# November 2008 Medicaid Bulletin

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

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

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## Attention: All Providers

# Frequently Asked Questions Regarding National Provider Identifiers

Providers who have questions regarding National Provider Identifiers (NPIs) should contact the NPI help desk, which is part of EDS Provider Services. The NPI help desk is available Monday through Friday from 8:00 a.m. to 4:30 p.m. to handle questions regarding NPI, taxonomy, and NPI communications sent to providers. Examples of NPI communications include the mismatch letter, the "unresolved" report, and the "unknown" report. To reach the NPI help desk, dial 1-800-688-6696 or 919-851-8888, and select option 3, then option 1.

Here are some of the frequently asked questions on the NPI help desk.

**1. What is a taxonomy code?**

A taxonomy code is a standard 10-character code that represents a provider's type and specialty. Taxonomy codes are required on all claims (except pharmacy), unless the provider is atypical.

**2. Where do providers find the taxonomy code?**

- The taxonomy codes recommended by DMA can be found at http://www.ncdhhs.gov/dma/NPI/taxonomy_codes.html.
- A complete list of taxonomy codes can be found at http://www.wpc-edi.com/taxonomy.

**3. Where do providers list the taxonomy code on claims?**

- On institutional claims, enter the taxonomy code in form locator 81.
- On dental claims, enter the taxonomy code in field 56a.
- On professional claims, the taxonomy placement depends on whether or not the Medicaid provider number (MPN) is submitted.
  - ♦ If the MPN is submitted, enter the billing taxonomy code in block 19 and the attending taxonomy in block 32b.
  - ♦ If you have received your ready letter, your MPN is not required. Enter the billing taxonomy code in block 33b and the attending taxonomy code in block 24j.

**Note:** Electronic claims can accept only one taxonomy code.

**4. I have two NPIs for Medicare and only one MPN. What should I do?**

N.C. Medicaid allows only one NPI to be reported per MPN. Therefore, providers must select the appropriate NPI to represent the MPN. Providers who have claims that cross over from Medicare should report the NPI used to bill Medicare (that is, the organizational NPI) so that, when the claim crosses over, Medicaid will recognize the NPI. An NPI can be changed using the Medicaid Provider Change Form. (Refer to DMA's website at http://www.ncdhhs.gov/dma/provider/changematrix.htm.)

**5. For claims that require Carolina ACCESS or referring provider information, where should the authorization number be listed on claims?**

Unless the referring provider is atypical, the referring NPI is now required if the service requires referral authorization. Submit the Carolina ACCESS/referring NPI, entered in block 17b on the CMS-1500 claim form or in form locator 78 on the UB-04 claim form. The Carolina ACCESS/referring MPN is optional.

For a complete list of NPI Frequently Asked Questions, refer to the DMA NPI website at http://www.ncdhhs.gov/dma/NPI/npifaq.html. Additional information can also be found in the following publications:

- *Basic Medicaid Billing Guide* at http://www.ncdhhs.gov/dma/medbillcaguide.htm
- May 2008 Special Bulletin, *National Provider Identifier*, at http://www.ncdhhs.gov/dma/bulletinspecial.htm
- June 2007 Special Bulletin, *New Claim Form Instructions*, at http://www.ncdhhs.gov/dma/bulletinspecial.htm

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

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

## Attention: All Providers

## Implementation of the PASARR Segment of the Medicaid Uniform Screening Tool

All individuals admitted to a nursing facility must be screened before, or at the time of, admission and annually thereafter, according to federal regulations. This is called the Pre-admission Screening and Annual Resident Review (PASARR). The PASARR segment of the Medicaid Uniform Screening Tool (MUST) will be implemented November 3, 2008.

Access to the PASARR component of the MUST requires each administrator and user to create a user account with North Carolina Identity Management (NCID) and then use that account to register their organization and/or themselves within the PASARR component. Instructions for creating an NCID account are available on the MUST website at http://www.ncmust.com. Providers should acclimate themselves to the registration process by reviewing the "Getting Started" page (http://www.ncmust.com/mustapp/gettingstarted.jsp) on the MUST website.

Providers must complete the NCID registration process by assigning themselves to the Uniform Screening Program (USP) Application Group. After completing this step, providers will also need to log into the MUST application and complete the user exam. Once both of these steps have been completed, registration can be approved.

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

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

## Attention: All Providers

# 2009 Checkwrite Schedule

Please refer to the following table for the 2009 Checkwrite Schedule.

| Month | Electronic Cut-Off Date | Checkwrite Date |
|---|---|---|
| January | 1/8/09 | 1/13/09 |
| | 1/15/09 | 1/21/09 |
| | 1/22/09 | 1/29/09 |
| | 1/29/09 | 2/3/09 |
| February | 2/5/09 | 2/10/09 |
| | 2/12/09 | 2/18/09 |
| | 2/19/09 | 2/26/09 |
| | 2/26/09 | 3/3/09 |
| March | 3/5/09 | 3/10/09 |
| | 3/12/09 | 3/17/09 |
| | 3/19/09 | 3/26/09 |
| April | 4/2/09 | 4/7/09 |
| | 4/9/09 | 4/14/09 |
| | 4/16/09 | 4/23/09 |
| | 4/30/09 | 5/5/09 |
| May | 5/7/09 | 5/12/09 |
| | 5/14/09 | 5/19/09 |
| | 5/21/09 | 5/28/09 |
| June | 6/4/09 | 6/9/09 |
| | 6/11/09 | 6/16/09 |
| | 6/18/09 | 6/25/09 |
| July | 7/2/09 | 7/7/09 |
| | 7/9/09 | 7/14/09 |
| | 7/16/09 | 7/23/09 |
| | 7/30/09 | 8/4/09 |
| August | 8/6/09 | 8/11/09 |
| | 8/13/09 | 8/18/09 |
| | 8/20/09 | 8/27/09 |
| September | 9/3/09 | 9/9/09 |
| | 9/10/09 | 9/15/09 |
| | 9/17/09 | 9/24/09 |
| October | 10/1/09 | 10/6/09 |
| | 10/8/09 | 10/14/09 |
| | 10/15/09 | 10/20/09 |
| | 10/22/09 | 10/29/09 |
| | 10/29/09 | 11/3/09 |
| November | 11/5/09 | 11/10/09 |
| | 11/12/09 | 11/19/09 |
| | 11/25/09 | 12/1/09 |
| December | 12/3/09 | 12/8/09 |
| | 12/10/09 | 12/15/09 |
| | 12/17/09 | 12/23/09 |

