# November 2009 Medicaid Bulletin



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

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## *Attention: All Providers*

# *EDS Announces New Name*

In August 2008, Hewlett-Packard (HP) acquired EDS, fiscal agent for the N.C. Medicaid Program. As a result of this acquisition, EDS is changing its name to HP Enterprise Services.

North Carolina Medicaid providers will not be affected by this change and will probably notice very few changes. Providers will begin to see the HP logo or the HP Enterprise Services name on correspondence and forms. The mailing address is not changing but providers should address the mail to HP Enterprise Services. E-mail correspondence will come from an "@hp.com" e-mail address rather than an "@eds.com" e-mail address. And, providers will hear the HP name when contacting the Raleigh call center. Think of it as a sports team changing jerseys. The same players are on the field working hard to deliver the outstanding Medicaid services you've come to expect from a trusted business ally.

The new name reflects HP's commitment to the longtime success of its clients. It also reminds our clients of the enhanced value they now get from the combination of EDS' proven operational excellence PLUS the best-in-class technology of HP.

**HP Enterprise Services**
**1-800-688-6696 or 919-851-8888**

## *Attention: All Providers*

# *Electronic Funds Transfer*

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

Providers must complete and submit an EFT Authorization Agreement for Automatic Deposits (http://www.ncdhhs.gov/dma/provider/forms.htm) immediately to ensure that there is no disruption to payments. Claims will suspend if an EFT Authorization Agreement for Automatic Deposit has not been submitted to and processed by the N.C. Medicaid Program.

Below are fax numbers available for providers to send EFT Authorization Agreements to HP Enterprise Services (EDS):

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

The e-mail address for submitting EFT Authorization Agreements to HP Enterprise Services (EDS) is NCXIXEFT@eds.com.

**HP Enterprise Services**
**1-800-688-6696 or 919-851-8888**

## *Attention: All Providers*

# *Electronic Claim Submission EOB Code*

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

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

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

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

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

**HP Enterprise Services**
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## *Attention: All Providers*

# *Paper Claim Submissions*

If a claim meets one of the exceptions to the electronic claims submission requirement (see http://www.ncdhhs.gov/dma/provider/ECSExceptions.htm), providers should submit the original claim and not a carbon copy or photocopy of the claim. Because paper claims are manually keyed into the system, submitting the original will decrease the number of denials that providers receive due to keying errors.

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

**HP Enterprise Services**
**1-800-688-6696 or 919-851-8888**

## *Attention: All Providers*

# *Urine Drug Testing*

Providers are reminded to use the appropriate codes when billing for urine drug testing. Providers must use CPT code 80100 (drug screen, qualitative; multiple drug classes chromatographic method, each procedure) or CPT code 80101 (single drug class method [eg, immunoassay, enzyme assay], each drug class) for initial drug screenings.

CPT code 80102 (drug confirmation, each procedure) must be used by laboratories for drug confirmation. When sending a urine drug test to an outside laboratory for confirmation, the provider should specify the positive results of the drug screen that need to be confirmed. The laboratory should confirm only the drugs that were positive and bill CPT code 80102 with the correct number of units.

**HP Enterprise Services**
**1-800-688-6696 or 919-851-8888**

## *Attention: All Providers*

# *Obtaining Informed Consent on Sterilization Consent Forms*

DMA has become aware that some providers have been referring Medicaid recipients to the local department of social services (DSS) to complete the federally mandated Sterilization Consent form and to obtain informed consent prior to a sterilization procedure. According to Clinical Coverage Policy 1E-3, *Sterilization Procedures*, "Providers must complete a valid sterilization consent form prior to rendering a sterilization procedure."

Moreover, review of federal guidelines located in 42 CFR 441.257 and 441.258 indicates that an individual who can answer specific questions about the procedure and potential complications should be counseling the recipient. Therefore, it is the medical provider's responsibility to obtain informed consent and this should not be delegated to DSS.

Beginning December 1, 2009, consent forms cannot be completed by DSS. Any consent form completed by a DSS agency on which the date completed is on or after December 1, 2009, will be considered an invalid consent. Claims submitted with these consent forms on file will be denied.

**HP Enterprise Services**
**1-800-688-6696 or 919-851-8888**

## *Attention: All Providers*

# *North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool*

In September 2009, the N.C. Medicaid Program implemented the North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool. This tool allows providers to access electronic recipient eligibility information via the North Carolina Electronic Claims Submission (NCECS) Web Tool at https://webclaims.ncmedicaid.com/ncecs/.

Use of this tool allows providers to immediately verify recipient information such as

- Current eligibility
- Medicaid program (benefit category)
- Medicare participation
- CCNC/CA (Carolina ACCESS) participation
- Transfer of asset information
- Other insurance information

This is the same information that providers receive today through the Automated Voice Response (AVR) system but the tool is quicker and easier to use. In order to use this tool, providers must have access to the NCECSWeb Tool. DMA encourages you to begin immediately the process of obtaining this access.

Providers who currently have an NCECSWeb logon ID and password can utilize this same logon information to access recipient eligibility verification. You do not need to take any further action.

Providers who do not currently have access to the NCECSWeb must take the following action.

### Step One:

Submit a completed and signed Electronic Claims Submission (ECS) Agreement to CSC. (Refer to the NC Tracks website at http://www.nctracks.nc.gov/provider/forms for a copy of the form and instructions.)

**Note:** Providers who have previously submitted the ECS Agreement do not need to resubmit the form.

### Step Two:

Contact the HP Enterprise Services (EDS) Electronic Commerce Services Unit (1-800-688-6696 or 919-851-8888, option 1) to obtain instructions and a logon ID and password for the NCECSWeb Tool.

For additional information on verifying recipient eligibility, refer to the *Basic Medicaid Billing Guide* on DMA's website at http://www.ncdhhs.gov/dma/basicmed/. For detailed information on the NCECSWeb Tool, refer to the September 2009 Special Bulletin, *North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool Instruction Guide*, on DMA's website at http://www.ncdhhs.gov/dma/bulletin/.

**HP Enterprise Services**
**1-800-688-6696 or 919-851-8888**

## *Attention: All Providers*

# *Notice of Medicaid Identification Card Changes*

On September 8, 2009, the N.C. Medicaid Program began issuance of one Medicaid identification (MID) card per year to each recipient (refer to the September 2009 Medicaid Bulletin article titled *Notice of Medicaid Identification Card Changes*). The new annual cards are printed on gray card stock. The blue, pink, green, and buff-colored MID cards are being phased out. The new cards include the case head name, recipient name, MID number, issue date, and Community Care of North Carolina/Carolina ACCESS (CCNC/CA) primary care provider information (if applicable). The new cards do not indicate dates of eligibility, Medicaid program or special coverage. Recipients who are issued new cards may have been approved for prior months only, the current month only, or an ongoing period of up to 12 months.

