December 2008 Medicaid Bulletin

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

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Attention: NCECSWeb Tool Users

Addition of Taxonomy Code to List Management Function

Providers are now able to save the taxonomy codes under the list management function on the NCECS Web Tool. This function allows providers to auto-populate taxonomy codes into the Billing Taxonomy and Rendering/Attending Taxonomy fields on the NCECSWeb Tool. As a reminder, the CMS-1500 (837P) and ADA (837D) electronic formats allow only one taxonomy code per claim.

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

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

Attention: All Providers

Change in Banks for EDS

DMA has approved EDS, an HP company, to make the following changes for N.C. Medicaid payments:

- Issue warrants on a State Treasurer account rather than issuing checks from a bank. This will have no impact to providers' receipt of payment; however, the appearance of the document will include these statements:
  - "Payable at par through Federal Reserve System" with references to the N.C. State Treasurer.
  - "VOID AFTER 90 DAYS."
- Issue Direct Deposit (or Electronic Funds Transfer or Electronic Warrant) on a new Wachovia account. There will be no need to resubmit requests for EFT and there will be no transition period in which checks will be issued. Providers receiving funds directly into designated accounts may see slight changes in how the payments are referenced in their bank records, but will probably see very few other changes.

Providers may anticipate seeing these changes in December 2008 or January 2009.

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

Attention: All Providers

Clinical Coverage Policies

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

- 1-O-2, Craniofacial Surgery

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

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

Denials for CPT Procedure Code 20551

CPT procedure code 20551 (injection(s); single tendon origin/insertion) is allowed up to six units per day. Some detail lines on claims have been denied or suspended for CPT procedure code 20551 with the following EOBs:

- EOB 080 (Units of service are not consistent with dates of service. Physician claims: If dates are not consecutive, list each date of service on a separate line. Correct and resubmit.)
- EOB 7995 (Please resubmit claim with documentation of all surgery procedures performed by this provider for this date of service.)

Changes have been made to the claims payment system to correct the problem. Providers who received claim detail denials related to EOB 080 or EOB 7995 for CPT procedure code 20551 may resubmit the denied charges as a new claim (not as an adjustment request) for processing.

When filing a claim for CPT procedure code 20551 with multiple units, bill procedure code 20551 with one unit on the first detail, and procedure code 20551 with modifier 51 and subsequent units on the second detail.

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

Attention: All Providers

Denials for CPT Procedure Codes 96401 and 96402

System issues occurred that may have caused some detail lines on claims to be denied with EOB 080 (Units of service are not consistent with dates of service. Physician claims: If dates are not consecutive, list each date of service on a separate line. Correct and resubmit.) for the following CPT procedure codes:

- 96401 (chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic)
- 96402 (chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic)

Changes have been made to the claims payment system to correct the problem. Providers who received claim detail denials related to EOB 080 for CPT procedure codes 96401 or 96402 may resubmit the denied charges as a new claim (not as an adjustment request) for processing.

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

Attention: All Providers

DTaP-Hib-IPV (Pentacel, CPT Procedure Code 90698) – Billing Guidelines

Effective with date of service September 1, 2008, N.C. Medicaid recognized DTaP-Hib-IPV (Pentacel) as a covered vaccine in the Universal Childhood Vaccine Distribution Program (UCVDP)/Vaccines for Children (VFC) Program. All of the vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) are available through the UCVDP/VFC Program. UCVDP/VFC provides Pentacel for all children as part of their primary series of DTaP, polio, and Hib vaccines.

Pentacel is licensed for a 4-dose series (three primary doses and one booster dose) of DTaP, Hib, and polio at 2, 4, 6, and 15 through 18 months of age. Due to the current reduced supply of PedvaxHIB and ActHIB, the introduction of Pentacel should allow providers to continue administering the primary series of Hib vaccine. However, the CDC continues to recommend deferral of the 12- through 15-month Hib booster dose, except for high-risk children, who should continue to receive the booster. Due to these recommendations, Pentacel may not be used for the 12- through 15-month booster in otherwise healthy children until further notice. For providers who choose to use Pentacel rather than the previously available DTaP, Hib, and polio vaccines, UCVDP recommends integrating Pentacel into your practice **for children born on or after July 1, 2008.** Children already started on Pediarix or separate DTaP, HiB, and polio vaccines should complete the series with those same products. Pentacel is not licensed for anyone over the age of 4 years.