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

## Attention: All Providers

# A Reminder about the Piedmont Cardinal Health Plan

Piedmont Cardinal Health Plan (PCHP) was introduced on April 1, 2005, in Cabarrus, Davidson, Rowan, Stanly, and Union counties. The plan administers all Medicaid-covered behavioral health and substance abuse treatment services and services for persons with developmental disabilities along with the Piedmont Innovations waiver program, which replaced the Community Alternatives Program for the Mentally Retarded/Developmentally Disabled (CAP/MR-DD) in these five counties. Intermediate care facilities for the mentally retarded (ICF-MR) and psychiatric inpatient hospitalizations are also included within the scope of services provided by PCHP.

PCHP is a prepaid managed care plan and is administered by Piedmont Behavioral Healthcare, a public mental health, developmental disabilities, and substance abuse (MH/DD/SA) services organization.

All Medicaid recipients in the five counties covered by PCHP, including recipients participating in other managed care programs, must obtain MH/DD/SA services from PCHP. Recipients participating in a managed care program do not require a referral authorization from their primary care physician to obtain services from PCHP. Medicaid does not reimburse individual providers of MH/DD/SA services on a fee-for-service basis in the five-county area. Except for emergency services, all providers must obtain approval/authorization from PCHP to qualify for reimbursement for MH/DD/SA services.

All eligible Medicaid recipients in the five counties covered by PCHP are automatically enrolled in PCHP. Medicaid recipients in these five Piedmont counties are identified as PCHP participant by an asterisk (*) beside the recipient'a name on the Medicaid identification (MID) card. The MID card indicates that "* = PCHP." Recipients who are participating in the Innovations waiver program have the indicator "CM" on their cards in addition to the "PCHP" indicator.

Some Medicaid recipients may reside and receive services outside of the five-county area but receive Medicaid from one of the five counties covered by PCHP. In these cases, PCHP is responsible for authorizing and paying for services. Medicaid does not reimburse providers on a fee-for-service basis for any MH/DD/SA services for recipients whose residency, for Medicaid purposes, is one of the five counties covered by PCHP.

For additional information, refer to the March 2005 Special Bulletin II, *Piedmont Cardinal Health Plan*, available on DMA's website a http://www.ncdhhs.gov/dma/bulletinspecial.htm.

**Behavioral Health Unit**
**DMA, 919-855-4290**

## Attention: All Providers

# Deferment of Inflationary Rate Increases

Effective October 1, 2008, DMA deferred implementation of inflationary adjustments allowed by SL 2008-107 (HB 2436). This deferment applies to all providers except those exempted in the Conference Report, Section G, item 65. This deferral affects those providers having rate adjustments with an effective date of October 1, 2008, and after, as well as any providers with a prior effective date but for which the new rates have not been activated in the payment system. Providers whose inflationary increases were loaded into the EDS payment system prior to an October 1, 2008 effective date will receive the rate increase. The deferred adjustment is projected through June 1, 2009, at which time state funding availability will be re-evaluated.

**Rate Reduction for Targeted Case Management**
Targeted Case Management, procedure code T1017 HI, will have its rate adjusted to meet CMS's approved rate methodology. The rate adjustment will be effective January 1, 2009, and the new rate will be $14.59. If any additional rate methodologies are required by CMS, further rate modifications may occur.

Please refer to the memo on the deferral of rate increases and the reduction of rates for targeted case management on DMA's website at http://www.ncdhhs.gov/dma/fee/fee.htm for more information. Please contact the DMA Rate Setting Section if you have any questions.

**Rate Setting**
**DMA, 919-855-4200**

## Attention: All Providers

# Medicaid Identification Card Changes

DMA is changing the size of the blue and pink Medicaid identification cards, as well as adding a new card color. These changes are being made to improve use of the card for both the recipient and the provider by generating cards in a reduced size that is more portable, and to better identify the type of services for which the cardholder is eligible. The buff card will not change.

**FAMILY PLANNING WAIVER** Medicaid identification cards printed on or after **December 12, 2008, will be GREEN.** This color change will enable a provider to identify those recipients eligible for only limited Family Planning Waiver services.

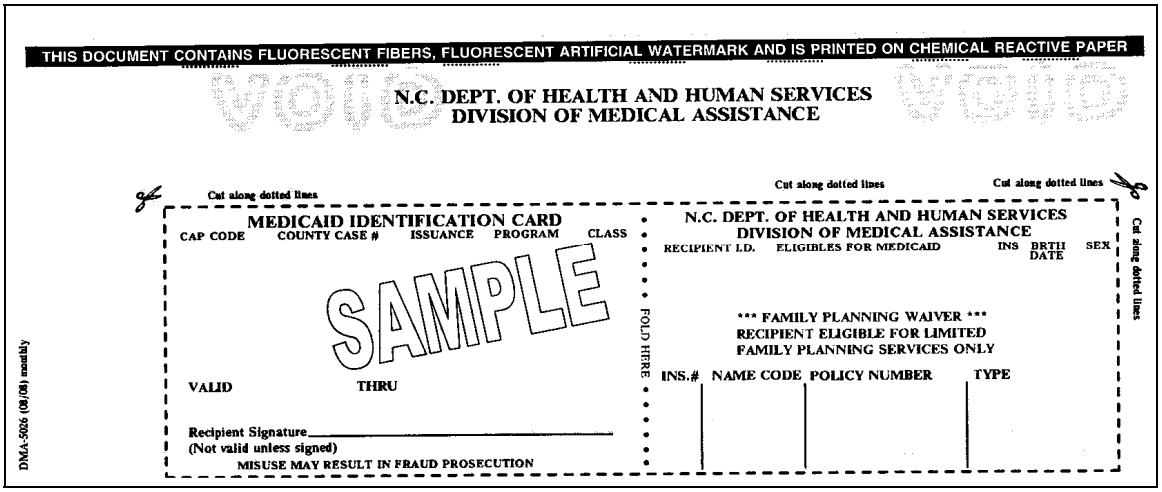
Beginning December 12, 2008, **BLUE MEDICAID** identification cards, issued for Adult and Family and Children's Medicaid programs, and **PINK MEDICAID** identification cards, issued for recipients of the Medicaid for Pregnant Women program (MPW), as well as the new **GREEN MEDICAID** identification card, will be reduced in size to allow recipients to easily cut out the card and carry it in a wallet. In order to be able to provide a smaller card, the location of some of the information on the card has changed. The detachable pharmacy stub is no longer necessary and has been removed.