Because the new card no longer serves as proof of eligibility, it is essential that at each visit providers verify the recipient's

- Identity (if an adult)
- Current eligibility
- Medicaid program, including restrictive coverage such as Family Planning Waiver and Medicaid for Pregnant Women
- Special coverage (Community Alternatives Program, Program of All-inclusive Care for the Elderly)
- CCNC/CA primary care provider information
- Other insurance information

To verify eligibility, a provider can choose to use the North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool (NCECSWeb), the real time or batch Eligibility Verification System (EVS), or the HP Enterprise Services (EDS) Automated Voice Response (AVR) system. Information on how to enroll and use the NCECSWeb tool can be found in the September 2009 Special Bulletin, *North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool*. For information regarding real-time and batch eligibility, contact the HP Enterprise Services (EDS) ECS Unit at 1-800-688-6696 (option 1). Information about the AVR system is available in the July 2001 Special Bulletin, *Automated Voice Response (AVR) System Provider Inquiry Instructions*, which is located at http://www.ncdhhs.gov/dma/bulletin/. To access the AVR system, call HP Enterprise Services (EDS) at 1-800-723-4337.

The methods listed above will not only serve to verify eligibility, but also to inform the provider as to whether the recipient is entitled to any special services, such as the Program of All-inclusive Care for the Elderly (PACE) or the Community Alternatives Programs, or enrolled in a restrictive program, such as the Family Planning Waiver or Medicaid for Pregnant Women. Recipients enrolled in PACE receive their medical care exclusively through the PACE organization. When using the AVR system, it is, therefore, important that providers listen to the entire recorded message and follow the prompts as directed or important parts of eligibility information may be missed.

Each year a recipient will receive a new card. The new card will be issued on the anniversary of the issuance of the previous card. When the recipient receives the card depends on the month in which the recipient received the previous card. Recipients should be referred to their local department of social services to request a replace card, if needed.

**Medicaid Eligibility Unit**
**DMA, 919-855-4000**

## *Attention: All Providers*

# *Influenza A (H1N1) 2009 Monovalent Vaccine and Reimbursement Guidelines for 2009/2010*

The N.C. Medicaid Program reimburses for vaccines in accordance with guidelines from the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP). ACIP recommendations on 2009/2010 *H1N1* influenza vaccine can be found on the CDC website at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5810a1.htm?s_cid=rr5810a1_e.

### N.C. Distribution Program for the H1N1 Vaccine

The federal government has purchased the H1N1 influenza vaccines to distribute for administration to persons of all ages, based on the established priority groups. H1N1 vaccine will not be available for providers to purchase. The majority of the H1N1 vaccine manufactured is expected to be injectable, with the balance being intranasal. The N.C. Immunization Branch of the Division of Public Health will distribute the H1N1 vaccines to providers.

### Reporting the H1N1 Influenza Vaccine and Billing for Administration Costs

The H1N1 **vaccine**, regardless of formulation, **CANNOT** be billed to Medicaid. The CPT code for all formulations of the H1N1 vaccine is **90663.** All providers are required to report the vaccine code, with a charge of $0.00. Providers **may bill** the N.C. Medicaid Program for the **administration** costs of the vaccines. Because the live **intranasal** seasonal (FluMist, CPT code 90660) **AND** live **intranasal** H1N1 influenza vaccines (CPT code 90663) **CANNOT** be administered simultaneously (same day), Medicaid cannot cover these two procedure codes billed on the same day.

The following tables indicate the vaccine code that must be reported for all of the formulations of the H1N1 influenza vaccine. The tables also indicate the administration codes that can be billed by providers, depending on the age of the recipient. The ICD-9-CM diagnosis for H1N1 influenza vaccine, V04.81, may be billed, as appropriate.

**Note:** The information in the following tables is **not** detailed billing guidance. Specific information on billing all immunization administration codes for recipients 0 through 20 years of age (6 months through 20 years of age for influenza vaccines) can be found in the April 2009 Special Bulletin, *Health Check Billing Guide 2009,* at http://www.ncdhhs.gov/dma/healthcheck/.

### Table 1: H1N1 Influenza Billing Codes for Recipients Age 6 Months through 20 Years of Age

### All Providers

Use the following CPT procedure code to **report** (with a charge of $0.00) the H1N1 vaccine administered to a recipient **6 months through 20 years of age.**

| Vaccine CPT Code to Report | CPT Code Description |
|---|---|
| 90663 | Influenza virus vaccine, pandemic formulation |

### Private Providers, Federally Qualified Health Centers, Rural Health Clinics, and Local Health Departments

The table below includes options for billing H1N1 as the **ONLY** vaccine administered on that day to a recipient 6 months through 20 years of age that day or as an additional vaccine administered that day. An injectable vaccine administered on the same day as an oral or intranasal vaccine should be considered the primary administration code.

| Administration CPT Code(s) to Bill | CPT Code Description |
|---|---|
| 90465EP | Immunization administration younger than 8 years of age (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); when the physician counsels the patient/family; first injection (single or combination vaccine/toxoid), per day |
| 90466EP | Each additional injection (single or combination vaccine/toxoid), per day (list separately in addition to code for primary procedure).<br>**Note:** Providers **may** bill more than one unit of 90466EP as appropriate. |
| 90467EP | Immunization administration younger than age 8 years (includes intranasal or oral routes of administration) when the physician counsels the patient/family; first administration (single or combination vaccine/toxoid), per day.<br>**Note:** Billing CPT code 90468 for a second administration of an intranasal/oral vaccine when physician counseling was performed is **not** applicable at this time. |
| 90468EP | Each additional administration (single or combination vaccine/toxoid) per day (list separately in addition to code for primary procedure).<br>**Note:** Billing CPT code 90468 for a second administration of an intranasal/oral vaccine is **not** applicable at this time. |
| 90471EP | Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid) |
| 90472EP | Each additional vaccine (single and combination vaccine/toxoid) (list separately in addition to code for primary procedure).<br>**Note:** Providers **may** bill more than one unit of 90472EP as appropriate. |
| 90473EP | Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid).<br>**Note:** Billing CPT code 90474 for a second administration of an intranasal/oral vaccine is **not** applicable at this time. |
| 90474EP | Each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure).<br>**Note:** Billing CPT code 90474 for a second administration of an intranasal/oral vaccine is **not** applicable at this time. |

### Table 2: H1N1 Influenza Billing Codes for Recipients 21 Years of Age and Older

### All Providers

Use the following CPT procedure code to report an H1N1 influenza vaccine administered to a recipient **21 years of age and older.**

| Vaccine CPT Code to Report | CPT Code Description |
|---|---|
| 90663 | Influenza virus vaccine, pandemic formulation |

### Private Providers and Local Health Departments

Use the following codes to bill for an administration fee for recipients 21 years of age or older. The table below includes options for billing H1N1 as the **ONLY** vaccine administered that day or as an additional vaccine administered that day. An injectable vaccine administered on the same day as an oral or intranasal vaccine should be considered the **primary** administration code.

| Administration CPT Code(s) to Bill | CPT Code Description |
|---|---|
| 90471 | Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid) |
| 90472 | Each additional vaccine (single and combination vaccine/toxoid) (list separately in addition to primary procedure) |
| 90473 | Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid).<br>**Note:** Billing CPT code 90474 for a second administration of an intranasal/oral vaccine is **not** applicable at this time. |
| 90474 | Each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure).<br>**Note:** Billing CPT code 90474 for a second administration of an intranasal/oral vaccine is **not** applicable at this time. |

For a recipient 21 years of age or older receiving an influenza vaccine, an evaluation and management (E/M) code **cannot** be reimbursed to any provider on the same day that injection administration fee codes are reimbursed unless the provider bills an E/M code for a separately identifiable service by appending modifier 25 to the E/M code.