Medicaid does not reimburse for the actual vaccine 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 Pentacel vaccine is administered, indicate the ICD-9-CM diagnosis code V06.3 on the claim when appropriate. Refer to the April 2008 Special Bulletin, *Health Check Billing Guide 2008* (http://www.ncdhhs.gov/dma/healthcheck.htm), for detailed billing guidelines.

For Medicaid Billing:

- Report Pentacel vaccine with CPT procedure code 90698 (diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated [DTaP-Hib-IPV], for intramuscular use).
- The ICD-9-CM diagnosis code for billing Pentacel is V06.3 (need for prophylactic vaccination and inoculation against combinations of diseases; DTP+polio).
- Providers who received claim detail denials for the administration of Pentacel for dates of service on or after September 1, 2008, may resubmit the denied charges as new claims (not as adjustment requests) for processing.
- Providers who received claim detail payments for the administration of other injections, and would like to receive additional reimbursement for the Pentacel administration for dates of service on or after September 1, 2008, may submit replacement claims for processing. If the electronic replacement claim option is not available, providers may submit adjustments.

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

Attention: All Providers

DTaP-IPV (Kinrix, CPT Procedure Code 90696) – Billing Guidelines

Effective with date of service September 1, 2008, N.C. Medicaid recognized DTaP-IPV (Kinrix) as a covered vaccine in the Universal Childhood Vaccine Distribution Program (UCVDP)/Vaccines for Children (VFC) Program. All of the vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) are available through the UCVDP/VFC Program. The UCVDP/VFC program provides state-supplied Kinrix as an alternative to currently available DTaP and polio vaccines only for the 4- through 6-year booster dose of DTaP and polio vaccines. For additional information, see the Kinrix package insert at http://us.gsk.com/products/assets/us_kinrix.pdf.

Medicaid does not reimburse for the actual vaccine 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 Kinrix vaccine is administered, indicate the ICD-9-CM diagnosis code V06.8 on the claim when appropriate. Refer to the April 2008 Special Bulletin, *Health Check Billing Guide 2008* (http://www.ncdhhs.gov/dma/healthcheck.htm), for detailed billing guidelines.

For Medicaid Billing:

- Report Kinrix vaccine with CPT procedure code 90696 (diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated [DTaP-IPV], when administered to children 4 years through 6 years of age, for intramuscular use).
- The ICD-9-CM diagnosis code for billing Kinrix is V06.8 (need for prophylactic vaccination and inoculation against combinations of diseases; other combinations).
- Providers who received claim detail denials for the administration of Kinrix for dates of service on or after September 1, 2008, may resubmit the denied charges as new claims (not as adjustment requests) for processing.
- Providers who received claim detail payments for the administration of other injections, and would like to receive additional reimbursement for the Kinrix administration for dates of service on or after September 1, 2008, may submit replacement claims for processing. If the electronic replacement claim option is not available, providers may submit adjustments.

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

Attention: All Providers

Out-of-State Enrollment

Enrollment of out-of-state providers, when applicable, is time-limited and may not exceed 365 days. As mandated by the N.C. Administrative Code (10A NCAC 22O.0119), reimbursement is limited to

- services rendered to N.C. Medicaid recipients in response to an emergency;
- prior-approved non-emergency services; and
- medical equipment and devices that are not available through an enrolled provider located within the State of North Carolina or in the 40-mile border area.

It is the responsibility of the out-of-state provider to re-enroll with the N.C. Medicaid Program each time an emergency service or prior-approved non-emergency service is rendered.

