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North Carolina Medicaid Bulletin

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

2007 Checkwrite Schedule

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

Month	Electronic Cut-Off	Checkwrite Date
January	01/05/07	01/09/07
	01/12/07	01/17/07
	01/19/07	01/25/07
February	02/02/07	02/06/07
	02/08/07	02/13/07
	02/15/07	02/20/07
	02/22/07	02/28/07
March	03/01/07	03/06/07
	03/08/07	03/13/07
	03/15/07	03/20/07
	03/22/07	03/29/07
April	04/05/07	04/10/07
	04/12/07	04/17/07
	04/19/07	04/26/07
May	05/03/07	05/08/07
	05/10/07	05/15/07
	05/17/07	05/22/07
	05/24/07	05/31/07
June	05/31/07	06/05/07
	06/07/07	06/12/07
	06/14/07	06/21/07

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

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

Attention: All Providers

Clinical Coverage Policies

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

Endovascular Repair of Aortic Aneurysm, #1A21
Kidney Transplantation, #11B4
Liver Transplantation, #11B5

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

Additionally, all policies have been revised this month to supply additional information related to Early and Periodic Screening, Diagnosis and Testing (EPSDT) for recipients under the age of 21.

Clinical Policy
DMA, 919-855-4260

Attention: All Providers

CPT Codes 90467, 90468, 90473 and 90474—Coverage of Immunization Administration Codes for Oral/Intranasal Vaccines

Effective with date of service Aug. 1, 2006, the N.C. Medicaid program covers CPT codes for the intranasal and oral administration of vaccines/toxoids. Their code descriptors are as follows:

90467 — Immunization administration under 8 years of age (includes intranasal or oral routes of administration) when the physician counsels the patient/family; first administration (single or combination vaccine/toxoid) per day. (For N.C. Medicaid, do not report in addition to 90465.)

90468 — Each additional administration (single or combination vaccine/toxoid) per day (list separately in addition to code for primary procedure). (For N.C. Medicaid, use 90468 in conjunction with 90465.)

90473 — Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid). (For N.C. Medicaid, do not report in addition to 90471.)

90474 — Each additional vaccine (single or combination vaccine/toxoid). (List separately in addition to code for primary procedure.) (For N.C. Medicaid, use 90474 in conjunction with 90471.)

The current codes used for immunization administration and their descriptors are as follows:

90465 — Immunization administration under 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. (For N.C. Medicaid, do not report 90465 in conjunction with 90467.)

90466 — Immunization administration under 8 years of age (includes percutaneous, intradermal, subcutaneous or intramuscular injections) when the physician counsels the patient/family; each additional injection (single or combination vaccine/toxoid) per day. (List separately in addition to code for primary procedure.) (For N.C. Medicaid, use in conjunction with 90465 or 90467.)

90471 — Immunization administration (includes percutaneous, intradermal, subcutaneous or intramuscular injections); **one vaccine** (single or combination vaccine/toxoid). (For N.C. Medicaid, do not report 90471 in conjunction with 90473.)

90472 — Immunization administration (includes percutaneous, intradermal, subcutaneous or intramuscular injections); one vaccine (single or combination vaccine/toxoid) **each additional vaccine** (single or combination vaccine/toxoid). (List separately in addition to code for primary procedure.) (For N.C. Medicaid, use 90472 in conjunction with 90471.)

The following principles should guide the billing of the six codes described above:

1. Apply the appropriate code depending on the age of the recipient and whether or not the physician has counseled the recipient and family.
2. CPT codes 90465 and 90466 are in the same code family, and 90471 and 90472 are in the same code family. A code from one injectable code family cannot be used with a code from another injectable code family.
3. CPT codes 90467 and 90468 are in one code family, and 90473 and 90474 are in another code family. A code from one intranasal/oral code family cannot be used with a code from the other intranasal/oral code family.
4. The physician counseling codes should not be used as an “add-on” counseling code to the other administration codes.
5. Physicians, nurse practitioners and physician assistants may perform these services.
6. When billing 90465, 90466, 90467 or 90468, the physician, nurse practitioner or physician assistant must perform face-to-face **vaccine counseling** associated with the administration and should document such. The physician, nurse practitioner or physician assistant is not required to administer the vaccine.
7. A “first” administration is defined as the first vaccine administered to a recipient during a single patient encounter.
8. At the present time, there should not be an occasion to bill a second intranasal/oral vaccine administration code.
9. When billing one or more injectable vaccines along with one oral/intranasal vaccine, the code for **the first injectable vaccine is the primary code**.

Billing Guideline Examples for Immunizations for Recipients Birth through Age 20

Vaccine: Injectable Provider Type: Private Sector Providers		
Service Type	**With Physician Counseling**	**Without Physician Counseling**
Health Check Screening with Immunization(s)	For one vaccine, bill 90465EP. Report vaccine CPT code. For two or more vaccines, bill 90465EP with 90466EP. Report vaccine CPT codes. Immunization diagnosis code(s) **not** required. Immunization procedure code(s) **are** required.	For one vaccine bill 90471EP. Report vaccine CPT code. For two or more vaccines bill 90471EP and 90472EP. Report vaccine CPT codes. Immunization diagnosis code(s) **not** required. Immunization procedure code(s) **are** required.
Immunization(s) Only	For one vaccine, bill 90465EP. Report vaccine CPT code. For two or more vaccines, bill 90465EP and 90466EP. Report CPT vaccine codes. One immunization diagnosis code **is** required. Immunization procedure code(s) **not** required.	For one vaccine, bill 90471EP. Report vaccine CPT code. For two or more vaccines, bill 90471EP and 90472EP. Report CPT vaccine codes. One immunization diagnosis code **is** required. Immunization procedure code(s) **not** required.

Vaccine: Injectable Provider Type: Private Sector Providers		
Service Type	**With Physician Counseling**	**Without Physician Counseling**
Office Visit with Immunization(s)	For one vaccine, bill 90465EP. Report vaccine CPT code. For two or more vaccines, bill 90465EP and 90466EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required. Immunization procedure code(s) **are** required.	For one vaccine, bill 90471EP. Report vaccine CPT code. For two or more vaccines, bill 90471EP and 90472EP. Report CPT codes. Immunization diagnosis code(s) **not** required. Immunization procedure code(s) **are** required.
Core Visit with Immunization(s)	N/A	N/A

Vaccine: Injectable Provider Type: FQHC/RHC		
Service Type	**With Physician Counseling**	**Without Physician Counseling**
Health Check Screening with Immunization(s)	For one vaccine, bill 90465EP. Report vaccine CPT code. For two vaccines or more, bill 90465EP and 90466EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required. Immunization procedure code(s) **are** required.	For one vaccine, bill 90471EP. Report vaccine CPT code. For two vaccines or more, bill 90471EP and 90472EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required. Immunization procedure code(s) **are** required.
Immunization(s) Only	For one vaccine, bill 90465EP. Report vaccine CPT code. For two vaccines or more, bill 90465EP and 90466EP. Report CPT vaccine codes. One immunization diagnosis code **is** required. Immunization procedure code(s) is **not** required.	For one vaccine, bill 90471EP. Report vaccine CPT code. For two vaccines or more, bill 90465EP and 90466EP. [90471EP & 90472EP??]Report CPT vaccine codes. One immunization diagnosis code **is** required. Immunization procedure code(s) is **not** required.
Office Visit with Immunization(s)	For one vaccine, bill 90465EP. Report vaccine CPT code. For two vaccines or more, bill 90465EP and 90466EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required. Immunization procedure code(s) **are** required.	For one vaccine, bill 90471EP. Report vaccine CPT code. For two vaccines or more, bill 90471EP and 90472EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required. Immunization procedure code(s) **are** required.
Core Visit with Immunization(s)	Cannot bill 90465EP or 90466EP. Immunization diagnosis code(s) are **not** required. Immunization procedure code(s) **are** required.	Cannot bill 90471EP or 90472EP. Immunization diagnosis code(s) are **not** required. Immunization procedure code(s) **are** required.