**Note:** In addition to local health departments and other identified providers, the federal government is supplying the H1N1 vaccine to federally qualified health centers (FQHCs) and rural health clinics (RHCs) at no charge. Therefore, FQHCs and RHCs **cannot** bill Medicaid for the cost of the vaccine for any recipient. Follow the guidelines in the April 2009 Special Bulletin, *Health Check Billing Guide 2009,* at http://www.ncdhhs.gov/dma/healthcheck/ for instructions on billing administration codes for recipients 0 through 20 years of age (6 months through 20 years of age for influenza vaccines) under the C suffix provider number for H1N1 influenza vaccine. For recipients 21 years of age and older seen in an FQHC or RHC, the cost of the administration may be included on the cost report for those recipients.

Private providers, local health departments, FQHCs, and RHCs may bill Medicaid for the administration fee for the H1N1 vaccine administered to Medicaid Pregnant Women (MPW) recipients. Refer to the guidelines above.

**HP Enterprise Services**
**1-800-688-6696 or 919-851-8888**

## *Attention: All Providers*

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

Prior authorization will be required for non-emergency outpatient high-tech radiology and ultrasound procedures. The recipient categories exempt from this requirement been updated to include:

- Recipients with emergency coverage for approved dates of service
- Undocumented or documented refugees
- Recipients incarcerated or confined in a mental institution
- Recipients enrolled in Aid to the Aged, Special Assistance for the Blind, and Special Assistance to the Aged

The other recipient categories exempt from prior authorization are:

- Recipients who are dually eligible for Medicare and Medicaid
- Recipients with third-party insurance
- Recipients with PACE
- Recipients with Health Choice
- Recipients with Family Planning Waiver
- Recipients in the Health Insurance Premium Payments Program

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

| Date | Procedures | Instructions for Providers |
|---|---|---|
| November 4, 2009 | Online Training Sessions | Online provider training sessions will be provided at 9:00 a.m. and 1:00 p.m. on each day. MedSolutions will be sending a packet of information to providers via the mail with instructions on how to access the online training sessions. |
| October 19, 2009 | CT, CTA, MR, MRA, PET | All ordering providers will begin requesting PA for tests scheduled November 1, 2009, and after. |
| November 1, 2009 | CT, CTA, MR, MRA, PET | Institutional and professional claims submitted to HP Enterprise Services (EDS) for testing performed on November 1, 2009, and after will require PA on file. Outpatient claims will require Revenue Codes and CPT codes on the UB-04 detail. |
| December 15, 2009 | Ultrasounds | All ordering providers will begin requesting PA for tests scheduled January 1, 2010, and after. |
| January 1, 2010 | Ultrasounds | Institutional and professional claims submitted to EDS for testing performed on January 1, 2010, and after will require PA on file. Outpatient claims will require Revenue Codes and CPT codes on the UB-04 detail. |

MedSolutions will accept authorization requests by web, phone, and fax. Please visit http://www.medsolutionsonline.com to register for PA services and to view MedSolutions' imaging guidelines.

The ordering physician is required to obtain the PA. This authorization should be obtained before the testing is scheduled. The authorization number should be provided to the facility performing the test. The authorization is good for 30 days following its issuance.

Procedures performed during an inpatient stay, during an emergency department visit, during an observation stay or as a referral from a hospital emergency department do not require PA. Refer to the following information on billing for procedures provided in these circumstances.

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

The following procedure codes require prior approval:

## Positron Emission Tomography (PET) Scans

| CPT Code | Description |
|---|---|
| 78608 | Brain imaging, positron emission tomography (PET); metabolic evaluation |
| 78609 | Brain imaging, positron emission tomography (PET); perfusion evaluation |
| 78811 | Positron emission tomography (PET) imaging; limited area (eg, chest, head/neck) |
| 78812 | Positron emission tomography (PET) imaging; skull base to mid-thigh |
| 78813 | Positron emission tomography (PET) imaging; whole body |
| 78814 | Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (eg, chest, head/neck) |
| 78815 | Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh |
| 78816 | Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; whole body |

## Computed Tomography Angiography (CTA)

| CPT Code | Description |
|---|---|
| 70496 | Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing |
| 70498 | Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing |
| 71275 | Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing |
| 72191 | Computed tomography angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing |
| 73206 | Computed tomographic angiography, upper extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing |
| 73706 | Computed tomographic angiography, lower extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing |
| 74175 | Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing |
| 75635 | Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed and image postprocessing |

## Computed Tomography (CT) Scans

| CPT Code | Description |
|---|---|
| 70450 | Computed tomography, head or brain; without contrast material |
| 70460 | Computed tomography, head or brain; with contrast material(s) |
| 70470 | Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections |
| 70480 | Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material |
| 70481 | Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material |
| 70491 | Computed tomography, soft tissue neck; with contrast material |
| 70492 | Computed tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections |
| 71250 | Computed tomography, thorax; without contrast material |
| 71260 | Computed tomography, thorax; with contrast material(s) |
| 71270 | Computed tomography, thorax, without contrast material, followed by contrast material(s) and further sections |
| 72125 | Computed tomography, cervical spine; without contrast material |
| 72126 | Computed tomography, cervical spine; with contrast material(s) |
| 72127 | Computed tomography, cervical spine; without contrast material, followed by contrast material(s) and further sections |
| 72128 | Computed tomography, thoracic spine; without contrast material |
| 72129 | Computed tomography, thoracic spine; with contrast material(s) |
| 72130 | Computed tomography, thoracic spine; without contrast material, followed by contrast material(s) and further sections |
| 72131 | Computed tomography, lumbar spine; without contrast material |
| 72132 | Computed tomography, lumbar spine; with contrast material(s) |
| 72133 | Computed tomography, lumbar spine; without contrast material, followed by contrast material(s) and further sections |
| 72192 | Computed tomography, pelvis; without contrast material |
| 72193 | Computed tomography, pelvis; with contrast material(s) |
| 72194 | Computed tomography, pelvis; without contrast material, followed by contrast material(s) and further sections |
| 73200 | Computed tomography, upper extremity; without contrast material |
| 73201 | Computed tomography, upper extremity, with contrast material(s) |
| 73202 | Computed tomography, upper extremity, without contrast material, followed by contrast material(s) and further sections |
| 73700 | Computed tomography, lower extremity; without contrast material |
| 73701 | Computed tomography, lower extremity, with contrast material(s) |
| 73702 | Computed tomography, lower extremity, without contrast material, followed by contrast material(s) and further sections |
| 74150 | Computed tomography, abdomen; without contrast material |
| 74160 | Computed tomography, abdomen; with contrast material(s) |
| 74170 | Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections |
| 76380 | Computed tomography, limited or localized follow-up study |
| 76497 | Unlisted computed tomography procedure (eg, diagnostic, interventional) |
| 77078 | Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine) |
| 77079 | Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel) |