Provider Services
DMA, 919-855-4050

Attention: All Providers

Payment of Annual Physical Exam Visits for Recipients with Family Planning Waiver Coverage

As documented in the May 2006 Special Bulletin, *Family Planning Waiver* (http://www.ncdhhs.gov/dma/bulletinspecial.htm), recipients with Family Planning Waiver (MAFD) benefits must receive an annual physical exam before other services provided through the waiver can be covered by Medicaid. An annual physical exam must be administered while the recipient is eligible under MAFD, regardless of procedures administered prior to MAFD eligibility and for which Medicaid covered under a different program.

DMA has become aware of the denial of claims submitted with annual physical exam codes for recipients who were covered under the Family Planning Waiver. These claims were denied because a claim with an annual physical exam code had been paid within 365 days of the current date of service, even if the recipient received Medicaid under another coverage category.

Changes have been made in the claims processing system that will allow a provider to bill for an annual physical exam for an MAFD recipient, even if the recipient had another annual physical exam within the previous 365-day period. Claims with dates of service from October 1, 2005, to October 15, 2008, that were denied because the MAFD recipient received another annual physical exam under another Medicaid coverage category within the previous 365 days can be resubmitted as new claims (not as adjustments). In order to qualify for reimbursement, providers must resubmit these claims between December 1, 2008, and February 28, 2009.

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

Attention: CAP/DA Lead Agencies

Automated Quality and Utilization Improvement Program Quarterly Training Seminar

The Carolinas Center for Medical Excellence (CCME; http://www.thecarolinascenter.org) announces continued quarterly training for new users of the Automated Quality and Utilization Improvement Program (AQUIP) for CAP/DA lead agencies.

The fourth quarterly training session this year will be held on December 17, 2008, at the Holiday Inn Crowne Plaza in Asheville. The seminar is scheduled to begin at 9:00 a.m. and end at 3:00 p.m. Attendance is of the utmost importance for new AQUIP users. CAP/DA lead agency contacts have been informed via e-mail of new users in their counties who should attend this session. Current users who would like to attend the session may do so if space is available. However, the information presented is intended for new users.

Pre-registration is required. New AQUIP users should contact their CAP/DA lead agency to verify if their name is on the required attendance list. Online registration for the seminar will be available beginning December 1, 2008, and can be accessed by going to https://www2.mrnc.org/aquip and clicking on "Training Sessions." Attendees will receive a computer-generated confirmation number, which they should bring to the seminar. Check-in will be from 8:30 a.m. until 9:00 a.m. on the day of the seminar; lunch will be on your own.

The session will provide information on Resource Utilization Group (RUG) scores, and will focus on accurately completing the three parts of the AQUIP tool (client information sheet, data set assessment, and plan of care) and resolving common data entry errors. The session will end with an overview of Health Check/Early Periodic Screening, Diagnostic and Treatment (EPSDT) for Medicaid-eligible recipients under the age of 21.

We recommend that all attendees read and become familiar with the AQUIP User Manual prior to the training session. The manual is available on the AQUIP website (https://www2.mrnc.org/aquip) under "Downloads."

Directions to the Seminar

Holiday Inn Crowne Plaza and Resort

Traveling West on I-40

Take I-40 West to Exit 53B. Merge onto I-240 towards downtown Asheville. As you cross the French Broad River Bridge, merge into the far right-hand lane for Exit 3B (Westgate and Resort Drive). Merge into the right lane as you pass the Westgate Shopping Center. The entrance to the hotel is on the right immediately as you round the curve in the road.

Traveling East on I-40

Take I-40 East to Exit 46. Merge onto I-240 towards downtown Asheville. Merge into the left lane and take Exit 3A, which merges onto Patton Avenue. At the 2nd traffic light, turn right onto Regent Park Boulevard (between Denny's and Pizza Hut). The road will bear to the right. The entrance to the hotel is on the left just before the entrance to the Sam's Club parking lot. Follow the road past the golf course to the main entrance of the hotel.

CCME, 1-800-682-2650

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

Changes to Outpatient Specialized Therapies

Effective with date of service December 22, 2008, prior approval through the Carolinas Center for Medical Excellence (CCME) will **NO** longer be required for outpatient specialized therapy treatment services. Do not send requests to CCME after this date.