The Medicaid identification cards will continue to include the Medicaid Program Abbreviation and the Class Identifier as defined below. However, some new Class Identifier codes will appear. The Class Identifier code, in conjunction with the dates covered by the Medicaid card, is important in determining whether the individual is eligible for full Medicaid coverage or other restricted or time-limited coverage.

Recipients in the Medicaid benefit categories listed below receive the **GREEN Medicaid identification card**:

| Medicaid Program Name | Abbreviation | Fourth Character Class Identifier | Medicaid Eligibility |
|---|---|---|---|
| Families and Children, Family Planning Waiver | MAF-D | D | Recipient is limited to **Family Planning Services only**, under the Family Planning Waiver. |

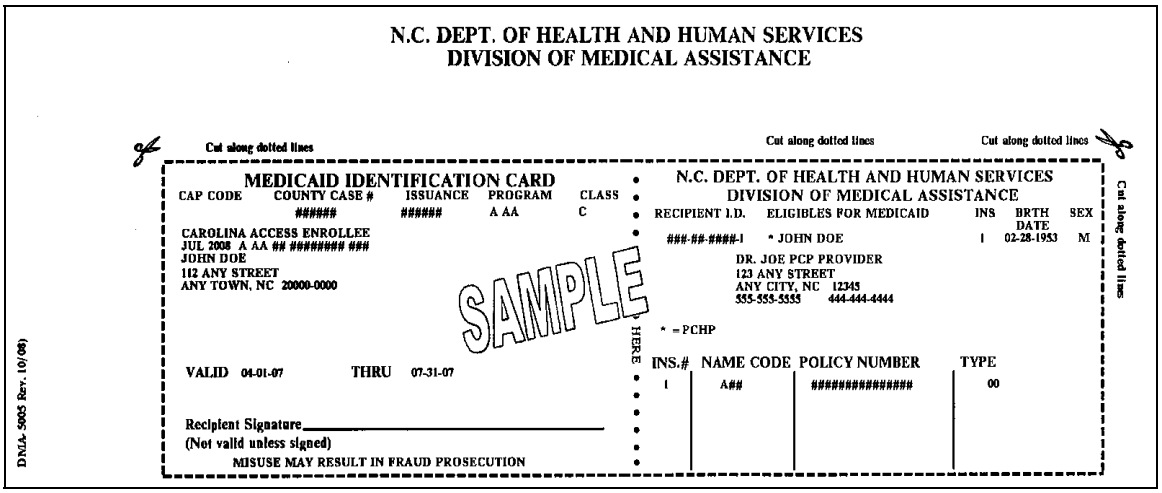
Refer to DMA's website at http://www.ncdhhs.gov/dma/MFPW/MFPWprovider.htm for additional information.



Recipients in the Medicaid benefit categories listed below receive the **BLUE Medicaid identification card**:

| Medicaid Program Name | Abbreviation | Fourth Character Class Identifier | Medicaid Eligibility |
|---|---|---|---|
| Work First Family Assistance | AAF | C | Recipient is eligible for full Medicaid coverage. |
| Aid to the Aged | MAA | C, G, or N | Recipient is eligible for full Medicaid coverage. |
| Aid to the Blind | MAB | B or Q | Recipient is eligible for Medicaid and payment of Medicare Part B premiums |
| Aid to the Disabled | MAD | M or P | Recipient has met a deductible and is eligible for full Medicaid coverage |
| | | F, H, O, or R | **Recipient is eligible for emergency coverage limited to the dates shown on the card.** |
| Special Assistance to the Blind | MSB | C | Recipient is eligible for full Medicaid coverage |
| Special Assistance – Aid to the Aged | SAA | B or Q | Recipient is eligible for full Medicaid coverage and payment of Medicare Part B premium |
| Special Assistance – Aid to the Disabled | SAD | | |
| Infants and Children | MIC | 1, G, or N | Recipient is eligible for full Medicaid coverage |
| | | F or H | **Recipient is eligible for emergency coverage limited to the dates printed on the card.** |
| Families and Children | MAF | C, G, N, T, or W | Recipient is eligible for Medicaid |
| | | M or P | Recipient has met a deductible and is eligible for Medicaid |
| | | F, H, O, R, U, or V | **Recipient is eligible for emergency coverage limited to the dates printed on the card.** |
| Foster Care; Adoption Subsidy | HSF; IAS | C, G, or N | Recipient is eligible for Medicaid |
| | | M or P | Recipient has met a deductible and is eligible for Medicaid |
| | | F, H, O, or R | **Recipient is eligible for emergency coverage limited to the dates printed on the card.** |
| Refugees | MRF | N | Recipient is eligible for Medicaid |
| | | M | Recipient has met a deductible and is eligible for Medicaid |
| Refugee Assistance | RRF | C | Recipient is eligible for Medicaid. |

Refer to DMA's website at http://www.ncdhhs.gov/dma/medicaid/who.htm and to the *Basic Medicaid Billing Guide* at http://www.ncdhhs.gov/dma/medbillcaguide.htm for additional information.