## Magnetic Resonance Angiography (MRA)

| CPT Code | Description |
|---|---|
| 70544 | Magnetic resonance angiography, head; without contrast material(s) |
| 70545 | Magnetic resonance angiography, head; with contrast material(s) |
| 70546 | Magnetic resonance angiography, head; without contrast material(s), followed by contrast material(s) and further sequences |
| 70547 | Magnetic resonance angiography, neck; without contrast material(s) |
| 70548 | Magnetic resonance angiography, neck; with contrast material(s) |
| 70549 | Magnetic resonance angiography, neck; without contrast material(s), followed by contrast material(s) and further sequences |
| 71555 | Magnetic resonance angiography, chest (excluding myocardium), with or without contrast material(s) |
| 72159 | Magnetic resonance angiography, spinal canal and contents, with or without contrast material(s) |
| 72198 | Magnetic resonance angiography, pelvis, with or without contrast material(s) |
| 73225 | Magnetic resonance angiography, upper extremity, with or without contrast material(s) |
| 73725 | Magnetic resonance angiography, lower extremity, with or without contrast material(s) |
| 74185 | Magnetic resonance angiography, abdomen, with or without contrast material(s) |

## Magnetic Resonance Imaging (MRI)

| CPT Code | Description |
|---|---|
| 70336 | Magnetic resonance (eg, proton) imaging, temporomandibular joint(s) |
| 70540 | Magnetic resonance (eg, proton) imaging, orbit, face and/or neck; without contrast material(s) |
| 70542 | Magnetic resonance (eg, proton) imaging, orbit, face and/or neck; with contrast material(s) |
| 70543 | Magnetic resonance (eg, proton) imaging, orbit, face and/or neck; without contrast material(s), followed by contrast material(s) and further sequences |
| 70551 | Magnetic resonance angiography, brain (including brain stem); without contrast material(s) |
| 70552 | Magnetic resonance angiography, brain (including brain stem);; with contrast material(s) |
| 70553 | Magnetic resonance angiography, brain (including brain stem);; without contrast material(s), followed by contrast material(s) and further sequences |
| 71550 | Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s) |
| 71551 | Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); with contrast material(s) |
| 71552 | Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s), followed by contrast material(s) and further sequences |
| 72141 | Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material |
| 72142 | Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s) |
| 72146 | Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material |
| 72147 | Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material(s) |
| 72148 | Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material |
| 72149 | Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material(s) |
| 72156 | Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical |

| CPT Code | Description |
|---|---|
| 72157 | Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic |
| 72158 | Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar |
| 72195 | Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s) |
| 72196 | Magnetic resonance (eg, proton) imaging pelvis; with contrast material(s) |
| 72197 | Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s), followed by contrast material(s) and further sequences |
| 73218 | Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s) |
| 73219 | Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; with contrast material(s) |
| 73220 | Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s), followed by contrast material(s) and further sequences |
| 73221 | Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s) |
| 73222 | Magnetic resonance (eg, proton) imaging, any joint of upper extremity; with contrast material(s) |
| 73223 | Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s), followed by contrast material(s) and further sequences |
| 73718 | Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s) |
| 73719 | Magnetic resonance (eg, proton) imaging, lower extremity other than joint; with contrast material(s) |
| 73720 | Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s), followed by contrast material(s) and further sequences |
| 73721 | Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material |
| 73722 | Magnetic resonance (eg, proton) imaging, any joint of lower extremity; with contrast material(s) |
| 73723 | Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material(s), followed by contrast material(s) and further sequences |
| 74181 | Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s) |
| 74182 | Magnetic resonance (eg, proton) imaging, abdomen; with contrast material(s) |
| 74183 | Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences |
| 76498 | Unlisted magnetic resonance procedure (eg, diagnostic, interventional) |
| 77058 | Magnetic resonance imaging, breast, without and/or with contrast material(s); unilateral |
| 77059 | Magnetic resonance imaging, breast, without and/or with contrast material(s); bilateral |

## Ultrasound

| CPT Code | Description |
|---|---|
| 76506 | Echoencephalography, real time with image documentation (gray scale) (for determination of ventricular size, delineation of cerebral contents, and detection of fluid masses or other intracranial abnormalities), including A-mode encephalography as secondary component where indicated |
| 76510 | Ophthalmic ultrasound, diagnostic; B-scan and quantitative A-scan performed during the same patient encounter |
| 76511 | Ophthalmic ultrasound, diagnostic; quantitative A-scan only |
| 76512 | Ophthalmic ultrasound, diagnostic; B-scan (with or without superimposed non-quantitative A-scan) |

| CPT Code | Description |
|---|---|
| 76513 | Ophthalmic ultrasound, diagnostic; anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy |
| 76514 | Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness) |
| 76516 | Ophthalmic biometry by ultrasound echography, A-scan: |
| 76519 | Ophthalmic biometry by ultrasound echography, A-scan: with intraocular lens power calculation |
| 76529 | Ophthalmic ultrasonic foreign body localization |
| 76536 | Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid) real time with image documentation |
| 76604 | Ultrasound, chest (includes mediastinum), real time with image documentation |
| 76645 | Ultrasound, breast(s) (unilateral or bilateral), real time with image documentation |
| 76700 | Ultrasound, abdominal, real time with image documentation; complete |
| 76705 | Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up) |
| 76770 | Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; complete |
| 76775 | Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited |
| 76776 | Ultrasound, transplanted kidney, real time and duplex Doppler with image documentation |
| 76800 | Ultrasound, spinal canal and contents |
| 76801 | Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; single or first gestation |
| 76802 | Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; each additional gestation |
| 76805 | Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or + 14 weeks 0 days), transabdominal approach; single or first gestation |
| 76810 | Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or + 14 weeks 0 days), transabdominal approach; each additional gestation |
| 76811 | Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation |
| 76812 | Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation |
| 76813 | Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation |
| 76814 | Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; each additional gestation |
| 76815 | Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses |
| 76816 | Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus |
| 76817 | Ultrasound, pregnant uterus, real time with image documentation, transvaginal |
| 76818 | Fetal biophysical profile; with non-stress testing |
| 76819 | Fetal biophysical profile; without non-stress testing |
| 76820 | Doppler velocimetry, fetal; umbilical artery |