DMA will announce changes to the limits on adult services and updates to Clinical Coverage Policy 10A, *Outpatient Specialized Therapies* (http://www.ncdhhs.gov/dma/mp/mpindex.htm), in a future Medicaid bulletin. Visit limits for children will remain at 52 visits per 6 months, per discipline, with prior approval requests required for visits over 52.

ALL policy guidelines for Clinical Coverage Policy 10A remain in effect except for the prior approval requirements. Post-payment validation will be conducted to ensure that all policy requirements and medical necessity criteria are met.

Important: All providers who bill using the CMS-1500 claim form still must enter the V code as a secondary diagnosis on the claim even after prior approval is terminated.

Nora Poisella, Clinical Policy and Programs
DMA, 919-855-4310

Attention: Durable Medical Equipment Providers and Home Health Agencies

Community Care of North Carolina/Carolina ACCESS

In October 2008, there were 1,010,208 Medicaid recipients in North Carolina enrolled in Community Care of North Carolina/Carolina ACCESS (CCNC/CA). Eligible recipients are enrolled in a medical home, which provides the patient with a primary care provider (PCP) who coordinates health care for their enrollees.

Providers of durable medical equipment (DME) and home health agencies must obtain the PCP's authorization for services in order to receive reimbursement from Medicaid. As the patient's coordinator of care, the PCP is responsible for authorizing services by another provider based on medical necessity whether or not the patient has been seen by the PCP. If a claim denies for EOB 270 or EOB 286, the service provider can request an override; however, an override will be considered only under certain circumstances (for example, a recipient was enrolled incorrectly). The following are procedures for requesting an override:

- The PCP must first deny authorization for the service.
- The request for an override must be submitted within six months of the date of service.
- The override request must be submitted using the Carolina ACCESS Override Request form. The form can be found on the DMA website at http://www.ncdhhs.gov/dma/formsca.html. It must be completed in its entirety and written legibly or it will be returned.
- Override requests may be mailed to EDS or faxed to EDS at 919-816-4420. Providers should not contact DMA.

It is the provider's responsibility to contact EDS to resolve any payment issue. Recipients should not be instructed to request an override; an override number **will not** be given to a recipient.

Although a PCP can authorize services after they have been rendered, it is in the best interest of the service provider to contact the PCP for authorization before providing the service. The name and contact information of the recipient's PCP is printed on the monthly Medicaid identification card. It is very important for the service provider to see the card each month as the PCP may change from month to month. The service provider may also get information about a recipient's current eligibility and PCP enrollment by calling Automated Voice Response (AVR) system at 1-800-723-4337.

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

Attention: Hospice Providers

Core Based Statistical Area Code Pricing Structure for Revenue Codes RC651, RC652, RC655, and RC656

Effective October 1, 2005, CMS changed the hospice pricing structure from Metropolitan Statistical Area (MSA) codes to Core Based Statistical Area (CBSA) codes. The N.C. Medicaid Program is mandated by the Social Security Act to follow Medicare's lead regarding pricing of hospice claims. DMA has priced hospice claims accordingly for the four prospectively determined rate categories (routine home care, continuous home care, inpatient respite care, and general inpatient care). Hospice providers should expect that their claims will price based on the location of the delivered service. Effective January 1, 2009, hospice providers are required to indicate on hospice claims the CBSA for the location where hospice care is provided (e.g., patient's residence, nursing homes, assisted living facility, hospital unit) on all claims submitted for payment.

Please refer to the UB-04 example below showing the Attending Service Facility Location ZIP code in FL1 and the Billing Location in FL2 (if different from FL1).

