarolinascenter.org) announces continued provider training for Personal Care Services (PCS) as approved by the Division of Medical Assistance (DMA).

The 4th calendar quarter training sessions (PCS Provider Training Session VI) of 2007 will be conducted in December 2007. The training is recommended for registered nurses, agency administrators and agency owners who have a working knowledge of the PCS program and applicable DMA policies.

Specific dates and locations are shown below and will be posted soon on CCME's registration site: http://www.thecarolinascenter.org/mrnc_web/mrnc/medicaid.aspx?ID=Registration. Preregistration, either online or by fax, is required. Space is limited to 150 participants at each session. To register **online,** visit the registration site and complete the registration process. You will be issued a computer-generated number to confirm your registration. To register by **fax,** please complete the form following this announcement and fax it to the attention of Jennifer Manning or Alisha Brister at 919-380-9457. A member of the PCS team will contact you with a registration number. If you need to **cancel** at any time, please contact Jennifer Manning (voice 919-380-9860, x2018; e-mail jmanning@thecarolinascenter.org) or Alisha Brister (x2033; e-mail abrister@thecarolinascenter.org) to allow others to attend those sessions that fill up early.

Because meeting room temperatures vary, dressing in layers is strongly advised. Sign-in will start at 8 a.m. at each location. The presentations will begin at 9 a.m. and continue until 1:30 p.m. There will be one or two 15-minute breaks, but only coffee, hot tea and water will be provided, so please plan ahead for the late lunch hour. This schedule allows us to offer 4.25 Continuing Nursing Education contract hours to all nurses at no cost to the participants.

Seminar Dates and Locations

Day & Date	City	Venue	Address & Telephone
Monday, Dec. 3	Greenville	Hilton Greenville	207 SW Greenville Blvd, 27834 252-355-5000
Tuesday, Dec. 4	Wilmington	Holiday Inn Wilmington–Market St.	5032 Market St., 28405 910-392-1101
Thursday, Dec. 6	Raleigh–Durham–Chapel Hill	Hilton Raleigh–Durham Airport at Research Triangle Park	4810 Old Page Rd., 27703 919-941-6000
Tuesday, Dec. 11	Hickory	Park Inn Hickory	909 Hwy 70 SW, 28602 828-328-5101
Wednesday, Dec. 12	Winston-Salem	The Hawthorne	420 High St., 27101 336-777-3000

The Carolinas Center *for* Medical Excellence

CCME PCS Provider Training Session VI
December 2007
Registration Form

Location requested: ___________________________ Location Date: ____________________

First Name: ____

Last Name: ____

Credentials: ____

Position: ____

Organization: ____

Facility: ____

Address: ____

City: ____, NC Zip: _________________

County: ____

NPI/UPIN/Provider #: ____

Phone #: ____ Ext: ______________________

Fax #: ____

E-mail: ____

Referred by/How did you hear about this event?

____

May we send you e-mail updates on new information, features, and tools on the CCME Web site?
please check: ☐ Yes ☐ No

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

Attention: Physicians

Physician Drug Program Pricing List Update

Effective with date of service October 1, 2007, 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.

Adjustment will not need to be made since the rate changes were in the system prior to the effective date of the change. Providers should continue to bill their usual and customary charges. Providers should not file adjustment claims.

For procedure codes J3490, J3590, and J9999, providers must continue to submit a copy of the invoice along with the CMS-1500 claim form. Providers must write the name of the recipient, the recipient's Medicaid identification number, the name of the medication, the dosage given, the National Drug Code(s) (NDC) from the vial(s) used, the number of each vial administered, and the cost per dose on the invoice. Payment is based on the invoice cost, shipping, and handling.

Financial Management
DMA, 919-855-4200

Attention: Physician and Physician Extenders Providing the Oral Screening and Preventive Package under ADA Codes D0145 and D1206

Oral Screening and Preventive Package Update

Health care providers who offer the oral screening and preventive package under ADA codes D0145 and D1206 need to know that a recent policy change has led to two new oral screening and preventive package program updates.

1) Medicaid will **reimburse** for a total of six oral screening and preventive package visits per patient from the time of tooth eruption **until age 3-1/2 (42 months).** Extending this "grace period" from age 3 to age 3-1/2 will allow the service to be provided at the 3-year (or 36-month) well-child (Health Check) visit, which is most often rendered after the child's third birthday. The Division of Medical Assistance (DMA) will not allow services to be provided on or after age 3-1/2 (42 months).

2) The allowed **frequency interval** between oral screening and preventive package visits has been **changed from every 90 days to every 60 days**. This change has been implemented to allow providers the flexibility to schedule oral screening and preventive package visits in conjunction with well-child visits. Many well-child visits in the early years of life occur every 3 months (90 days). Ideally, the oral screening and preventive package should be performed every 3 to 6 months; flexibility is allowed to account for scheduling conflicts, to allow recipients who have missed well-child visits to get caught up and to accommodate the care of certain high risk children.

The policy changes are retroactive to January 1, 2007. Previous claims with dates of service after December 31, 2006, that were denied with EOB 1411 ("Allow one oral evaluation every three months") can be resubmitted for payment.

Example of Oral Screening Preventive Package Visits:

Well-Child Visit (months)	Procedure Performed?
6	Yes (if teeth are erupted)
9	Yes (if teeth are erupted)
12	Yes
18	Yes
24	Yes
Before 42	Yes

Begin providing the services as soon as the first teeth erupt. If services are provided at the 6- or 9-month well-child checkup, you must wait at least 60 days before providing the services again. These services can continue to be provided at well-child visits, during a sick visit or at a separately scheduled visit.

The complete clinical coverage policy for Physician Fluoride Varnish Services can be found on the DMA Web site (http://www.ncdhhs.gov/dma/mp/mpindex.htm).

Dental Program
DMA, 919-855-4280

Proposed Clinical Coverage Policies

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

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

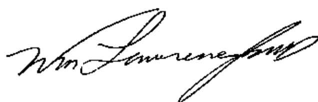
The initial comment period for each proposed policy is 45 days. An additional 15-day comment period will follow if a proposed policy is revised as a result of the initial comment period.

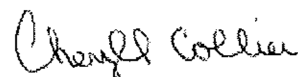
2007 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
November	11/01/07	11/06/07
	11/08/07	11/14/07
	11/15/07	11/21/07
December	11/29/07	12/04/07
	12/06/07	12/11/07
	12/13/07	12/20/07

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

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





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

Cheryll Collier
Executive Director
EDS