| CPT Code | Description |
|---|---|
| 76821 | Doppler velocimetry, fetal; middle cerebral artery |
| 76825 | Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording; |
| 76826 | Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording; follow-up or repeat study |
| 76827 | Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; complete |
| 76828 | Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; follow-up or repeat study |
| 76830 | Ultrasound, transvaginal |
| 76831 | Saline infusion sonohysterography (SIS), including color flow Doppler, when performed |
| 76856 | Ultrasound, pelvic (nonobstetric), real time with image documentation; complete |
| 76857 | Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles) |
| 76870 | Ultrasound, scrotum and contents |
| 76872 | Ultrasound, transrectal; |
| 76873 | Ultrasound, transrectal; prostate volume study for brachytherapy treatment planning (separate procedure) |
| 76880 | Ultrasound, extremity, nonvascular, real time with image documentation |
| 76885 | Ultrasound, infant hips, real time with imaging documentation; dynamic (requiring physician manipulation) |
| 76886 | Ultrasound, infant hips, real time with imaging documentation; limited, static (not requiring physician manipulation) |
| 76970 | Ultrasound study follow-up |
| 76999 | Unlisted ultrasound procedure (eg, diagnostic, interventional) |
| 93875 | Noninvasive physiologic studies of extracranial arteries, complete bilateral study (eg, periorbital flow direction with arterial compression, ocular pneumoplethysmography, Doppler ultrasound spectral analysis) |
| 93880 | Duplex scan of extracranial arteries; complete bilateral study |
| 93882 | Duplex scan of extracranial arteries; unilateral or limited study |
| 93886 | Transcranial Doppler study of the intracranial arteries; complete study |
| 93888 | Transcranial Doppler study of the intracranial arteries; limited study |
| 93890 | Transcranial Doppler study of the intracranial arteries; vasoreactivity study |
| 93892 | Transcranial Doppler study of the intracranial arteries; emboli detection without intravenous microbubble injection |
| 93893 | Transcranial Doppler study of the intracranial arteries; emboli detection with intravenous microbubble injection |
| 93922 | Non-invasive physiologic studies of upper or lower extremity arteries, single level, bilateral |
| 93923 | Non-invasive physiologic studies of upper or lower extremity arteries, multiple levels or with provocative testing, complete bilateral study |
| 93924 | Noninvasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, complete bilateral study |
| 93925 | Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study |
| 93926 | Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study |
| 93930 | Duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study |
| 93931 | Duplex scan of upper extremity arteries or arterial bypass grafts; unilateral or limited study |
| 93965 | Noninvasive physiologic studies of extremity veins, complete bilateral study (eg, Doppler waveform analysis with responses to compression and other maneuvers, phleborheography, impedance plethysmography) |
| 93970 | Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study |

| CPT Code | Description |
|---|---|
| 93971 | Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study |
| 93975 | Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study |
| 93976 | Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study |
| 93978 | Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study |
| 93979 | Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; unilateral or limited study |
| 93990 | Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow) |

## Other

| CPT Code | Description |
|---|---|
| 76376 | 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; not requiring imaging postprocessing on an independent workstation |
| 76377 | 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; requiring imaging postprocessing on an independent workstation |

## Revenue Codes

| RC Code | Description |
|---|---|
| 350 | CT Scan – General Classification |
| 351 | CT Scan – Head Scan |
| 352 | CT Scan – Body Scan |
| 359 | CT Scan – Other |
| 402 | Other Imaging Services – Ultrasound |
| 404 | Other Imaging Services – Positron Emission Tomography |
| 409 | Other Imaging Services – Other Imaging Services |
| 610 | Magnetic Resonance Technology (MRT) – General Classification |
| 611 | Magnetic Resonance Technology (MRT) – MRI Brain/Brainstem |
| 612 | Magnetic Resonance Technology (MRT) – MRI Spinal Cord/Spine |
| 614 | Magnetic Resonance Technology (MRT) – MRI Other |
| 615 | Magnetic Resonance Technology (MRT) – MRA Head and Neck |
| 616 | Magnetic Resonance Technology (MRT) – MRA Lower Extremities |
| 618 | Magnetic Resonance Technology (MRT) – MRA Other |
| 619 | Magnetic Resonance Technology (MRT) – Other MRT |

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

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

## *Attention: All Providers*

## *Retroactive Eligibility for Family Planning Waiver*

As of November 1, 2009, there will no longer be retroactive eligibility for Family Planning Waiver (FPW). Medicaid applicants with a medical need in the three months prior to the month of application will be evaluated for eligibility for all other Medicaid programs.

**Medicaid Eligibility Unit**
**DMA, 919-855-4000**

## *Attention: All Providers*

## *Suspension of New Enrollment for At-Risk Case Management Providers*

DMA has temporarily suspended enrollment for providers of Case Management Services for Children and Adults Who Are at Risk for Abuse, Neglect or Exploitation. Due to this action, the Division of Aging and Adult Services (DAAS) is not currently accepting applications for certification as an "At Risk Case Management Certified Agency" from any provider agencies except local county departments of social services. This policy will be evaluated at the conclusion of the work of the Consolidated Case Management Task Force and subsequent payment study. We apologize for any inconvenience due to these actions.

**Julie Budzinski**
**DMA, 919-855-4368**

**Charles Williams**
**DAAS, 919-733-3818**

## *Attention: All Providers*

## *Dietary Evaluation and Counseling*

Providers are reminded that the diagnosis codes listed in Attachment A of the Clinical Coverage Policy 1-I, *Dietary Evaluation and Counseling*, must be used when a pregnant or postpartum recipient is 21 years of age or older. Children ages 0 through 20 years are not limited to the diagnosis list in Attachment A of the policy.

**HP Enterprise Services**
**1-800-688-6696 or 919-851-8888**

## *Attention: Durable Medical Equipment Providers*

## *Coverage for Servicing and Repairing Durable Medical Equipment*

Effective with date of service October 31, 2009, the following HCPCS code was end-dated and removed from the Durable Medical Equipment (DME) Fee Schedule.

| HCPCS Code | Description |
|---|---|
| E1340 | Repair or nonroutine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes |

Effective with date of service November 1, 2009, the following HCPCS code was added to the DME Fee Schedule.

| HCPCS Code | New Description |
|---|---|
| K0739 | Repair or nonroutine service for durable medical equipment other than oxygen requiring the skill of a technician, labor component, per 15 minutes |

The coverage criteria for servicing and repairing DME have not changed. Prior approval is required. Refer to Section 5.8 of Clinical Coverage Policy 5A, *Durable Medical Equipment*, on DMA's website at http://www.ncdhhs.gov/dma/mp/ for more coverage details.

**HP Enterprise Services**
**1-800-688-6696 or 919-851-8888**

## *Attention: Durable Medical Equipment Providers*

## *Coverage for Standers*

Effective with date of service November 1, 2009, newly established coverage criteria for standers were implemented. This policy revision includes the addition of four new codes for standers and coverage of standers for recipients ages 0 through 20 years of age.

| HCPCS Code | New Description | Lifetime Expectancy or Quantity Limitation |
|---|---|---|
| E0637 | Combination sit to stand system, any size including pediatric, with seatlift feature, with or without wheels | 0 through 20 only; 3 years |
| E0638 | Standing frame system, one position (e.g., upright, supine, or prone stander), any size including pediatric, with or without wheels | 0 through 20 only; 3 years |
| E0641 | Standing frame system, multi-position (e.g., three-way stander), any size including pediatric, with or without wheels | 0 through 20 only; 3 years |
| E0642 | Standing frame system, mobile (dynamic stander), any size including pediatric | 0 through 20 only; 3 years |

Prior approval guidelines for standers have been added. Refer to Section 5.3.24 of Clinical Coverage Policy 5A, *Durable Medical Equipment*, on DMA's website at http://www.ncdhhs.gov/dma/mp/ for more coverage details.