Vaccine: Injectable Provider Type: Local Health Departments		
Service Type	**With Physician Counseling**	**Without Physician Counseling**
Health Check Screening with Immunization(s)	For one vaccine, bill 90465EP. Report vaccine CPT code. For two or more vaccines, bill 90465EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required. Immunization procedure code(s) **are** required.	For one vaccine, bill 90471EP. Report vaccine CPT code. For two or more vaccines, bill 90471EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required. Immunization procedure code(s) **are** required.
Immunization(s) Only	For one vaccine, bill 90465EP. For two vaccines or more, bill 90465EP. Report CPT vaccine codes. One immunization diagnosis code **is** required. Immunization procedure code(s) **not** required.	For one vaccine, bill 90471EP. For two vaccines or more, bill 90471EP. Report CPT vaccine codes. One immunization diagnosis code **is** required. Immunization procedure code(s) **not** required.
Office Visit with Immunization(s)	For one vaccine, bill 90465EP. Report vaccine CPT code. For two or more vaccines, bill 90465EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required. Immunization procedure code(s) **are** required.	For one vaccine, bill 904671EP. [90471EP??] Report vaccine CPT code. For two or more vaccines, bill 90471EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required. Immunization procedure code(s) **are** required.
Core Visit with Immunization(s)	N/A	N/A

Vaccine: Intranasal/Oral Provider Type: Private Sector Providers		
Service Type	**With Physician Counseling**	**Without Physician Counseling**
Health Check Screening with Immunization(s)	For one vaccine, bill 90467EP. Report vaccine CPT code. Two or more vaccines – N/A. Immunization diagnosis code is **not** required. Immunization procedure code **is** required.	For one vaccine, bill 90473EP. Report vaccine CPT code. Two or more vaccines – N/A. Immunization diagnosis code is **not** required. Immunization procedure code **is** required.
Immunization(s) Only	For one vaccine, bill 90467EP. Report vaccine CPT code. Two or more vaccines – N/A. Immunization diagnosis code **is** required. Immunization procedure code is **not** required.	For one vaccine, bill 90473EP. Report vaccine CPT code. Two or more vaccines – N/A. Immunization diagnosis code **is** required. Immunization procedure code is **not** required.

Vaccine: Intranasal/Oral Provider Type: Private Sector Providers		
Office Visit with Immunization(s)	For one vaccine, bill 90467EP. Report vaccine CPT code. Two or more vaccines – N/A. Immunization diagnosis code is **not** required. Immunization procedure code **is** required.	For one vaccine, bill 90473EP. Report vaccine CPT code. Two or more vaccines – N/A. Immunization diagnosis code is **not** required. Immunization procedure code **is** required.
Core Visit with Immunization(s)	N/A	N/A

Vaccine: Intranasal/Oral Provider Type: FQHC/RHC		
Service Type	**With Physician Counseling**	**Without Physician Counseling**
Health Check Screening with Immunization(s)	For one vaccine, bill 90467EP. Report vaccine CPT code. Two vaccines or more – N/A. Immunization diagnosis code is **not** required. Immunization procedure code **is** required.	For one vaccine, bill 90473EP. Report vaccine CPT code. Two vaccines or more – N/A. Immunization diagnosis code is **not** required. Immunization procedure code **is** required.
Immunization(s) Only	For one vaccine, bill 90467EP. Report vaccine CPT code. Two vaccines or more – N/A. Immunization diagnosis code **is** required. Immunization procedure code is **not** required.	For one vaccine, bill 90473EP. Report vaccine CPT code. Two vaccines or more – N/A. Immunization diagnosis code **is** required. Immunization procedure code is **not** required.
Office Visit with Immunization(s)	For one vaccine, bill 90467EP. Report vaccine CPT code. Two vaccines or more – N/A. Immunization diagnosis code is **not** required. Immunization procedure code **is** required.	For one vaccine, bill 90473EP. Report vaccine CPT code. Two vaccines or more – N/A. Immunization diagnosis code is **not** required. Immunization procedure code **is** required.
Core Visit with Immunization(s)	Cannot bill 90467EP. Immunization diagnosis code is **not** required. Immunization procedure code **is** required.	Cannot bill 90473EP. Immunization diagnosis code is **not** required. Immunization procedure code **is** required.

Vaccine: Intranasal/Oral **Provider Type: Local Health Departments**		
Service Type	**With Physician Counseling**	**Without Physician Counseling**
Health Check Screening with Immunization(s)	For one vaccine, bill 90467EP. Report vaccine CPT code. Two vaccines or more – N/A. Immunization diagnosis code is **not** required. Immunization procedure code **is** required.	For one vaccine, bill 90473EP. Report vaccine CPT code. Two vaccines or more – N/A. Immunization diagnosis code(s) **not** required. Immunization procedure code **is** required.
Immunization(s) Only	For one vaccine, bill 90467EP. Report vaccine CPT code. Two vaccines or more – N/A. Immunization diagnosis code **is** required. Immunization procedure code is **not** required.	For one vaccine, bill 90473EP. Report vaccine CPT code. Two vaccines or more – N/A. Immunization diagnosis code **is** required. Immunization procedure code is **not** required.
Office Visit with Immunization(s)	For one vaccine, bill 90467EP. Report vaccine CPT code. Two vaccines or more – N/A. Immunization diagnosis code **not** required. Immunization procedure code **is** required.	For one vaccine, bill 90473EP. Report vaccine CPT code. Two vaccines or more – N/A. Immunization diagnosis code **not** required. Immunization procedure code **is** required.
Core Visit With Immunization(s)	N/A	N/A

Vaccine: Injectable with Intranasal/Oral **Provider Type: Private Sector Providers**		
Service Type	**With Physician Counseling**	**Without Physician Counseling**
Health Check Screening with Immunization(s)	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90465EP and 90468EP. Report CPT vaccine codes. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90465EP, 90466EP and 90468EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required. Immunization procedure code(s) **are** required.	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90471EP and 90474EP. Report CPT vaccine codes. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90471EP, 90472EP and 90474EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required. Immunization procedure code(s) **are** required.

Vaccine: Injectable with Intranasal/Oral Provider Type: Private Sector Providers		
Immunization(s) Only	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90465EP and 90468EP. Report CPT vaccine codes. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90465EP, 90466EP and 90468EP. Report CPT vaccine codes. One immunization diagnosis code **is** required. Immunization procedure code(s) **not** required.	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90471EP and 90474EP. Report CPT vaccine codes. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90471EP, 90472EP and 90474EP. Report CPT vaccine codes. One immunization diagnosis code **is** required. Immunization procedure code(s) **not** required.
Office Visit with Immunization(s)	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90465EP and 90468EP. Report CPT vaccine codes. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90465EP, 90466EP and 90468EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required. Immunization procedure code(s) **are** required.	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90471EP and 90474EP. Report CPT vaccine codes. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90471EP, 90472EP and 90474EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required. Immunization procedure code(s) **are** required.
Core Visit With Immunization(s)	N/A	N/A