N.C. DEPT. OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE

Cut along dotted lines

MEDICAID IDENTIFICATION CARD

| CAP CODE | COUNTY CASE # | ISSUANCE | PROGRAM | CLASS |
|---|---|---|---|---|
| | ###### | ###### | A AA | C |

CAROLINA ACCESS ENROLLEE
JUL 2008 A AA ## ######### ###
JOHN DOE
112 ANY STREET
ANY TOWN, NC 20000-0000

SAMPLE

VALID 04-01-07 THRU 07-31-07

Recipient Signature _____
(Not valid unless signed)
MISUSE MAY RESULT IN FRAUD PROSECUTION

DMA-5005 Rev. 10/06)

HERE

Cut along dotted lines

N.C. DEPT. OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE

| RECIPIENT I.D. | ELIGIBLES FOR MEDICAID | INS | BRTH DATE | SEX |
|---|---|---|---|---|
| ###-##-####-I | * JOHN DOE | I | 02-28-1953 | M |

DR. JOE PCP PROVIDER
123 ANY STREET
ANY CITY, NC 12345
555-555-5555 444-444-4444

* = PCHP

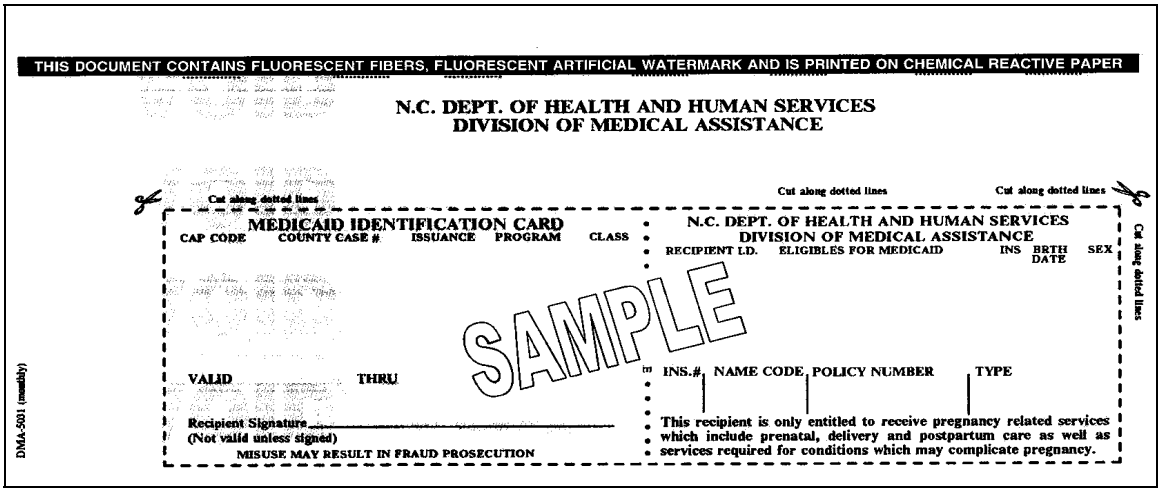
| INS.# | NAME CODE | POLICY NUMBER | TYPE |
|---|---|---|---|
| I | A## | ################ | 00 |

Cut along dotted lines

Recipients in the Medicaid benefit categories listed below receive the **PINK Medicaid identification card**:

| Medicaid Program Name | Abbreviation | Fourth Character Class Identifier | Medicaid Eligibility |
|---|---|---|---|
| Pregnant Women | MPW | I or N | Recipient is **eligible for limited pregnancy-related services.** |
| | | F or H | Recipient is **eligible for emergency coverage only, including labor and delivery, limited to the dates shown on the card.** |

Refer to DMA's website at http://www.ncdhhs.gov/dma/medicaid/families.htm#pregnant and to the *Basic Medicaid Billing Guide* at http://www.ncdhhs.gov/dma/medbillcaguide.htm for additional information.


THIS DOCUMENT CONTAINS FLUORESCENT FIBERS, FLUORESCENT ARTIFICIAL WATERMARK AND IS PRINTED ON CHEMICAL REACTIVE PAPER

N.C. DEPT. OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE

Cut along dotted lines

MEDICAID IDENTIFICATION CARD

| CAP CODE | COUNTY CASE # | ISSUANCE | PROGRAM | CLASS |
|---|---|---|---|---|

SAMPLE

VALID THRU

Recipient Signature _____
(Not valid unless signed)
MISUSE MAY RESULT IN FRAUD PROSECUTION

DMA-5031 (monthly)

Cut along dotted lines

N.C. DEPT. OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE

| RECIPIENT I.D. | ELIGIBLES FOR MEDICAID | INS | BRTH DATE | SEX |
|---|---|---|---|---|

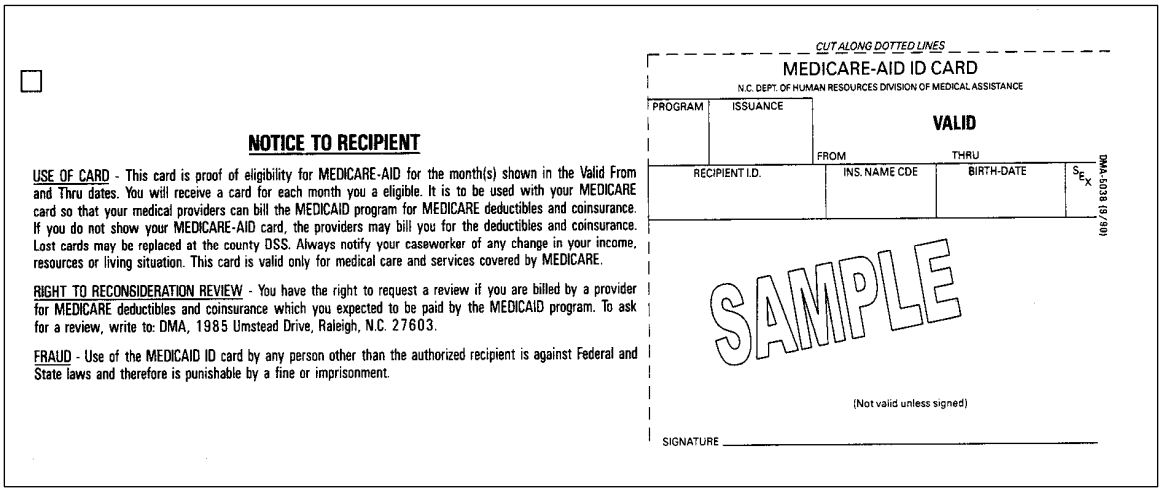
| INS.# | NAME CODE | POLICY NUMBER | TYPE |
|---|---|---|---|

This recipient is only entitled to receive pregnancy related services which include prenatal, delivery and postpartum care as well as services required for conditions which may complicate pregnancy.