**HP Enterprise Services**
**1-800-688-6696 or 919-851-8888**

## *Attention: Durable Medical Equipment Providers*

# *Medically Necessary Incontinence, Ostomy, and Urological Supplies*

Effective November 1, 2009, durable medical equipment (DME) providers can seek reimbursement for medically necessary incontinence, ostomy, and urological supplies. Please refer to Clinical Coverage Policy #5A, *Durable Medical Equipment*, on DMA's website at http://www.ncdhhs.gov/dma/mp/ for specific coverage details.

DME providers can submit their claims for these supplies (when the recipient meets the coverage criteria) through HP Enterprise Services (EDS).

**Note:** Any recipient who currently receives other home health services should continue to receive their incontinence, ostomy, and urological supplies though the home health provider.

**HP Enterprise Services**
**1-800-688-6696 or 919-851-8888**

## *Attention: CAP/MR-DD Providers, Enhanced Behavioral Health (Community Intervention) Services Providers, Local Management Entities, and Residential Child Care Treatment Facilities*

# *Mental Health Cost Report Training Sessions*

Training is being offered for those providers who have a fiscal year end of September 30, 2009, or December 31, 2009. The training is being offered at several locations across the state during the month of December 2009 and January 2010. Those providers with a fiscal year end of March 31, 2010, or June 30, 2010, should wait to go to training when sessions are offered next summer.

To learn more about training, 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 and click on *Mental Health Cost Report Training Memo*. The memo also provides the link to the website where you can register.

For questions concerning this training or the Mental Health Cost Report, contact Wilma Marrow at Wilma.marrow@dhhs.nc.gov or 919-855-3681.

**Wilma Marrow**
**Office of the Controller, 919-855-3681**

## *Attention: Nurse Practitioners and Physicians*

# *Infliximab (Remicade, HCPCS Code J1745) and Rituximab (Rituxan, HCPCS Code J9310): New Billing Guidelines*

Effective with date of service October 1, 2009, claims billed for Remicade or Rituxan will be checked for a covered diagnosis codes in accordance with the Food and Drug Administration guidelines. The N.C. Medicaid Program cannot reimburse for drugs or services considered to be investigative or experimental.

### Remicade

The ICD-9-CM diagnosis codes required when billing for J1745 are:

- 555.0 (regional enteritis of the small intestine); or
- 555.1 (regional enteritis of the large intestine); or
- 555.2 (regional enteritis of the small intestine with large intestine); or
- 555.9 (regional enteritis of an unspecified site); or
- 556.0 through 556.9 (ulcerative colitis); or
- 565.1 (anal fistula); or
- 569.81 (fistula of intestine, excluding rectum and anus); or
- 696.0 (psoriatic arthopathy); or
- 696.1 (other psoriasis); or
- 714.0 through 714.2 (rheumatoid arthritis); or
- 720.0 (ankylosing spondylitis and other inflammatory spondylopathies).

### Rituxan

The ICD-9-CM diagnosis codes required when billing for J9310 are:

- 200.00 through 200.88 (lymphosarcoma and reticulosarcoma and other specified malignant tumors of lymphatic tissue); or
- 202.00 through 202.98 (other malignant neoplasms of lymphoid and histiocytic tissue); or
- 714.0 through 714.2 (rheumatoid arthritis).

**HP Enterprise Services**
**1-800-688-6696 or 919-851-8888**

## *Attention: Enhanced Behavioral Health (Community Intervention) Services Providers*

# *Provider Verification and Credentialing Activities*

As noted in the July 2009 Medicaid Bulletin, the process to re-verify information and to credential enrolled Medicaid Community Intervention Services providers is scheduled to begin immediately. CSC will be notifying providers by mail and sending the notification packet to the provider's billing/accounting address. This will include a pre-printed report of information currently on file with N.C. Medicaid plus a checklist of credentialing-related documents that must be returned to CSC. (Providers may verify their billing/accounting address via the DMA Provider Services NPI and Address Database at http://www.ncdhhs.gov/dma/WebNPI/default.htm or by calling the EVC Call Center at 1-866-844-1113.)

The pre-printed NC MMIS Verification Form includes demographic data and NPI information currently on file with N.C. Medicaid and also contains space for providers to enter license/certification numbers, type of ownership, and contact information. Providers must complete the form, attach copies of documents required for credentialing, and return the verification packet to CSC within 30 days of the date of receipt. The verification process will take up to three weeks from the time CSC receives the correct and complete verification packet from the provider; the return of incomplete or incorrect information may lead to an interruption in enrollment. Lack of compliance in these procedures could result in suspension of enrollment and eventual termination.

Please pay special attention to the designation for Community Support Team. Community Support Team providers are required to submit the verification packet with appropriate credentials, including all current Notifications of Endorsement Actions, to qualify for enrollment as a provider of Community Support Team services. This will effectively separate Community Support Child (H0036 HA), Community Support Adult (H0036 HB), and Community Support Group (H0036 HQ) services from Community Support Team services.

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

## *Attention: Pharmacists and Prescribers*

# *New Prior Authorization Requirements for Leukotriene Modifiers*

Effective with date of service of October 28, 2009, the N.C. Outpatient Pharmacy Program began requiring prior authorization for Leukotriene Modifiers. Prescribers can request prior authorization by contacting ACS at 1-866-246-8505 (telephone) or 866-246-8507 (fax). The criteria and PA request form for these medications are available on the N.C. Medicaid Enhanced Pharmacy Program website at http://www.ncmedicaidpbm.com. Medications that now require prior authorization include Accolate, Singulair, and Zyflo.

**HP Enterprise Services**
**1-800-688-6696 or 919-851-8888**

## *Attention: Nurse Practitioners and Physicians*

# *Canakinumab Single-use Vials (180 mg) (Ilaris, HCPCS Code J3590): Billing Guidelines*

Effective with date of service August 1, 2009, the N.C. Medicaid program covers canakinumab injectable (Ilaris) for use in the Physician's Drug Program when billed with HCPCS code J3590 (unclassified biologics). Ilaris is available as single-use vials containing 180 mg of Ilaris as a lyophilized powder for reconstitution.

Ilaris is a monoclonal antibody that blocks the activity of IL-1β. It is indicated for the treatment of Cryopyrin-Associated Periodic Syndrome (CAPS), including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS), in adults and children **four years of age and older.**

A single does of Ilaris should be administered every 8 weeks as a subcutaneous injection. The dose is 150 mg for adults and children with body weight greater than 40 kg, and 2 mg/kg for patients with body weight between 15 kg and 40 kg. For children between 15 kg to 40 kg with an inadequate response, the dose can be increased to 3 mg/kg.