Vaccine: Injectable with Intranasal/Oral Provider Type: FQHC/RHC		
Service Type	**With Physician Counseling**	**Without Physician Counseling**
Health Check Screening with Immunization(s)	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90465EP and 90468EP. Report CPT vaccine codes. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90465EP, 90466EP and 90468EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required. Immunization procedure code(s) **are** required.	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90471EP and 90474EP. Report CPT vaccine codes. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90471EP, 90472EP and 90474EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required. Immunization procedure code(s) **are** required.
Immunization(s) Only	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90465EP and 90468EP. Report CPT vaccine codes. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90465EP, 90466EP and 90468EP. Report CPT vaccine codes. One immunization diagnosis code **is** required. Immunization procedure code(s) is **not** required.	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90471EP and 90474EP. Report CPT vaccine codes. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90471EP, 90472EP and 90474EP. Report CPT vaccine codes. One immunization diagnosis code **is** required. Immunization procedure code(s) is **not** required.
Office Visit with Immunization(s)	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90465EP and 90468EP. Report CPT vaccine codes. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90465EP, 90466EP and 90468EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required. Immunization procedure code(s) **are** required.	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90471EP and 90474EP. Report CPT vaccine codes. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90471EP, 90472EP and 90474EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required. Immunization procedure code(s) **are** required.
Core Visit with Immunization(s)	Cannot bill 90465EP, 90466EP or 90468EP. Immunization diagnosis code(s) are **not** required. Immunization procedure code(s) **are** required.	Cannot bill 90471EP, 90472EP or 90474EP. Immunization diagnosis code(s) are **not** required. Immunization procedure code(s) **are** required.

Vaccine: Injectable with Intranasal/Oral Provider Type: Local Health Departments		
Service Type	**With Physician Counseling**	**Without Physician Counseling**
Health Check Screening with Immunization(s)	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90465EP and 90468EP. Report CPT vaccine codes. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90465EP and 90468EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required. Immunization procedure code(s) **are** required.	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90471EP and 90474EP. Report CPT vaccine codes. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90471EP and 90474EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required. Immunization procedure code(s) **are** required.
Immunization(s) Only	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90465EP and 90468EP. Report CPT vaccine codes. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90465EP and 90468EP. Report CPT vaccine codes. One immunization diagnosis code **is** required. Immunization procedure code(s) **not** required.	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90471EP and 90474EP. Report CPT vaccine codes. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90471EP and 90474EP. Report CPT vaccine codes. One immunization diagnosis code **is** required. Immunization procedure code(s) **not** required.
Office Visit with Immunization(s)	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90465EP and 90468EP. Report CPT vaccine codes. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90465EP and 90468EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required. Immunization procedure code(s) **are** required.	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90471EP and 90474EP. Report CPT vaccine codes. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90471EP and 90474EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required. Immunization procedure code(s) **are** required.
Core Visit with Immunization(s)	N/A	N/A

Billing Guidelines for Immunization Codes for Recipients Aged 21 and Above

Vaccine: Injectable Provider Type: Private Sector Providers		
Service Type	**Number of Vaccines**	
	One	**Two or More**
Immunization(s) Only	Bill 90471 administration code. Bill vaccine CPT code. Report diagnosis codes as appropriate.	Bill 90471 and 90472. Bill CPT vaccine codes. Report diagnosis codes as appropriate.
Office Visit with Immunization(s)	Bill 90471 administration code or E/M code. May bill E/M code with modifier 25 appended in addition to 90471 if a separately identifiable service was performed. Bill vaccine CPT code.	Bill 90471 and 90472. May bill E/M code with modifier 25 appended in addition to 90471 and 90472 if a separately identifiable service was performed. Bill CPT vaccine codes.

Vaccine: Injectable Provider Type: FQHC/RHC		
Service Type	**Number of Vaccines**	
	One	**Two or More**
Immunization(s) Only	Bill under the C suffix code. Bill 90471 administration code. Report the vaccine code if vaccine was provided at no charge from the State of North Carolina. **OR** Bill the vaccine CPT code if vaccine was purchased. Report diagnosis codes as appropriate.	Bill 90471 and 90472 administration codes. Report the CPT vaccine codes if vaccines were provided at no charge from the State of North Carolina. **OR** Bill the CPT vaccine codes if the vaccines were purchased. Report diagnosis codes as appropriate.
Core Visit with Immunization(s)	Immunization administration fees cannot be billed with core visits.	Immunization administration fees cannot be billed with core visits.

Vaccine: Injectable Provider Type: Local Health Departments		
Service Type	**Number of Vaccines**	
	One	**Two or More**
Immunization(s) Only	Bill 90471 administration code. Bill vaccine CPT code. Report diagnosis codes as appropriate.	Bill 90471 and 90472. Bill CPT vaccine codes. Report diagnosis codes as appropriate.
Office Visit with Immunization(s)	Bill 90471 administration code or E/M code. May bill E/M code with modifier 25 appended in addition to the administration code if a separately identifiable service was performed. Bill vaccine CPT code.	Bill 90471 and 90472. May bill E/M code with modifier 25 appended in addition to 90471 and 90472 if a separately identifiable service was performed. Bill CPT vaccine codes.

Currently, providers cannot bill for an intranasal or oral vaccine alone or in addition to an injectable vaccine for recipients 21 years of age and older.

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

Attention: All Providers

Influenza Vaccine and Reimbursement Guidelines for 2006-2007

The North Carolina 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). Information pertinent to influenza disease, vaccine and recommendations regarding who should receive the vaccine for the 2006–2007 flu season can be found at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5510a1.htm?s_cid=rr5510a1_e

Additional information regarding the 2006-2007 flu season can be found at http://www.cdc.gov/flu/.

Per ACIP, annual influenza vaccination is recommended for the following groups.

1. Persons with increased risk for complications from influenza:
   - children aged 6–23 months
   - children and adolescents (aged 6 months through 18 years) who are receiving long-term aspirin therapy
   - women who will be pregnant during the influenza season
   - adults and children who have chronic disorders of the pulmonary or cardiovascular systems, including asthma (hypertension is not considered a high-risk condition)
   - adults and children who have required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic diseases (including diabetes mellitus), renal dysfunction, hemoglobinopathies or immunodeficiency (including immunodeficiency caused by medications or by human immunodeficiency virus [HIV])
   - adults and children who have any condition (e.g., cognitive dysfunction, spinal cord injuries, seizure disorders or other neuromuscular disorders) that can compromise respiratory function or the handling of respiratory secretions or that can increase the risk for aspiration
   - residents of nursing homes and other chronic-care facilities that house persons of any age who have chronic medical conditions
   - persons aged 65 years and older

2. Persons who have increased risk for influenza-associated clinic, emergency department or hospital visits:
   - children aged 24–59 months
   - persons aged 50–64 years

3. Persons who live with or care for persons at high risk for influenza-related complications:
   - healthy household contacts and caregivers of children aged 0–59 months and persons at high risk for severe complications from influenza
   - health-care workers

4. Healthy young children aged 6–59 months

The North Carolina Immunization Branch distributes childhood vaccines to local health departments, hospitals and private providers under guidelines of the North Carolina Universal Distribution Program/Vaccine for Children (UCVDP/VFC).