Cut along dotted lines

Recipients in Medicaid benefit categories listed below receive the **BUFF Medicaid identification card**:

| Medicaid Program Name | Abbreviation | Fourth Character Class Identifier | Medicaid Eligibility |
|---|---|---|---|
| Medicare-Qualified Beneficiaries | MQB | Q | Medicaid is limited to payment of Medicare premiums, deductibles and co-insurance. **Medicaid does not pay toward any service that is not covered by Medicare.** |



NOTICE TO RECIPIENT

USE OF CARD - This card is proof of eligibility for MEDICARE-AID for the month(s) shown in the Valid From and Thru dates. You will receive a card for each month you a eligible. It is to be used with your MEDICARE card so that your medical providers can bill the MEDICAID program for MEDICARE deductibles and coinsurance. If you do not show your MEDICARE-AID card, the providers may bill you for the deductibles and coinsurance. Lost cards may be replaced at the county DSS. Always notify your caseworker of any change in your income, resources or living situation. This card is valid only for medical care and services covered by MEDICARE.

RIGHT TO RECONSIDERATION REVIEW - You have the right to request a review if you are billed by a provider for MEDICARE deductibles and coinsurance which you expected to be paid by the MEDICAID program. To ask for a review, write to: DMA, 1985 Umstead Drive, Raleigh, N.C. 27603.

FRAUD - Use of the MEDICAID ID card by any person other than the authorized recipient is against Federal and State laws and therefore is punishable by a fine or imprisonment.

CUT ALONG DOTTED LINES

MEDICARE-AID ID CARD

N.C. DEPT. OF HUMAN RESOURCES DIVISION OF MEDICAL ASSISTANCE

PROGRAM | ISSUANCE | VALID FROM | THRU

RECIPIENT I.D. | INS. NAME CDE | BIRTH-DATE | SEX

DMA-5038 (8/90)

SAMPLE

(Not valid unless signed)

SIGNATURE _____

Refer to the *Basic Medicaid Billing Guide* at http://www.ncdhhs.gov/dma/medbillcaguide.htm for additional information.

Providers who have general eligibility questions should contact their local Department of Social Services office. A list of all the local offices is available online at http://www.ncdhhs.gov/dss/local/.

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

## Attention: All Providers

## Clinical Coverage Policies

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

- A5, Mental Health Drug Management Program Administrative Procedures
- 1A-5 Case Conference for Sexually Abused Children
- 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

# Registration for Independent Practitioner Program Seminars

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

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

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

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

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

**Directions to the Independent Practitioner Seminars**

**RALEIGH**

***Wake Technical Community College***

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

**HICKORY**

***Lenoir-Rhyne University***

Traveling on I-40

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

**WILMINGTON**

***Coastline Convention Center***

Traveling East on I-40

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

Traveling South on US 17

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

Traveling North on US 17 or NC 74/76

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

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

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

Provider Name _____

Medicaid Provider Number _____ NPI Number _____

Mailing Address _____

City, Zip Code _____ County _____

Contact Person _____ E-mail _____

Telephone Number (_____) _____ Fax Number _____

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

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

## Attention: All Providers

# Services That Cannot Be Billed to the N.C. Medicaid Program

Providers are reminded of the following:
In accordance with federal or state regulations or Medicaid policy, the N.C. Medicaid Program cannot reimburse for certain drugs or services. The following drugs and services cannot be reimbursed by Medicaid and should not be billed to Medicaid:

1. Erectile dysfunction drugs, such as Viagra, Cialis, etc.
2. Abortifacients (such as RU-486) unless an abortion review has been done **PRIOR** to the dispensing of this type of drug
3. Infertility drugs or services
4. Non-rebatable drugs or biologics

   **Note:** On rare occasions, DMA may reimburse for a drug that is non-rebatable. Once a rebatable National Drug Code (NDC) is established for the drug, however, DMA will no longer reimburse for the non-rebatable NDCs and providers must use the rebatable NDCs.

   **Note:** Rebatable baclofen NDCs are now available. **Effective with date of service November 1, 2008, claims for non-rebatable baclofen NDCs will be denied.**
5. Any drug or service that is experimental or investigational
6. Any drug or service that has been dispensed or performed solely for cosmetic purposes

Except in the situation described above for the reimbursement of claims for baclofen, any claim submitted for reimbursement for any of the drugs or services listed above is subject to denial and/or recoupment.

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

## Attention: Nurse Practitioners, Optical Service Providers, and Physicians

# Denials for New Patient Eye Exams

Coverage of CPT procedure codes 92002 and 92004 (new patient eye exams) is limited to once every three years. However, claims have been inappropriately denied even when it has been more than three years since the last time the same attending or billing provider has billed with one of these codes. Changes have been made to the claims payment system to correct this problem.

Claims that were denied with EOB 0777 (rebill established visit code 92012 or 92014) that have not exceeded the timely filing limit may be refiled as new claims (not as adjustment requests) for processing.

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

## Attention: All Providers

# Suspension of Medicaid Benefits for Incarcerated Recipients and Recipients in Institutions for Mental Diseases

Effective September 1, 2008, if a Medicaid recipient age 21 through 64 enters an Institution for Mental Disease (IMD) or a Medicaid recipient of any age becomes incarcerated, his benefits will be suspended through the end of his current Medicaid certification period.

For an incarcerated recipient, Medicaid only covers medical services received during an inpatient hospital stay. When the recipient is released from incarceration, he should report his release to the Medicaid caseworker at the county department of social services (DSS). If the certification period has not expired, the Medicaid case may be reactivated. An eligibility redetermination will be completed at the end of the certification period. If the recipient is still incarcerated, he is ineligible.

For a recipient in an IMD, age 21 through 64, Medicaid does not cover any services during the suspension period. When the recipient is released from the IMD he should report his release to the Medicaid caseworker at the county DSS. If the certification period has not expired, the Medicaid case may be reactivated. An eligibility redetermination will be completed at the end of the certification period. If the recipient is still in the IMD, he is ineligible.