### For Medicaid Billing

- The ICD-9-CM diagnosis codes required for billing Ilaris are:
  - ♦ 708.2 (Urticaria due to cold and heat [FCAS])

    **OR**
  - ♦ 279.4 (Autoimmune disease, not elsewhere classified)
- Providers should bill Ilaris with HCPCS code J3590 (unclassified biologics).
- One Medicaid unit of coverage is one 180-mg vial. The maximum reimbursement rate, per one 180-mg vial, is $17,812.51. An entire single-use vial may be billed.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Ilaris should be reported as "units." The drug in its original state must be considered, NOT the reconstituted amount. If billing for the entire 180-mg single-dose vial, report the NDC units as "UN1." If the drug was purchased under the 340B Drug Pricing Program, place a "UD" modifier in the modifier field for that drug detail.
- Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III,* on DMA's website (http://www.ncdhhs.gov/dma/bulletin/) for additional instructions.
- Medicaid covers only rebatable NDCs.
- Providers must bill their usual and customary charge.

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

**HP Enterprise Services**
**1-800-688-6696 or 919-851-8888**

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

# Changes to Outpatient Specialized Therapies

Effective with date of service December 1, 2009, prior authorization (PA) for outpatient specialized therapies (occupational therapy, physical therapy, speech therapy, respiratory therapy, and audiology services) will once again be required for recipients under 21 years of age. Effective with date of service January 1, 2010, PA for outpatient specialized therapies will also be required for recipients 21 years of age and older. Prior authorization will be required for all therapy treatments regardless of the setting. The Carolinas Center of Medical Excellence (CCME) will introduce a new website (http://www.medicaidprograms.org/nc/therapyservices/) where providers can access detailed information and instructions for registering and submitting requests. All requests must be submitted via this website.

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

All requests for PA must be submitted via CCME's new website. Providers will need to register and obtain password information to access these secure pages. Requests for recipients ages 21 and older will not be accepted until at least December 1, 2009. Online provider training will be available. CCME's website will also include instructions and training material for the electronic submission process and FAQs, helpful hints, and a help desk for technical support.

Required information must be submitted by completing the online form, which is composed of the following sections:

A. Recipient Demographics

B. Provider Demographics

C. Requested Dates of Service/Units or Visits

D. Order for Therapy

E. Treatment Plan of Care

F. ICD-9-CM Codes

G. Evaluation

H. Goals

I. Progress Towards Goals

The medical necessity determination will be based on the recipient's medical history, measurable goals with objective baselines or, in the case of reauthorizations, measurable progress and the provider's rationale for skilled intervention. Supplemental information will be requested only if a medical necessity determination cannot be made from the submitted data.

Since adults will have visit limits, it is important that providers submit discharge information via the website. This information must include the number of visits completed and the date of discharge. Timely submission of this information is imperative for determination of medical necessity for future authorization requests. A paper version of this form will be available online as a tool for providers.

CCME will also conduct post-payment reviews to ensure that all policy requirements and medical necessity criteria are met. Providers will be expected to provide documentation as requested by CCME via mail or fax. Recoupment of overpayments based on review findings will occur. While services provided by LEAs are excluded from prior authorization, they will be subject to post-payment review.

## Remember:

- Use the same billing provider number for PA that you use for claims billing. If you bill using a group number, request PA using the group number.
- Only home health agencies and hospitals request PA in visits. Therefore, one visit equals one unit. All other providers request PA according to how the CPT code is billed. The billing unit for all of the CPT procedure codes for speech therapy and respiratory therapy is an event. One event equals one unit. **Example:** Both CPT code 92501 and 92526 will be billed for speech therapy that will occur during the same therapy session. Thus, providers must request PA for two units and bill for two units.
- CCME is not responsible for ensuring that the correct billing provider number, the correct number of billing units, and the correct dates of service are used on the PA requests.
- It is the provider's responsibility to request PA for additional units of service before the approved units of service end or before the PA period expires.
- If two providers (for example, a school and an independent practitioner) are providing services to the same recipient there must be coordination of services. Services should not be provided on the same day.
- Claims for physical therapy, occupational therapy, respiratory therapy, and speech therapy – including claim adjustments and resubmitted claims – submitted for billing with CPT codes, must include one of the discipline-specific ICD-9-CM diagnosis codes listed below as a secondary diagnosis on the claim. This allows Medicaid to correctly accrue the units billed for each specialized therapy authorized during the prior approval process. This does not change the requirement to bill the primary diagnosis that justifies the need for the specialized therapy.
- **The primary treatment ICD–9-CM diagnosis code must be entered first on the claim form. The discipline-specific V code should follow the primary treatment code**:
  - V57.0 – Respiratory Therapy
  - V57.1 – Physical Therapy
  - V57.21 – Occupational Therapy
  - V57.3 – Speech Therapy
- All of the elements documented in Clinical Coverage Policy 10A, *Outpatient Specialized Therapies*, (http://www.ncdhhs.gov/dma/mp/) apply and must be indicated in the record.
- Retroactive PA is only considered when a recipient, who does not have Medicaid coverage at the time of the procedure, is later approved for Medicaid with a retroactive eligibility date.

Obtaining PA does not guarantee payment or ensure recipient eligibility on the date of service. In addition to obtaining PA, providers must follow the established guidelines for their respective programs. Clinical Coverage Policy 10A, *Outpatient Specialized Therapies*, is not all inclusive of program requirements.

## Implementation Timeline

| Date | Instructions to Providers | Procedure |
|---|---|---|
| 10/26/09 | Launch of New Prior Authorization Website | Providers can access general information about the PA process and instructions on how to register for access for submitting requests electronically.<br><br>CCME will begin processing registrations upon receipt from the provider. |
| 11/16/09 | CCME Will Begin Accepting PA Submissions for Recipients Under 21 via the New Prior Authorization Website | Provider notification of review outcomes will not begin until 12/1/09.<br><br>PA requests received prior to 12/1/09 will be processed as if the received date is 12/1/09 and will be reviewed within five business days (12/8/09). (Note: 12/5/09 is a Saturday and 12/6/09 is a Sunday.)<br><br>Technical assistance will be available beginning 11/16/09. |
| 12/15/09 | CCME will Begin Accepting PA Submissions for Recipients 21 and Older via the New Prior Authorization Website | All PAs received prior to 1/4/10 will be processed as if the received date is 1/4/10 and will be reviewed within five business days (1/11/10) (Note: 1/1/10 is a holiday, 1/2/10 is a Saturday, and 1/3/10 is a Sunday.) |

A provider training webinar is scheduled for November 12, 2009. Please check CCME's Prior Authorization Website for detailed information, including the time of the webinar session, and instructions on how to register for the webinar. Provider will receive an e-mail confirmation of their successful registration to participate in the webinar.