Location of Services 111 Main St. Greensboro, NC 27410-1234	Hospice Billing Information 222 First St. Greensboro, NC 27410-4321

The table below reflects the CBSA codes in comparison with the MSA coding:

Metropolitan Statistical Area (Counties)	SC	CBSA	MSA
Asheville, NC **(Buncombe, Haywood, Henderson, Madison Co.)**	39	**11700**	480
Burlington, NC **(Alamance Co.)**	00B	**15500**	34
Charlotte/Gastonia/Rock Hill/Concord, NC/SC **(Anson, Cabarrus, Gaston, Mecklenburg, Union, York Co.)**	41	**16740**	1520
Durham, NC **(Chatham, Durham, Orange, Person Co.)**	00A	**20500**	6640
Fayetteville, NC **(Cumberland, Hoke Co.)**	42	**22180**	2560
Goldsboro, NC **(Wayne Co.)**	105	**24140**	2980
Greensboro/High Point, NC **(Guilford, Randolph, Rockingham Co.)**	43	**24660**	3120
Greenville, NC **(Greene, Pitt Co.)**	106	**24780**	3150
Hickory/Lenoir/Morganton, NC **(Alexander, Burke, Caldwell, Catawba Co.)**	44	**25860**	3290
Jacksonville, NC **(Onslow Co.)**	45	**27340**	3605
Raleigh/Cary, NC **(Franklin, Johnston, Wake Co.)**	46	**39580**	6640

Metropolitan Statistical Area (Counties)	SC	CBSA	MSA
Rocky Mount, NC (Edgecombe, Nash Co.)	108	**40580**	6895
Wilmington, NC (Brunswick, New Hanover, Pender Co.)	47	**48900**	9200
Winston-Salem, NC (Davie, Forsyth, Stokes, Yadkin Co.)	00C	**49180**	3120
Rural Counties	53	**34**	9934
Norfolk (Currituck Co.)	107	**47260**	5720

Please refer to the UB-04 claim example below reflecting the Value Code 61 and an example CBSA code:

	39 VALUE CODES CODE	AMOUNT		40 VALUE CODES CODE	AMOUNT		41 VALUE CODES CODE	AMOUNT	
a				61	15500				
b									
c									
d									

For further information, please refer to Clinical Coverage Policy 3D, *Hospice Services*, on DMA's website at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

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

Attention: Laboratories

Pap Smear Interpretation Billed for Recipients with Family Planning Waiver Coverage (MAFD)

CPT procedure code 88141 (cytopathology, cervical or vaginal [any reporting system] requiring interpretation by physician) is billed only for interpretation of a Pap smear. The May 2006 Special Bulletin, *Family Planning Waiver* (http://www.ncdhhs.gov/dma/bulletinspecial.htm), instructs providers to bill CPT procedure code 88141 in conjunction with procedure codes 88142 through 88154 or 88164 through 88167. DMA has become aware that claims have incorrectly denied with EOB 2700 (Exceeds limitation(s) for waiver recipient) when procedure code 88141 was billed with the Pap smear procedure codes.

The claims processing system has been modified to allow CPT procedure code 88141 to be billed in conjunction with 88142 through 88154 or 88164 through 88167. Claims for dates of service October 1, 2005, to August 15, 2008, that were denied with EOB 2700 when procedure code 88141 was billed with another Pap smear procedure code have been systematically reprocessed. It is not necessary for providers to resubmit the claim.

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

Attention: Institutional (UB-04/837I) Billers and NCECSWeb Tool Users

New Payer Codes

With the implementation of the UB-04 claim form, the N.C. State Uniform Billing Committee eliminated the Payer Class and Carrier Code and replaced it with a Payer Code. As a result, Payer Codes must be billed on the UB-04, 837 institutional transactions, and the NCECSWeb Tool institutional claims. The Payer Code for N.C. Medicaid is "MC" and must be used instead of the Payer Class and Carrier Code "DNC00," previously used to designate the payer.