The only exception to the suspension of benefits is for a recipient who turns age 21 while residing in an IMD. A recipient who is in an IMD when he turns age 21 can receive Medicaid payment for IMD services, if medically necessary, through the month of his 22nd birthday.

Providers may use the Automated Voice Response system to check the eligibility status of these recipients. The telephone number is 1-800-723-4337.

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

## Attention: CAP/MR-DD Service Providers and Targeted Case Managers for MR-DD Recipients

# Implementation of New CAP/MR-DD Waivers

The current operation of the CAP/MR-DD Comprehensive Waiver (Control Number 0429.04) expired October 31, 2008. Two new 3-year waivers are expected to replace it. The Supports Waiver (Tier 1) carries a cost limit of $17,500 a year; the Comprehensive Waiver (Tier 2) bears a cost limit of $135,000 a year.

All providers need to verify recipients' waiver participation by checking the CAP/MR-DD indicator code on each recipient's Medicaid identification card. Individuals in the Supports Waiver have a C2 indicator; those in the Comprehensive Waiver will continue to have a CM indicator.

Note the changes for these two new waivers:

- Starting with date of receipt November 1, 2008, ValueOptions will authorize all individual plans of care for **one year.** Plans of care received before November 1, 2008, were authorized for 6 months and will require the provider to submit a CAP/Targeted Case Management (CTCM) form to ValueOptions at the end of the initial 6-month authorization. All plans will be phased into the yearly authorization timeline.
- The service definition of Vehicle Adaptations (T2039) carries a third-party liability requirement.
- The maximum billable amount for Transportation (T2001) is increased from $1,200 to $2,000 per waiver year, per person.
- The proposed fee schedules for the Supports and Comprehensive waivers are located on DMA's website at http://www.ncdhhs.gov/dma/fee/capfee.html. Providers may need to adjust plans of care, cost summaries, and other documentation to be in line with current rates. Providers are reminded to bill their usual and customary rates for all billing. Do not automatically bill the established maximum reimbursement rate. Payment will be the lesser of either the billed usual and customary rate or the maximum reimbursement rate.
- Providers may not directly submit billing for any expense for Specialized Equipment and/or Supplies (T1999). Use of this code for a waiver recipient requires prior authorization from ValueOptions. All requested items **must** go through the individual's case manager for inclusion in the plan of care, which must state clearly defined goals and outcomes related to use for the item. The family, individual, and case manager are able to pick the appropriate item according to the service definition of coverable items, and only one estimate is required. ValueOptions has the authority to request additional information to help demonstrate medical necessity for the piece of equipment or supply item requested.
- Waiver items billed using T1999 are not subject to EPSDT, as these are specific equipment items and supplies that support needs for the targeted population of MR-DD.
- Items requested from any other Medicaid fee list, or non-covered items that are requested for a child under the age of 21 and that are on the 1905(a) list, are subject to EPSDT and may be requested utilizing established EPSDT policy and guidelines. These guidelines can be found at http://www.ncdhhs.gov/dma/EPSDTprovider.htm.
- Home Modifications and Vehicle Adaptations require at least two cost estimates. ValueOptions will request these if they are not submitted with the plan.

- Recipients receiving personal care services in a licensed day support setting need to be transitioned to an appropriate service effective November 1, 2008. Recipients attending a licensed day support program will be required to have goals listed on their plan of care supportive of the service setting. Medicaid will no longer individually override these claims to authorize payment for personal care on the same day of service as Residential Services. MR Personal Care, Medicaid State Plan Personal Care, or Domiciliary Care cannot be billed or authorized on the same day of service as Residential Supports or Home Supports Services. These are daily rate services that include components of personal care.
- Adaptive car seats have been added to the waiver. Established guidelines will be used to authorize these seats on an individual basis.

Service definitions, training sessions, endorsement criteria, and provider enrollment information are posted on both the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services' website (http://www.ncdhhs.gov/mhddsas) and DMA's website (http://www.ncdhhs.gov/dma).

**Patricia Kirk, Behavioral Health Section**
**DMA, 919-855-4290**
**Mishawn Davis, Rate Setting**
**DMA, 919-855-4200**

## Attention: Community Alternatives Program Providers

## Provider Requirements for the Provision of CAP/MR-DD Services

DMA will be implementing three new services through the CAP/MR-DD waiver:

- Home Supports
- Long Term Vocational Service
- Crisis Respite

To qualify for reimbursement of the new services, existing CAP/MR-DD providers must complete the CAP Addendum to Add Services Packet located on DMA's website at http://www.ncdhhs.gov/dma/provenroll.htm.

Existing providers currently providing **Residential Supports, Personal Care Services, or Home and Community Support** who wish to provide **Home Supports** must also complete the CAP/MR-DD Attestation Letter (http://www.ncdhhs.gov/mhddsas/cap-mrdd/index.htm) in addition to the DMA CAP Addendum to Add Services Packet.

- Providers are required to sign the CAP/MR-DD Attestation Letter and send the original of the CAP/MR-DD Attestation Letter to the Local Management Entity (LME) located in the catchment area where the provider's corporate headquarters is located.
- A copy of the signed CAP/MR-DD Attestation Letter must also be sent to all LMEs with whom there is a signed Memorandum of Agreement (MOA).
- Providers are required to submit a copy of the signed CAP/MR-DD Attestation Letter and the completed DMA CAP Addendum to Add Services Packet to DMA Provider Services.

By signing the CAP/MR-DD Attestation Letter, the provider fully understands all of the requirements of the Home Supports service definition, including, but not limited to, all elements of the definition, limitations, staff training and qualifications. Further, the provider understands they are solely responsible for ensuring the service is provided as defined in the service definition and are attesting to compliance to the Home Supports service definition requirement effective November 21, 2008. The provider understands failure to comply with all requirements shall result in withdrawal of provider endorsement and enrollment with DMA.

In addition to the implementation of these new services, DMA has revised the requirements for the following CAP/MR-DD services:

- Adult Day Health
- Crisis Services
- Day Supports
- Home and Community Support
- Personal Care
- Residential Supports
- Respite
- Supported Employment

To qualify for reimbursement of these services, existing providers must complete the CAP/MR-DD Attestation Letter.