UCVDP/VFC influenza vaccine is available at no charge to providers for children who meet one of the following criteria:

- all healthy children 6 months through 59 months of age
- all high-risk children 6 months through 18 years of age, as identified in the ACIP recommendations
- any child (6 months through 18 years of age) who is a household contact of
    a. any child age 0 through 59 months of age or
    b. any high-risk child or adult

Billing Reminders:

1. Medicaid does not cover influenza vaccine that is supplied through UCVDP/VFC for recipients through 18 years of age.
2. Medicaid will reimburse for either the injectable or the intranasal (FluMist) influenza vaccine for those recipients 19 through 20 years of age who are vaccinated in accordance with the ACIP recommendations.
3. Medicaid does not reimburse for FluMist for recipients aged 21 years or older.
4. Medicaid will reimburse for the administration of FluMist vaccine by either CPT code 90467, 90468, 90473 or 90474 with the EP modifier appended.
5. Private providers may bill for administration fees of the injectable vaccines when physician counseling is NOT performed using CPT code 90471 or 90471 and 90472 with the EP modifier for recipients under 19 years of age. If physician counseling IS performed for children under the age of 8 years, bill using CPT code 90465 or 90465 and 90466 with the EP modifier. Local health departments may bill CPT code 90471 (non-physician counseling) or 90465 (physician counseling for recipients under 8 years of age), as appropriate, with the EP modifier for any visit other than a Health Check screening. Rural health clinics and federally qualified health centers, using the C suffix, may bill 90471 or 90465 if the immunization administration is during a Health Check visit.
6. For recipients 19 and 20 years of age in the high-risk categories, private providers may bill Medicaid for injectable influenza vaccine using CPT procedure code 90656 or 90658 and the administration CPT code 90471 or 90471 and 90472 with the EP modifier. Local health departments can bill for the influenza vaccine for 19 and 20 year olds using CPT procedure code 90656 or 90658 and the administration CPT code 90471.
7. Private providers and local health departments may bill Medicaid for injectable influenza vaccine for high-risk adults 21 or more years of age using CPT code 90656 or 90658 and the administration CPT code 90471 or 90471 and 90472.

The following tables indicate the vaccine codes that can either be reported or billed for an influenza vaccine, depending on the age of the recipient. The tables also indicate the administration codes that can be billed, depending on the age of the recipient.

NOTE: The information in the following tables IS NOT detailed billing guidance. Specific information on billing ALL immunization administration codes can be found in this bulletin ("CPT Codes 90467, 90468, 90473 and 90474—Coverage of Immunization Administration Codes for Oral/Intranasal Vaccines," p. 4).

Table 1 Influenza Billing Codes for Recipients Less Than 19 Years of Age

Vaccine CPT Code to Report	CPT Code Description
90655	Influenza virus vaccine, split virus, preservative free, for children 6-35 months of age, for intramuscular use
90656	Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, for intramuscular use
90657	Influenza virus vaccine, split virus, for children 6-35 months of age, for intramuscular use
90658	Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use
90660	Influenza virus vaccine, live, for intranasal use (FluMist)
Administration CPT Code(s) to Bill	**CPT Code Description**
90465EP	Immunization administration under 8 years of age (includes percutaneous, intradermal, subcutaneous or intramuscular injections); when the physician counsels 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)
90467EP	Immunization administration under 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
90468EP	Each additional administration (single or combination vaccine/toxoid), per day (List separately in addition to code for primary procedure) 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.
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)
90473EP	Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid).
90474EP	Each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure) NOTE: Billing CPT code 90474 for a second administration of an intranasal/oral vaccine is not applicable at this time.

Use the following codes in Table 2 to **bill** Medicaid for an influenza vaccine purchased and administered to a recipient **19 through 20 years of age**.

Table 2 Influenza Billing Codes for Recipients 19 and 20 Years of Age

Vaccine CPT Code to Bill	CPT Code Description
90656	Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, for intramuscular use
90658	Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use
90660	Influenza virus vaccine, live, for intranasal use (FluMist)
Administration CPT Code(s) to Bill	**CPT Code Description**
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)
90473EP	Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)
90474EP	Each additional vaccine (single and combination vaccine/toxoid) (List separately in addition to code for primary procedure)

Use the following codes in Table 3 to **bill** Medicaid for an influenza vaccine purchased and administered to a recipient **21 or more years of age**.

Table 3 Influenza Billing Codes for Recipients 21 or More Years of Age

Vaccine CPT Code to Bill	CPT Code Description
90656	Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, for intramuscular use
90658	Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use
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)

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 (90471 or 90471 and 90472) are reimbursed, unless the provider bills an E/M code for a separately identifiable service by appending modifier 25 to the E/M code.

EDS 1-800-688-6696 or (919) 688-6696

Attention: All Providers

Medicare Part D Prescription Drug Changes Beginning Jan. 1, 2007

Medicare and Social Security are making decisions about whether some people who qualify for extra prescription drug help, low income subsidy (LIS) or dual status in 2006, will continue to qualify in 2007. Therefore, beginning Jan. 1, 2007, providers should verify if an individual continues to qualify for the low-income subsidy (LIS), or dual status, which means these individuals would have co-pays as low as $0 and as high as $5.35. Providers should also remember to verify the prescription drug plan (PDP), as some individual plans may change with an effective date of Jan. 1, 2007.

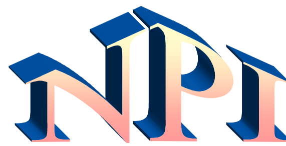
Individuals affected by these changes will receive information and notices from Medicare or Social Security. The individuals that receive notices stating that they will not qualify for the extra prescription drug help in 2007 are encouraged to complete another application, which will be enclosed with their notice.

Individuals that will automatically continue to qualify for the extra help in 2007 will also receive notices. These notices will state that they continue to qualify for the extra prescription drug help for 2007, and they do not need to take any action, as they will automatically continue to be enrolled for the extra prescription drug assistance. Also, these individuals who continue to automatically qualify for the extra prescription drug help in 2007 may be subject to co-pay increases or decreases. The co-payment level change will depend upon changes to their living arrangement, income level, resources, and household size.

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

Attention: All Providers

National Provider Identifier (NPI) Seminar



National Provider Identifier

National Provider Identifier (NPI) seminars are being held during the month of January 2007. Seminars are intended for providers that would like more detailed information on how NC Medicaid will be implementing NPI. Please go to http://www.dhhs.state.nc.us/dma/NPI/NPI%20Agenda.pdf to access the agenda to see specific topics that will be discussed.

The seminars are scheduled at the locations listed below. **Pre-registration is required.** Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

Providers may register for the NPI seminars by completing and submitting the registration form online at http://www.dhhs.state.nc.us/dma/semreg/seminar_npi.aspx. If you are planning on attending the Raleigh location that has 2 sessions, please indicate the session you plan to attend on the registration form. Morning sessions of the seminars will begin at 9:30 a.m. and end at 11:30 a.m.

Providers are encouraged to arrive by 9:15 a.m. to complete registration. Afternoon sessions will begin at 1:30 p.m. and end at 3:30 p.m. Providers are encouraged to arrive by 1:15 to complete registration.

Providers must print the PDF version of the Special December 2006 Bulletin, New Claim Form Instructions and bring it to the seminar. Providers may access the Special December 2006 Bulletin, New Claim Form Instructions using the following link: http://www.dhhs.state.nc.us/dma/bulletin/NewClaimFormInstructions.pdf.

The seminar dates, registration form and directions are on the next 2 pages of this bulletin.

Monday, January 8, 2007 Jane S. McKimmon Center 1101 Gorman Street Raleigh, North Carolina	**Tuesday, January 9, 2007** Coastline Convention Center 501 Nutt Street Wilmington, North Carolina
Tuesday, January 16, 2007 Matthews Community Center 100 McDowell Street East Matthews, North Carolina	**Wednesday, January 24, 2007** Crown Plaza Hotel and Resort One Holiday Inn Drive Asheville, North Carolina

Directions to the NPI Seminars

Jane S. McKimmon Center – Raleigh

Traveling East on I-40: Take Exit 295 and turn left onto Gorman Street. Travel approximately 2.5 miles. The McKimmon Center is located on the right at the corner of Gorman Street and Western Boulevard.