**CCME, 1-800-228-3365**

## *Attention: Durable Medical Equipment Providers and Pharmacy Providers*

## *Prodigy Diabetic Supplies Under the Durable Medical Equipment and Pharmacy Programs*

Effective November 15, 2009, Prodigy Diabetes Care, LLC, will be N.C. Medicaid's designated preferred manufacturer for glucose meters, diabetic test strips, control solutions, lancets, lancing devices, and syringes. Beginning on this date of service, only Prodigy test strips, control solutions, lancets, lancing devices, and syringes will be covered by N.C. Medicaid. This change will apply only to Medicaid-primary recipients (dually eligible and third-party recipients are not affected). **Note:** These requirements will not apply to private duty nursing and home health providers until February 1, 2010.

The following table lists the National Drug Codes (NDCs) that are included under this program; for meters, please call your wholesaler or Prodigy Diabetes Care, LLC.

| Covered Product | Package Size | Unit Type | NDC-11 |
|---|---|---|---|
| Prodigy Pocket™ Meter Kit - Black | 1 Meter Kit | 1 Meter | 08484-0708-00 |
| Prodigy Pocket™ Meter Kit - Pink | 1 Meter Kit | 1 Meter | 08484-0708-01 |
| Prodigy Pocket™ Meter Kit - Blue | 1 Meter Kit | 1 Meter | 08484-0708-02 |
| Prodigy Pocket™ Meter Kit -Green | 1 Meter Kit | 1 Meter | 08484-0708-03 |
| Prodigy Pocket™ Meter Kit -Camouflage | 1 Meter Kit | 1 Meter | 08484-0708-04 |
| Prodigy Pocket™ Meter Kit –Pink Camouflage | 1 Meter Kit | 1 Meter | 08484-0708-05 |
| Prodigy AutoCode® Talking Meter Kit | 1 Meter Kit | 1 Meter | 08484-0701-20 |
| Prodigy Voice™ Meter Kit | 1 Meter Kit | 1 Meter | 08484-0719-50 |
| Prodigy™ No Coding Test Strips | 50 ct Bottle | 1 Bottle | 08484-9902-50 |
| Prodigy Control Solution (Low) | 1 Bottle | 1 Bottle | 08484-9903-10 |
| Prodigy Twist Top Lancets 28G | 100 ct Box | 1 Box | 08484-9903-28 |
| Prodigy Lancing Device, Adj. Depth w/ Clear Cap | 100 ct Box | 1 Box | 08484-9903-55 |
| Prodigy Syringe 28G 12.7mm – 1 cc (100 ct) | 100 ct Box | 1 Box | 08484-9904-30 |
| Prodigy Syringe 31G 8mm – ½ cc (100 ct) | 100 ct Box | 1 Box | 08484-9904-35 |

In addition, effective November 15, 2009, diabetic test strips, control solutions, lancets, and lancing devices will be added to the list of over-the-counter products covered under the Outpatient Pharmacy Program. These products will be covered under the pharmacy point-of-sale system with a prescription.

### Billing Instructions for Submitting Claims for Diabetic Supplies under Durable Medical Equipment

Claims for diabetic test strips, control solutions, lancets, lancing devices, and syringes submitted under the Durable Medical Equipment (DME) Program must be billed using the NDC in addition to the HCPCS code. The NDC will be entered in the shaded area of block 24A of the CMS-1500 claim form. (For information on how to bill with NDCs, please refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III,* on DMA's website (http://www.ncdhhs.gov/dma/bulletin/).

Test strips must be billed in units (1 unit = 50 strips) and syringes and lancets must also be billed in units (1 unit = 100 syringes or lancets).

A transition period will be in place from November 15, 2009, through February 15, 2010 (this transition period is not a postponement), in which a one-time, per-recipient, per-product override will be allowed. In addition to

modifier NU, DME providers will need to place the SC modifier in block 24D of the CMS-1500 claim form to bypass the requirement to bill for Prodigy NDCs (as listed in the chart above). Following February 15, 2010, this modifier will no longer be acceptable for use with diabetic supplies for DME and only the Prodigy NDCs referenced above will be covered.

HCPCS codes and supply limits for diabetic supplies remain the same as outlined in Clinical Coverage Policy 5A, *Durable Medical Equipment,* as indicated below:

| HCPCS Code | Product Description | Quantity |
|---|---|---|
| S8490 | Insulin syringes (1 unit = 100 syringes) | 200 syringes per month |
| A4253 | Blood glucose test or reagent strips (1 unit = 50 strips) | 200 strips per month |
| A4259 | Lancets (1 unit = 100 lancets) | 200 per month |
| A4258 | Lancing Device | 2 per year |
| A4256 | Normal, high, low calibrator solution | 4 per year |
| E0607 | Home blood glucose monitor | 1 every 2 years |
| E2100 | Blood glucose monitor with voice synthesizer | 1 every 3 years |

Effective November 15, 2009, HCPCS codes E0607 and E2100 will be end-dated.

**Note:** These requirements will not apply to private duty nursing and home health providers until February 1, 2010.

### Billing Instructions for Submitting Diabetic Supplies under Pharmacy Point-of-Sale System

Claims for diabetic test strips, control solutions, lancets, lancing devices, and syringes submitted at point-of-sale must be billed using the NDC. Test strips must be billed in multiples of 50 and syringes and lancets must be billed in multiples of 100. For Medicaid billing, 1 lancing device = 1 unit. Rates apply to these diabetic supplies; therefore, no copayments and no dispensing fees apply.

A transition period will be in place from November 15, 2009, through February 15, 2010 (this transition period is not a postponement), in which a one-time, per-recipient, per-product override will be allowed under the pharmacy point-of-sale system for covered diabetic supplies that are not the Prodigy brand. Pharmacy providers can place a "1" in the prior authorization type code field (461-EU) or a "2" in the submission clarification code field (420-DK) to override the requirement to bill for Prodigy NDCs. Following February 15, 2010, this override will no longer be available and only the Prodigy NDCs referenced above will be covered. Diabetic supply limits will be the same as under the DME Program. Prior authorization requests for additional quantities or for non-Prodigy diabetic supplies must go through the DME Program.

Diabetic supplies do not have to be purchased at the same pharmacy unless the recipient is locked into a pharmacy. Recipients identified for the Focused Risk Management (FORM) Program who require more than 11 unduplicated prescriptions each month are restricted to a single pharmacy. In these cases, the diabetic supplies must be purchased at the same pharmacy.

For additional information, providers may call Prodigy Diabetic Care, LLC at 1-866-540-4816, DMA Clinical Policies and Programs at 919-855-4310 (DME) or 919-855-4300 (Pharmacy).

**Durable Medical Equipment Program**
**DMA, 919-855-4310**

**Outpatient Pharmacy Program**
**DMA, 919-855-4300**

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

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

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

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

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

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

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

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

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

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

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

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

## *Proposed Clinical Coverage Policies*

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

Lorie Williams
Division of Medical Assistance
Clinical Policy Section
2501 Mail Service Center
Raleigh NC 27699-2501

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

## *2009 Checkwrite Schedule*

| Month | Electronic Cut-Off Date | Checkwrite Date |
|---|---|---|
| **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 |

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

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

**Melissa Robinson**
**Executive Director**
**HP Enterprise Services**