- Providers are required to sign the CAP/MR-DD Attestation Letter and send the original of the CAP/MR-DD Attestation Letter to the Local Management Entity (LME) located in the catchment area where the provider's corporate headquarters is located.
- A copy of the signed CAP/MR-DD Attestation Letter must also be sent to all LMEs with whom there is a signed MOA.
- Providers are **not** required to send a copy of the CAP/MR-DD Attestation Letter to DMA.
- Providers are **not** required to complete and submit the DMA CAP Addendum to Add Services Packet for these services.

Standard policy for endorsement is required for all other additional service definitions.

All prospective CAP providers must apply for and be enrolled as a Medicaid provider with N.C. Medicaid to qualify for reimbursement for CAP services. Enrollment applications are located on DMA's website at http://www.ncdhhs.gov/dma/provenroll.htm.

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

## Attention: Hospitals

# Implementation of Diagnostic Related Groups: Grouper 25

The October 2008 general Medicaid Bulletin included an article regarding the implementation of Diagnostic Related Groups: Grouper 25. Since its initial publication, it has been identified that the article inadvertently omitted one neonate/newborn DRG (i.e., 789) and transposed one transfer DRG (i.e., 447 should have been 477). The article that follows has been republished to include the corrected information.

DMA has submitted a State Plan Amendment (SPA) to CMS for purposes of implementing the Diagnostic Related Groups (DRG) Grouper 25. At this time, SPA approval has not been received from CMS. Therefore, DMA will not be able to implement the new grouper on October 1, 2008. Additionally, new provider rates that were to be effective October 1, 2008, will also be delayed until such time as the SPA is approved. Until CMS approval is received, hospital inpatient claims for dates of service on or after October 1, 2008, will continue to be paid using the current grouper version and hospital specific rates. Hospital providers can expect a future status update in upcoming general Medicaid Bulletins. The North Carolina Hospital Association will be receiving periodic updates on the approval and implementation status.

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

The following chart highlights the significant changes mentioned above.

| | **Grouper Version 24** | **Grouper Version 25** |
|---|---|---|
| Neonates/Newborns | 385, 801, 802, 803, 804, 805, 810, 389, 390, and 391 | 789, 790, 791, 792, 793, 794, and 795 |
| Psychiatric Inpatient | 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 521, 522, and 523 | 876, 880, 881, 882, 883, 884, 885, 886, 887, 894, 895, 896, and 897 |
| Transfers | 14, 113, 209, 210, 211, 236, 263, 264, 429, and 483 | 28, 29, 30,40, 41, 42, 219, 220, 221, 477, 478, 479, 480, 481, 482, 492, 493, 494, 500, 501, 502, 515, 516, 517, and 956 |
| Rehabilitation | 462 | 945 and 946 |

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

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

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

## Attention: Behavioral Health Providers, CAP/MR-DD Service Providers, and Residential Treatment Facility Providers

# Mental Health Cost Report Due Date Extension and Cost Report Training

The deadline for Mental Health, CAP/MR-DD and Residential Treatment Facility providers who have an accounting year end of June 30, 2008, and have a Mental Health Cost Report due on November 30, 2008, is being extended until December 31, 2008. This extension is being granted due to the delays of getting the Mental Health Cost Report application updated and ready for release. The extension to December 31, 2008, does not affect any provider with a year end other than June 30, 2008.

Training for those providers who have an accounting year end of September 30, 2008, or December 31, 2008, have been scheduled for December. Those providers with an accounting year end of March 31, 2009, or June 30, 2009, should wait to go to training when sessions are offered next summer.

To find out more about the due date extension, training dates, locations, times, and information on how to register for training, visit the Office of the Controller's website at http://www.ncdhhs.gov/control/amh/amhauth.htm.

For questions concerning this extension or the Mental Health Cost Report, contact Bill Caddell at Bill.Caddell@ncmail.net or 919-855-3681.

**Rate Setting**
**DMA, 919-855-4200**

## Attention: Personal Care Services and Personal Care Services-Plus

# Personal Care Services Provider Training Sessions

The Carolinas Center for Medical Excellence (CCME; http://www.thecarolinascenter.org ) announces continued provider training for Personal Care Services (PCS) as approved by DMA.

The 4th calendar quarter training sessions (PCS Provider Training Session X) of 2008 will be conducted in December 2008. 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.

Dates and locations will be posted on CCME's website under "Upcoming Events." Pre-registration is required and space is limited. Registration will be provided online or by fax. **To register online,** visit CCME's website and click on the appropriate link in Upcoming Events. When you have completed and submitted the online registration, you will see a computer-generated number to confirm your registration. Bring the number with you to the session. **To register by fax,** complete the form following this announcement and fax it to the attention of Alisha Brister at 919-380-9457. A member of the PCS team will contact you with a registration number, which you should bring with you to the session. If you need to **cancel** at any time, please contact Alisha Brister (919-380-9860, x2018) to allow others to register. Please e-mail Alisha Brister at CCME (abrister@thecarolinascenter.org) for further information on registering.

Detailed information regarding times and session content will be posted on CCME's website.

The Carolinas Center *for* Medical Excellence

**CCME PCS Provider Training Session 10**
**December 2008**
**Registration Form**

Location requested: _____ Location Date: _____

First Name: _____

Last Name: _____

Credentials: _____

Position: _____

Organization: _____

Facility: _____

Address: _____

City: _____, NC Zip: _____

County: _____

UPIN/Provider #: _____

Phone #: _____ Ext: _____

Fax #: _____

Email: _____

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**
**Alisha Brister at 919-380-9457**

## Attention: Personal Care Services Providers

# New Personal Care Services/PCS-Plus Orientation for Registered Nurses

In October 2008, DMA began holding combined Personal Care Services (PCS)/PCS-Plus training sessions in their office in Raleigh. The purpose of the sessions is to provide a policy orientation for registered nurses (RNs) who are new to the PCS program and who conduct PCS and/or PCS-Plus assessments of Medicaid recipients. The training for novice PCS nurses includes a review of the policy guidelines for both the PCS and PCS-Plus programs. Attendees learn the proper way to conduct and document a PCS assessment and re-assessment and the Activities of Daily Living scoring process as well as how to develop a PCS plan of care based on needs using the time and task guidance. Quality assurance/utilization review (QA/UR) issues in PCS and how to develop a corrective action plan before and after a state QA/UR review are also addressed.