Traveling West on I-40: Take Exit 295 and turn right onto Gorman Street. Travel approximately 2.5 miles. The McKimmon Center is located on the right at the corner of Gorman Street and Western Boulevard.

Coastline Convention Center – Wilmington

From I-40 East / Raleigh Durham Area: Follow Interstate 40 East to Wilmington. As you approach Wilmington, turn right onto MLK Parkway/74 West/Downtown. Continue on route to downtown and it will become 3rd Street. Follow 3rd Street for five blocks until you reach Red Cross Street. Turn right onto Red Cross Street and follow for two blocks. Turn right onto Nutt Street. Second drive way on left is the entrance to the convention center.

From Hwy 17 S. (Jacksonville area): Stay on Hwy 17 S. as it turns into Market Street. Follow Market Street until you see the sign for 74 West / Downtown (MLK Parkway). Take 74 West (MLK Parkway) to downtown (approx 4 miles), turn right on Red Cross Street, come 2 blocks, turn right on Nutt Street. Second drive way on left is the entrance to the convention center.

From Hwy 17 N. or Hwy 74-76 (Myrtle Beach or Fayetteville area): Come across the Cape Fear Memorial Bridge into Wilmington. Take a left at the first stoplight onto 3rd Street and come downtown. Follow 3rd Street to Red Cross Street and turn left at the stoplight. Go to the bottom of the hill (approximately 3 blocks). Take a right onto Nutt Street, turn left into the main parking lot of the Coast Line Center.

Matthews Community Center – Matthews

From the North from I-77: From I-77 South, take the I-277/BROOKSHIRE FRWY/NC-16 exit- exit number 11. Merge onto I-277 S/W BROOKSHIRE FRWY/NC-16 S via exit number 11A- on the left. Merge onto US-74 E via exit number 2B- on the left- toward NC-27 E/INDEPENDENCE BLVD. Go about 9.3 miles on E. Independence Boulevard/74-East. At the light turn RIGHT onto SAM NEWELL RD (NTB and Boston Market are on the right at the corner). Go through the light at Sam Newell and 51/Matthews Township Parkway. SAM NEWELL RD becomes N TRADE ST. Go through the light, over the train tracks, then through another light at John Street. Go about two blocks and turn LEFT onto MCDOWELL ST. We are between the Matthews Elementary School and the First Baptist Church. It is a brick building with white pillars that says "Community Center" on the front. The main entrance is on the left side with the parking lot.

From the North from I-85: From I-85 South, take the I-485 exit (it is a brand new exit so I don't know the exit # and it only goes one way and that is east). Take EXIT 52 for MATTHEWS and make a RIGHT at the light at the bottom of the ramp onto West John Street. You will go about 2 miles to the stoplight at JOHN AND TRADE STREETS. Make a LEFT onto South Trade street. Go about two blocks and turn left onto Mc Dowell street We are between the Matthews Elementary School and the First Baptist Church. Arrive at 100 Mc Dowell street. It is a brick building with white pillars that says "Community Center" on the front. The main entrance is on the left side with the parking lot.

From the West: From Billy Graham Parkway go South to I-77 junction. Take I-77 South to I-485 East EXIT 2 toward PINEVILLE. Take EXIT 52 for MATTHEWS and make a LEFT at the light at the bottom of the ramp onto WEST JOHN STREET. You will go about 2 miles to the stoplight at JOHN AND TRADE STREETS. Make a LEFT onto SOUTH TRADE STREET. Go about two blocks and turn LEFT onto MCDOWELL ST. We are between the Matthews Elementary School and the First Baptist Church. It is a brick building with white pillars that says "Community Center" on the front. The main entrance is on the left side with the parking lot.

If you are coming from the South: Take I-77 North to I-485 East EXIT 2 toward PINEVILLE. Take EXIT 52 for MATTHEWS and make a LEFT at the light at the bottom of the ramp onto WEST JOHN STREET. You will go about 2 miles to the stoplight at JOHN AND TRADE STREETS. Make a LEFT onto SOUTH TRADE STREET. Go about two blocks and turn LEFT onto MCDOWELL ST. We are between the Matthews Elementary School and the First Baptist Church. Arrive at 100 MCDOWELL STREET. It is a brick building with white pillars that says "Community Center" on the front. The main entrance is on the left side with the parking lot.

From the East: From 74-WEST merge onto HIGHWAY 51 via the ramp on the RIGHT. At the end of the ramp, make a LEFT onto HIGHWAY 51 towards Matthews. At the next light, make a LEFT onto SAM NEWELL ROAD. SAM NEWELL ROAD turns into TRADE STREET. Go through the light, over the train tracks, then through another light at JOHN STREET. Go about two blocks and turn LEFT onto MCDOWELL ST. We are between the Matthews Elementary School and the First Baptist Church. Arrive at 100 MCDOWELL STREET. It is a brick building with white pillars that says "Community Center" on the front. The main entrance is on the left side with the parking lot.

Crown Plaza and Resort – Asheville

Traveling from South or West: Travel west on I-26. Follow signs for I-240 to Asheville. Stay in the left lane and take Exit 3A. Circle around right and exit onto Patton Avenue. Turn right at the second light into Regents Business Park (between Denny's and Pizza Hut). It will turn to the right; our entrance sign is on the immediate left. Follow our road (Holiday Inn Drive) past our golf course to the main entrance.

Traveling from North or East: Travel west on I-40. Take Exit 53 to I-240 West. Pass downtown Asheville. As you cross the French Broad River Bridge, stay in the right lane and take Exit 3B (Westgate and Holiday Inn Drive). Pass the Westgate Shopping Center on your right. After passing Mr. Transmission, you will see our entrance sign. Turn right onto Holiday Inn Drive and proceed to the main entrance.

"Get It! Share It! Use It! Now! Getting one is free - Not having one can be costly!"

National Provider Identifier (NPI)
Seminar Registration
(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)

For Raleigh location ONLY: 9:30-11:30________ 1:30-3:30___________

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

New Claim Form Instructions Special Bulletin

The CMS 1500 (12/90), the UB92 and the American Dental Association (ADA) 2002 paper forms have been revised and will be replaced with the new CMS 1500 (08/05), the UB-04 and ADA 2006 claim forms, respectively.

Providers may access the Special December 2006 Bulletin, New Claim Form Instructions using the following link: http://www.dhhs.state.nc.us/dma/bulletin/NewClaimFormInstructions.pdf. Providers should contact EDS with any billing questions.

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

Attention: All Providers

NDCs On Outpatient Physician-Administered Drug Claims

The Deficit Reduction Act of 2005 (DRA) includes provisions regarding State collection and submission of data for the purpose of collecting Medicaid drug rebates from manufacturers for all outpatient drug claims. In order to do this, North Carolina Medicaid will require that outpatient drug claims include both the National Drug Code (NDC) and the NDC units in addition to the HCPCS code and units. This change will be implemented sometime mid-2007 for providers who bill for drugs on the CMS-1500 claim form and for dialysis providers who bill drugs on the UB-92 claim form. The NDC numbers and NDC units will be required on the 837P and 837I transaction sets. Please look for future bulletin articles regarding this change.

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

Attention: All Providers

Payment Error Rate Measurement in North Carolina

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

CMS is using three national contractors to measure improper payments. One of the contractors, Livanta LLC (Livanta), will be communicating directly with providers and requesting medical record documentation associated with the sampled claims (approximately 800 – 1,200 claims for North Carolina). Providers will be required to furnish the records requested by Livanta, within a timeframe indicated by Livanta.

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

Provider cooperation to furnish requested records is critical in this CMS project. No response to requests and/or insufficient documentation will be considered a payment error. This can result in a payback by the provider and a monetary penalty for North Carolina Medicaid.