Payer Codes

Payer Code	Description	Payer Code	Description
09	Self Pay	DS	Disability
10	Central Certification	HM	Health Maintenance Organization
11	Other Non-Federal Programs	LI	Liability
12	Preferred Provider Organization (PPO)	LM	Liability Medical
13	Point of Service (POS)	MA	Medicare Part A
14	Exclusive Provider Organization (EPO)	MB	Medicare Part B
15	Indemnity Insurance	MC	Medicaid
16	Health Maintenance Organization (HMO) Medicare Risk	OF	Other Federal Program
AM	Automobile Medical	TV	Title V
BL	Blue Cross/Blue Shield	VA	Veteran Administration Plan
CH	CHAMPUS	WC	Workers' Compensation Health Plan
CI	Commercial Insurance Company	ZZ	Mutually Defined

Please refer to the ASC X12N 837 (004010X096) Implementation Guide under Claim Filing Indicator Code for additional filing instructions related to 837I transactions.

The NCECSWeb Tool was modified to use the Payer Code on the following screens:

- UB Data (claim display)
- UB Data Add/Edit
- UB Insurance Add/Edit Detail
- Payer List Select
- Payer List Add
- Payer List Edit

The Payer Code selection can be driven by a standardized list stored in the NCECSWeb Tool institutional claim.

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

Attention: Nurse Practitioners and Physicians

Romiplostim (Nplate, HCPCS Procedure Code J3490) – Billing Guidelines

Effective with date of service August 1, 2008, the N.C. Medicaid Program covers romiplostim injectable (Nplate) for use in the Physician's Drug Program when billed with HCPCS procedure code J3490 (unclassified drug). Nplate is available as 250-mcg and 500-mcg single-use vials.

Nplate is indicated for the treatment of thrombocytopenia in patients with chronic immune (idiopathic) thrombocytopenic purpura (ITP) who have had an insufficient response to corticosteroids, immunoglobulins or splenectomy. Nplate should be used only in patients with ITP whose degree of thrombocytopenia and clinical condition increase the risk for bleeding. Nplate should not be used in an attempt to normalize platelet counts.

Nplate should be administered as a subcutaneous injection. The initial dose of Nplate should be 1 mcg/kg once weekly. Adjust the weekly dose by increments of 1 mcg/kg to achieve and maintain a platelet count $\geq 50 \times 10^9$/L as necessary to reduce the risk for bleeding. Do not exceed the maximum weekly dose of 10 mcg/kg. Do not dose if platelet count is $> 400 \times 10^9$/L. In clinical studies, most patients who responded to Nplate achieved and maintained platelet counts of at least 50×10^9/L with a median dose of 2 mcg/kg.

Nplate is available only through a restricted distribution program called the Nplate NEXUS (Network of Experts Understanding and Supporting Nplate and Patients) Program.

For Medicaid Billing:

- The ICD-9-CM diagnosis code required for billing Nplate is **287.31** (idiopathic thrombocytopenic purpura).
- Providers should bill Nplate with HCPCS procedure code J3490 (unclassified drug).
- One Medicaid unit of coverage is 10 mcg. The maximum reimbursement rate, per 10 mcg, is $47.82. The entire single-use vial(s) of Nplate may be billed.
- Providers must bill National Drug Codes (NDCs); a paper invoice is not required. Refer to the October 2008 Special Bulletin, *National Drug Code Implementation Phase III* (http://www.ncdhhs.gov/dma/bulletinspecial.htm), for instructions.
- Providers must bill their usual and customary charges.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Proposed Clinical Coverage Policies

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

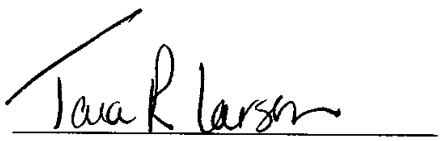
Loretta Bohn
Division of Medical Assistance
Clinical Policy Section
2501 Mail Service Center
Raleigh NC 27699-2501

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

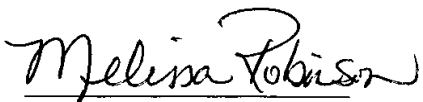
2008/2009 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
December	11/26/08	12/02/08
	12/04/08	12/09/08
	12/11/08	12/16/08
	12/18/08	12/29/08
January	01/08/09	01/13/09
	01/15/09	01/21/09
	01/22/09	01/29/09
	01/29/09	02/03/09

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.



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



Melissa Robinson
Executive Director
EDS, an HP Company