The classes are scheduled once per month and are taught by DMA PCS/PCS-Plus Nurse Consultants Phyllis Stevens, RN, and Paula Botto, RN. The training classes are by DMA invitation or by agency request when approved by DMA. Attendance is limited to 10 to 15 nurses per class to allow for one-to-one time for individual nurses. Each class lasts 5 to 6 hours with time scheduled for breaks.

Agencies receiving an invitation for one of their nurses to attend are requested to send **ONLY** that nurse. If the nurse who is registered to attend a class cancels, DMA must be contacted as soon as possible. This will allow DMA to notify another nurse from the request list to attend the training.

To request that a new nurse be added to the training list, please call Phyllis Stevens at 919-689-2293. Once DMA has enrolled a nurse in a class, an enrollment confirmation will be sent to the nurse with the date of the training session, class instructions, and directions to DMA's office on the Dorthea Dix campus in Raleigh.

The quarterly DMA-sponsored training provide by the Carolinas Centers for Medical Excellence (CCME) will not change. Notification of and registration for these classes are found on the CCME website at http://www.thecarolinascenter.org. These classes are recommended for all PCS providers' clinical staff.

**Phyllis Stevens, R.N., Facility and Community Care Section**
**DMA, 919-689-2293**

## Attention: Pharmacists

# Enhanced Specialty Drug Discount Reimbursement Inquiries

With the implementation of the new enhanced specialty drug discount on October 10, 2008, pharmacy providers may need to report specialty drug reimbursement issues to N.C. Medicaid. The State Maximum Allowable Cost (SMAC) inquiry worksheet will be revised so that issues with specialty drug reimbursement may also be reported on the same worksheet as SMAC drug reimbursement issues. Pharmacists should fax the completed worksheet to the number listed on the worksheet (612-642-8931). The worksheet is available on DMA's website at http://www.ncdhhs.gov/dma/pharmacy.htm.

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

## Attention: Pharmacists

# Focused Risk Management Program Reviews and Submission of Fees

This is a reminder that N.C. Medicaid requires that recipients receiving more than 11 unduplicated prescriptions per month be evaluated as part of a Focused Risk Management (FORM) program. The first review must be completed within two months of the recipient's identification for the program; subsequent reviews must be performed at least every three months thereafter. Pharmacies participating in the FORM program are eligible for a quarterly FORM professional service fee upon completion of the FORM review. **Pharmacy providers should submit FORM fees to N.C. Medicaid for reimbursement.** A quarterly FORM fee of $30.00 per provider per recipient will be paid to one pharmacy provider each quarter.

Program Integrity will perform audits to ensure adherence to this program. Failure to perform the required review and failure to have documentation of the review on file at the pharmacy will result in recoupment of the FORM fee payment as well as payment for all claims exceeding the limit of 11 prescriptions per month.

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

## Attention: Pharmacists

# Overrides for Monthly Supplies of Insulin

Some pediatric recipients have recently experienced difficulty obtaining insulin from their local pharmacies, resulting in unnecessary admissions to hospital emergency rooms. These recipients had already received their 34-day supply of insulin for the month, but their insulin had been lost or the dose had changed, thus causing them to need more insulin before the end of the month. N.C. Medicaid has measures in place for these types of situations when it is necessary for recipients to obtain additional supplies of critical medications such as insulin.

For non-controlled medications, overrides are available at the discretion of the pharmacist when he or she determines that it is in the best interest of the recipient to obtain additional medication. N.C. Medicaid relies on the judgment of pharmacists to ensure that these override codes are used only when necessary to allow for the continuation of optimal recipient care.

Please refer to Clinical Coverage Policy # 9, *Outpatient Pharmacy Program*, on DMA's website at http://www.ncdhhs.gov/dma/mp/mpindex.htm, for additional information on the use of override codes.

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

## Attention: Pharmacists and Prescribers

# New Appeals Process Affecting Prior Authorized Medications

During its last session, the General Assembly enacted S.L. 2008-118 s. 3.13, effective July 1, 2008**,** which changes how Medicaid appeals are handled. As a result of this legislation, DMA will implement a process to allow for notification to a recipient by mail when it is determined that the recipient does not meet criteria for coverage of a medication that requires prior approval. The notification will state the decision, the citations that support the decision, and the recipient's appeal rights. The recipient has 30 days from the date the notice is mailed to appeal the decision to the Office of Administrative Hearings.

Recipients who have been receiving the medication in the past 34 days **AND** file a request for an appeal will be granted a prior approval for the medication as a maintenance of service until their appeal has been heard and decided. Recipients who have not been receiving the medication in the past 34 days will not be eligible for the maintenance of service while waiting for their appeal to be heard and decided.

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

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

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

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

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

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

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

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

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

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

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

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

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

## Proposed Clinical Coverage Policies

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

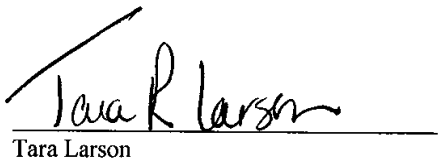
Loretta Bohn
Division of Medical Assistance
Clinical Policy Section
2501 Mail Service Center
Raleigh NC 27699-2501

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

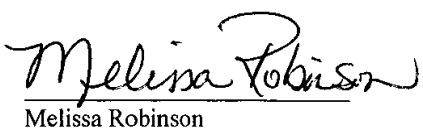
## 2008 Checkwrite Schedule

| Month | Electronic Cut-Off Date | Checkwrite Date |
|---|---|---|
| November | 10/30/08 | 11/04/08 |
| | 11/06/08 | 11/13/08 |
| | 11/13/08 | 11/20/08 |
| December | 11/26/08 | 12/02/08 |
| | 12/04/08 | 12/09/08 |
| | 12/11/08 | 12/16/08 |
| | 12/18/08 | 12/29/08 |

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



Tara Larson
Acting Director
Division of Medical Assistance
Department of Health and Human Services



Melissa Robinson
Executive Director
EDS, an HP Company