Program Integrity
DMA, 919-647-8000

Attention: All Providers

Rotavirus Vaccine, Pentavalent, Three-Dose Schedule, Live for Oral Use (RotaTeq), CPT 90680

Effective with date of service Aug. 1, 2006, the N.C. Medicaid program recognizes rotavirus vaccine as a covered vaccine in the Universal Childhood Vaccine Distribution Program (UCVDP)/Vaccine for Children (VFC) program. The UCVDP/VFC program provides all vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC). Currently, there is one rotavirus vaccine product, RotaTeq, manufactured by Merck and Company.

State-supplied rotavirus vaccine is available for any Medicaid-enrolled child between 6 and 32 weeks of age who meets the recommendations listed by the ACIP. ACIP recommendations can be viewed at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5512a1.htm.

Rotavirus vaccine should be administered in three doses. The first dose should be administered between 6 and 12 weeks of age, with two subsequent doses administered at 4- to 10-week intervals and all three doses administered by 32 weeks of age.

Medicaid does not reimburse for the actual vaccine for children between 6 and 32 weeks of age because state-supplied vaccine is available to all providers enrolled in the UCVDP/VFC program. Medicaid will reimburse for a vaccine administration fee, if applicable. When state-supplied rotavirus vaccine is administered, the ICD-9-CM diagnosis code V04.89 should be indicated on the claim when appropriate.

Billing Guidelines

- Report rotavirus vaccine with CPT procedure code 90680.
- Use ICD-9-CM diagnosis code V04.89 when reporting rotavirus.
- Effective with date of service Aug. 1, 2006:
  - Report CPT procedure code 90680 with no modifier at a charge of $0.00 for vaccine that was state-supplied and administered to a Medicaid recipient 6 to 32 weeks of age.
  - Bill CPT code 90473 with the EP modifier for oral rotavirus vaccine administration when appropriate.
  - Bill CPT code 90467 with the EP modifier when provider counseling is provided for children under 8 years of age.
- Refer to “CPT Codes 90467, 90468, 90473 and 90474—Coverage of Immunization Administration Codes for Oral/Intranasal Vaccines,”p.4, for how to bill using immunization administration codes.
- Providers who have had claims denied for dates of service on or after Aug. 1, 2006, may re-file those claims.

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

Attention: All Providers

Submitting Both National Provider Identifier (NPI) and Provider Number on Claims

N.C. Medicaid would like to encourage providers to begin submitting both the NPI and the Medicaid provider number on electronic claims no later than Jan. 1, 2007. If your software is not updated to submit the NPI number, please contact your clearinghouse or software vendor as soon as possible to obtain the appropriate updates. Please ensure that you keep the capability to submit the Medicaid provider number along with the NPI. N.C. Medicaid will continue to process claims using the Medicaid provider number until NPI is implemented in May 2007.

The NCECS Webtool already contains a field for submitting the NPI, so providers can begin to populate that field. For providers who bill on paper, the new paper claim forms will be available in 2007. We plan to begin testing changes to the MMIS in January 2007, and at that time we will need both the NPI and Medicaid provider numbers.

"Get It! Share It! Use It! Now! Getting one is free - Not having one can be costly!"

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

Attention: All Providers

Termination of Community Alternatives Program for Persons with AIDS

Effective with date of service Dec. 31, 2006, N.C. Medicaid will terminate the Community Alternatives Program for Persons with AIDS (CAP/AIDS) Waiver Program. A transition plan has been developed to refer the current CAP/AIDS recipients to other waiver programs, where they will be reassessed for participation.

Current providers of CAP/AIDS Waiver services must verify their recipients' participation in either CAP/DA (Disabled Adults) or CAP/C (Children) before providing services on or after January 1, 2007. The January 2007 Medicaid ID cards for the recipients who choose and are eligible to continue CAP participation will have new CAP indicator codes consistent with the waiver programs they select (CS or CI for CAP/DA; HC, SC or IC for CAP/C).

Waiver Services Offered

Additionally, case managers are responsible for issuing new service authorizations to providers of waiver services. These are required to authorize services **before** billing may occur. The waiver services for CAP/DA include:

- in-home aide (HCPCS procedure code S5125)
- personal emergency response system (PERS) (HCPCS procedure code S5161)
- adult day health care (HCPCS procedure code S5102)
- respite care, either in-home (HCPCS procedure code S5150) or institutional (HCPCS procedure code H0045)
- preparation and delivery of meals (HCPCS procedure code S5170)

The waiver services for CAP/C include:

- in-home aide (HCPCS procedure code S5125)
- nursing services (HCPCS procedure code T1000)
- in-home respite care, nurse level (HCPCS procedure code T1005)
- in-home respite care, aide level (HCPCS procedure code S5150)
- institutional respite care (HCPCS procedure code H0045)

New Referrals

Adults — All future referrals for recipients aged 18 and above who have an AIDS diagnosis, are appropriate for nursing home level of care, and have a need for services formerly covered under the CAP/AIDS program should be made by contacting the CAP/DA Lead Agency for the county where the recipient resides http://www.ncdhhs.gov/dma/CAPContactList.pdf.

Children — Recipients aged 18 and under who meet the criteria below should be referred to CAP/C by contacting the local case management agency or the Home Care Initiatives Unit at DMA, 919-855-4380.

Requirements for Children to Transition from CAP/AIDS to CAP/C

One of These…	AND…	AND…
Be an individual up to age 18 who is diagnosed with AIDS, OR Be a child up to 2 years of age who is seropositive, OR Be a child 2 through 12 years of age who is HIV seropositive and who has at least two conditions resulting from the HIV infection. These are conditions that place the child in clinical category A, B or C as defined by the Centers for Disease Control and Prevention (CDC).	Be appropriate for nursing home level of care and meet the criteria for risk of institutionalization.	Have needs for Medicaid coverage of in-home nursing or nurse-aide services. These services must include actual interventions that are medically based, continuous in nature and not solely appropriate to the child's age.

Refer to clinical coverage policies on the DMA Web site for information on CAP/DA (http://www.ncdhhs.gov//dma/cc/12.pdf) and CAP/C (http://www.ncdhhs.gov/dma/cc/capc.htm).

Clinical Policy
DMA, 919-855-4389

Attention: All Providers

Updated Effective Dates for Revised Billing Forms

This bulletin article is revised from the November 2006 general bulletin article.

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

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

The new UB04 claim form released by the NUBC for institutional providers to replace the current UB92 claim form will be accepted by North Carolina Medicaid beginning March 1, 2007. As with the CMS 1500 (08/05), the Division of Medical Assistance will allow a transition period for providers to submit either the UB92 or the UB04 until April 30, 2007. Any paper claims received on or after May 1, 2007, must be filed on the UB04 format.

The revised ADA 2006 claim form released by the ADA for dental providers to replace the current ADA 2002 claim form will be accepted by North Carolina Medicaid beginning March 1, 2007. The Division of Medical Assistance will allow a transition period from March 1, 2007, through April 30, 2007, for providers to submit either the ADA 2002 or the ADA 2007 claim forms. Any paper claims received on or after May 1, 2007, must be filed on the ADA 2006 format.

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

Attention: All Providers

Updated National Provider Identifier (NPI) Collection Forms

The Division of Medical Assistance (DMA) is currently collecting National Provider Identifier (NPI) numbers from Medicaid providers. Healthcare providers are required to complete one NPI collection form for each Medicaid provider number to ensure that North Carolina Medicaid captures the NPIs which will be used for claims processing. There are now two different collection forms on the DMA Web site: one for individual provider numbers and one for group provider numbers. Providers who have obtained an organizational or group NPI must complete an NPI collection form for the group provider number. In addition, an individual NPI collection form must be completed for each individual provider number within the group.

The required fields for completing the NPI collection form are: Medicaid Provider Number, NPI, Physical and Billing address including Zip +4 and taxonomy code(s). If more than three taxonomy codes need to be linked to one NPI number, an additional taxonomy page has been provided on the Web site. Providers can link up to 15 taxonomies to one NPI. Also, providers need to include a copy of the notification letter from the National Plan and Provider Enumeration System (NPPES). The address information provided will overlay the information currently in the system. Any other change request will require a separate change request form

The collection forms are located on the following Web site: http://www.dhhs.state.nc.us/dma/NPI.htm. Forms must be typed and returned no later than March 15, 2007. The form can be returned by the mail, fax or email addresses listed on the form. Providers will receive a confirmation notice once the NPIs have been added.

"Get It! Share It! Use It! Now! Getting one is free - Not having one can be costly!"

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

Attention: CAP/DA Lead Agencies and AQUIP Users

Quarterly Automated Quality and Utilization Improvement Program Training Seminar

The fourth quarterly Automated Quality and Utilization Improvement Program (AQUIP) training seminar for new AQUIP users in CAP/DA lead agencies is scheduled for Dec. 12, 2006, at the Park Inn in Hickory.

Attendance at this meeting is of the utmost importance for new AQUIP users. CAP/DA lead agency contacts have been informed via e-mail of any identified new AQUIP users in their counties who should attend this session. Any current AQUIP users who would like to attend the session may do so if space permits.

The AQUIP seminar is scheduled to begin at 9:00 a.m. and end at 4:00 p.m. The session will begin with discussion of Resource Utilization Group (RUGs) information. The seminar will then turn the focus toward how to maneuver a new CAP/DA client from the waiting list through the termination process while accurately completing the Client Information Sheet, Data Set Assessment and Plan of Care. System overview will be addressed in the afternoon.

Pre-registration is required; **due to holiday scheduling constraints, you will need to start registering as soon as possible on Dec. 1, 2006.** Contact your CAP/DA lead agency to verify if your name is on the required attendance list. You may register for the seminar online by going to https://www2.mrnc.org/aquip and clicking on Registrations. You will receive a computer-generated confirmation number, which you should bring to the seminar. Check-in will be from 8:30 until 9:00 a.m. on the day of the seminar; lunch will be on your own.

Park Inn Hickory - Hickory
Traveling east or west on Interstate 40, take exit 123B to U.S. 321-Business/U.S. 70, exit 44. Turn right off the exit. The hotel and Gateway conference center are on the right.

CCME, 1-800-682-2640

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

Prior Authorization for Outpatient Specialized Therapies—Implementation Date for Electronic Submission and New Forms

Beginning Feb. 5, 2007, outpatient specialized therapy providers will have the option to electronically submit prior authorization (PA) requests. For providers who continue to submit requests via fax or mail, the new PA form will also begin on Feb. 5. Refer to the July and October 2006 general Medicaid bulletins (pp. 9 and 11, respectively) for background information about this procedure change.

On Dec. 15, 2006, details and instructions about electronic submission and the new form will be available at https://www2.mrnc.org/priorauth/. All site visitors will have access to the following information:

- required documentation for electronic and fax/mail submission and how the new process differs from the current one
- description of Web site features for providers who plan to use electronic submission
- instructions to register provider number and obtain log-in information
- downloadable new PA form and instructions
- FAQs about the PA process

Once a provider registers and obtains log-in information, the following information will also be available:

- detailed instructions for electronically submitting PA, responding to missing information requests and checking the review status
- training videos demonstrating the entire submission process and account management
- PA discussion board for the provider community

All provider training and education about electronic submission and the new PA form will be performed through the Web site. After viewing the information, submit any questions/comments about the new PA process to CCME at priorauth@thecarolinascenter.org.

Ancillary Services
DMA, 919-855-4310

Attention: CMS 1500 Billers

CMS-1500 (08/05) Claim Form Information

CMS-1500 (08/05) – Medicaid will begin accepting the new claim form on Jan. 1, 2007. Please review the NUCC website at www.nucc.org for information and view the instruction manual.

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

Attention: Hospice Providers

Billing for Hospice Nursing Facility Room and Board Charges

Claims for reimbursement of hospice nursing facility room and board submitted on or after Dec. 1, 2006, must list the provider number of the facility where the recipient is in residence. This requirement applies to revenue codes 658, intermediate care, and 659, skilled care. Enter the provider number in form locator 82 on the UB-92 claim form or in the "Attending Physician ID (UPIN)" field when billing electronically. Both of the revenue codes will reimburse 95% of the nursing facility rate.

Hospice claims submitted for revenue code 658 or 659 without the nursing facility's provider number in the appropriate block will be denied.

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

Attention: Nursing Facility Providers

Activities of Daily Living (ADL) Clarification for Minimum Data Set (MDS) Validation Review

It is essential that ADL keys used by nursing facilities to code section G of the MDS are equivalent to the intent and definition of the MDS ADL key and Resident Assessment Instrument (RAI) Manual. Late loss ADL MDS values (including bed mobility, transfers, an eating component, and toilet use) are reviewed for all assessments selected for the MDS Validation review. Therefore, correct ADL definitions, supported by documentation, are crucial to a successful review. Some of the generic keys used in nursing facilities are missing key words found in the MDS key, resulting in unsupported reviews because they are inconsistent with the definitions in the RAI manual.

Some nursing facilities choose to use one set of ADL definitions on the Certified Nursing Assistant (CNA) documentation tool and a different set of definitions for the licensed nurse documentation. In this case, the facility must specify which set of ADL definitions will be used for the review.

Nursing facilities whose ADL definitions deviate from the MDS ADL key should use words that maintain the intent of the definitions like the words in bold below.

Code	Self Performance	Definition
0	Independent	**No help or oversight**
1	Supervision	**Oversight, encouragement, cueing**
2	Limited assistance	Resident highly involved in activity; **received physical help in guided maneuvering of limbs or other non–weight-bearing assistance**
3	Extensive assistance	Resident performed part of activity, **help of the following provided:** • **Weight-bearing support** • **Full staff performance**
4	Total dependence	**Full staff performance**
8	Activity did not occur	

If the ADL key intent is not clear, the MDS Validation reviewers cannot support the ADL documentation.

Other ADL MDS Validation Review Requirements:

- Providers with no ADL key associated with the ADL values will be considered unsupported.
- Providers with two different ADL supporting documentation tools per assessment (one the CNA completes and one the licensed nurse completes) will be asked to designate the one to be used for the MDS Validation review. The designated tool must be maintained in the medical record as a legal document.
- ADL keys with words for self-performance such as limited, extensive assist, etc., without the full definitions will be considered unsupported for the MDS Validation review.

- All MDS ADL codes must be represented on the ADL supporting documentation tool. For example, for self performance, the ADL supporting documentation tool must contain the codes for independent, supervision, limited assistance, extensive assistance, total dependence, and activity did not occur. ADL tools that lack codes for all the possible MDS coding options will not be accepted as supporting documentation.
- The ADL supporting documentation tool must contain the appropriate keys for both self-performance and support provided.
- The above criteria will be enforced beginning with assessments dated (in box A3a) on or after January 1, 2007.

Contacts for questions related to the MDS or MDS Validation Program are as follows:

Myers and Stauffer
Patty Padula or Cindy Smith
1-317-846-9521

North Carolina MDS Help Line
Cindy DePorter, State RAI/MDS Coordinator
919-715-1872

MDS Validation Program
Peggy Scott, RN, CRNAC, Nursing Facility Consultant
DMA Clinical Policy, 919-855-4356

Attention: Nursing Facility Providers

Nursing Facility Quality Improvement Initiatives

North Carolina Medicaid case mix reimbursement to nursing facilities began in October 2003. As a condition of receiving case mix reimbursement, nursing facilities are required to participate in quality improvement initiatives.

Points to consider when adopting quality initiatives are listed below:

1. A quality improvement initiative is a facilitywide program that has a measurable impact on the quality of care the resident receives or the quality of life the resident enjoys.
2. The impact of the initiative should be supported by current research or statistical data.
3. A quality improvement initiative could potentially span years. The initiative should be evaluated and updated by the facility for effectiveness at least annually.
4. Examples of quality initiatives that a facility might adopt include programs designed to retain and stabilize the direct-care workforce, incentive programs for direct-care workers, long-term-care staff mentoring, educational programs for staff, enhanced services for residents and adoption of Best Practices Guidelines or pieces of the facility's existing quality assurance program.
5. The facility must provide evidence that a program is in place. Evidence may include written documentation, facility staff interviews (in writing, by telephone or in person) or an on-site review of program.
6. Division of Medical Assistance (DMA) may review the facility's quality initiative(s) every 12 to 15 months.

DMA supports the N.C. New Organizational Vision Award (NC NOVA) quality initiative currently piloted in 30 different North Carolina facilities and agencies. For more information about NOVA, go to www.ncdhhs.gov/ltc, click on "Workforce Issues," then click on NOVA.

Contacts at DMA for quality initiatives:

Peggy Scott, RN, CRNAC
Case Mix Nurse Consultant
(919) 855-4356

Margaret Comin, RN, BSN, MPA
Facility Services Supervisor
(919) 855-4355

Attention: Optical Service Providers

Expediting Medically Necessary Early Eye Exams and Visual Aids

Occasionally, an urgent situation may arise in which an early eye exam or visual aid is medically necessary and requires expedition.

When this occurs, the provider should contact the Visual Services Specialist at (919) 855-4310. If deemed medically necessary by the Visual Services Specialist, the services will be expedited. Since each request is unique, the Visual Services Specialist will provide specific processing instructions for each approved, expedited request.

Continue to submit routine and non-urgent early eye exam and visual aid prior approval requests to EDS on the following forms:

- Eye exam—Request for Prior Approval North Carolina Medicaid Program (372-118)
- Visual aid—Request for Prior Approval for Visual Aids Form (372-017 or 372-017A)

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

Attention: Optical Service Providers

Update of ICD-9-CM Diagnosis Codes for Visual Field Exams (92081, 92082 and 92083)

According to the *ICD-9-CM 2006 Professional Coding Manual* (6th edition), the following ICD-9-CM diagnosis codes for billing visual field testing now require 4th and possibly 5th digits.

250.00	250.01	250.02	250.03	250.50	250.51	250.52	250.53
343.0	360.00	360.40	361.00	362.30	362.40	362.50	362.60
362.70	363.20	364.10	365.00	365.60	369.00	369.20	370.00
377.00	377.10	377.30	379.50	710.00	743.20	950.0	

This list is not an all-inclusive listing of diagnosis codes covered for visual field exams; it includes only the diagnosis codes that were updated. Please refer to the Optical Services Manual located on the DMA Web site at http://www.ncdhhs.gov/dma/optical.htm for further information on optical services.

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

Attention: Physicians and Nurse Practitioners

Bevacizumab (Avastin, J9035)—Update to Billing Guidelines

The N.C. Medicaid program covers bevacizumab (Avastin) for use in the Physician's Drug Program for the diagnosis of malignant neoplasm of the colon, rectum, rectosigmoid junction and anus. The Food and Drug Administration has also approved Avastin for the diagnosis of non–small cell lung carcinoma.

In accordance with the new FDA-approved diagnosis for Avastin, the following ICD-9-CM **diagnosis codes** are required when billing for Avastin:

- **V58.1**—admission or encounter for chemotherapy **must be billed**

  and
- an **ICD-9-CM** diagnosis code in one of the following groups:
  1. 153.0 through 154.8
  2. 162.2 through 162.9

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

Attention: Physicians and Nurse Practitioners

Ibandronate Sodium 3-mg/3-mL injection (Boniva, HCPCS Procedure Code J3490)—Billing Guidelines

Effective with date of service March 1, 2006, the N.C. Medicaid program covers ibandronate sodium (Boniva) injection for use in the Physician's Drug Program when billed with HCPCS procedure code J3490 (unclassified drug code). Boniva injection is a nitrogen-containing bisphosphonate that inhibits osteoclast-mediated bone resorption. It is indicated for the treatment of osteoporosis in postmenopausal women. The injectable form of Boniva is intended for intravenous administration only. According to the manufacturer's guidelines, Boniva should not be administered more often than every three months. It is available in a 3-mg/3-mL single-use, prefilled syringe.

For Medicaid Billing:

- Bill one of the following ICD-9-CM diagnosis codes for Boniva:
  - 733.01 (senile osteoporosis) OR
  - 733.09 (drug-induced osteoporosis) with the E code to identify the drug
- Bill Boniva with HCPCS code J3490 (unclassified drug code).
- Submit an original invoice, or copy of the original invoice, with the CMS-1500 claim form. **An invoice must be submitted with each claim.** The paper invoice must include the recipient's name and Medicaid identification number, the name of the medication, the dosage given, the National Drug Code (NDC) number from the vial(s) used, the number of vials used and the cost per dose.
- Indicate the unit given in block 24G on the CMS-1500 claim form.
- Bill the usual and customary charge.

For Medicaid billing, one unit of coverage is the 3-mg/3-mL syringe. The maximum reimbursement rate is $406.57 per unit. Claims denied for dates of service on or after March 1, 2006, may be resubmitted.

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

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

Attention: Prescribers

Behavioral Pharmacy Management Project

Division of Medical Assistance (DMA) is engaged in an ongoing project to provide information to prescribers about behavioral medication usage of N.C. Medicaid recipients. The informational product, Behavioral Pharmacy Management (BPM), was developed by Comprehensive Neuroscience Inc. (CNS), an independent company. BPM analyzes pharmacy claims for certain quality indicators that suggest a possible variance from generally accepted evidence-based or consensus-based prescribing guidelines and thus may either represent high risk to patients or pose problems for continuity and coordination of care.

Once a month, prescribers are mailed information about any of their patients whose pharmacy claims triggered such an alert. Feedback is encouraged; a feedback form and addresses for Web-based or mailed responses are included in the packet.

If any information in the packet is incorrect (for example, not my patient, did not write script), please respond by faxing the prescriber feedback form to 919-674-2538.

DMA, 919-855-4300

Attention: All Providers

Required Fields on New Provider Enrollment Applications and Provider Change Form

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

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

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

If you have not enumerated, please check our website at http://www.dhhs.state.nc.us/dma/NPI.htm for info or enumerate at NPI at https://nppes.cms.hhs.gov/NPPES/Welcome.do.

"Get It! Share It! Use It! Now! Getting one is free - Not having one can be costly!"

Providers Services
DMA, 919-855-4050

NCLeads Update

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

Provider Relations
Office of MMIS Services
919-647-8315

Proposed Clinical Coverage Policies

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

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.

2006-2007 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
December	12/01/06	12/05/06
	12/08/06	12/12/06
	12/15/06	12/21/06
January	01/05/07	01/09/07
	01/12/07	01/17/07
	01/19/07	01/25/07
February	02/02/07	02/06/07
	02/08/07	02/13/07
	02/15/07	02/20/07
	02/22/07	02/28/07

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

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

Cheryll Collier
Executive Director
EDS