December 2009 Medicaid Bulletin

In This Issue . . . ***Page***

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

Attention: All Providers

EDS Announces New Name

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

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

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

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

Attention: All Providers

Electronic Funds Transfer

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

Providers must complete and submit an EFT Authorization Agreement for Automatic Deposits (http://www.ncdhhs.gov/dma/provider/forms.htm) immediately to ensure that there is no disruption to payments. Claims will suspend for 45 days if an EFT Authorization Agreement has not been submitted to and processed by the N.C. Medicaid Program. After 45 days, the claim will deny with EOB 2901 (Denied due to inactive EFT status). Providers must complete and submit an EFT Authorization Agreement prior to resubmitting a new claim (not an adjustment).

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

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

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

Notice of the requirement for electronic payments was first published in the June 2009 Medicaid Bulletin with additional articles published in July, September, October, and November. The Medicaid Bulletin is available on DMA's website at http://www.ncdhhs.nc.gov/dma/bulletin/.

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

Attention: All Providers

Electronic Claim Submission EOB Code

The following article was originally published in the October 2009 and November 2009 Medicaid Bulletin (http://www.ncdhhs.nc.gov/dma/bulletin/).

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

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

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

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

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

Notice of the requirement for electronic claims submission was first published in the June 2009 Medicaid Bulletin with additional articles published in July, August, September, and October. The Medicaid Bulletin is available on DMA's website at http://www.ncdhhs.nc.gov/dma/bulletin/.

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

Attention: All Providers

Paper Claim Submissions

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

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

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

Attention: All Providers

North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool

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

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

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

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

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

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

Step One:

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

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

Step Two:

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

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

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

Attention: All Providers

Notice of Legislative Mandate for PASRR

As of November 1, 2009, DMA and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH) no longer require an Annual Resident Review (ARR) for level II recipients. Please note that nursing facilities are still responsible for completing a change in condition screen should there be a change in the condition of the admitted recipient. The change in condition review will determine if serious mental illness (SMI), mental retardation (MR) or a related condition (RC) is evident and, if so, a new level II will be initiated and scheduled. Also note that **the name of this program has changed to Preadmission Screening and Resident Review (PASRR).**

Notice of Legislative Mandate for PASRR

The House and Senate voted and approved a $19 billion state budget. With the budget passed, the N.C. Legislature will mandate the use of electronic transactions by all providers who are required to conduct a PASRR.

Who Will this Affect?

This mandate will affect all providers who are currently submitting PASRR requests and Tracking forms by fax, regular mail or phone. Beginning on December 1, 2009, all providers will be required to submit PASRR screening or Tracking forms through the State's web-based tool or through a third-party vendor with interface capabilities into the State's web-based tool.

When is the Effective Date?

The effective date mandated by the bill is September 1, 2009; however, DMA will continue to accept fax transmissions for up to 90 days as providers transition to the web-based tool. Effective December 1, 2009, all providers will be required to submit PASRR and Tracking forms through the State's web-based tool or through a third-party vendor with interface capabilities into the State's web-based tool.

The North Carolina Health Care Facilities and Hospital Associations have worked with HP Enterprise Services (EDS) and DMA to ease the facilitation of compliance with this mandate. The PASRR form that is available by virtue of DMA's contract with HP Enterprise Services (EDS) has been reduced to required information, is equipped with user-friendly auto population of information, and has easy to use default mechanisms. The Associations believe that the time required to complete the automated form will be minimal.

Please Note: Organizations currently submitting PASRR screenings and Tracking forms through Provider Links Online Application can continue to use this method.

For more information, please visit http://www.ncmust.com or call the NC PASRR team at 1-800-688-6696 or 919-851-8888, option 7.

HP Enterprise Services
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, CMS implemented a national Payment Error Rate Measurement (PERM) Program to measure improper payments in the Medicaid Program and the State Children's Health Insurance Program (SCHIP). North Carolina has been selected as one of 17 states required to participate in PERM reviews of Medicaid fee-for-service and Medicaid managed care claims paid in federal fiscal year 2010 (October 1, 2009, through September 30, 2010). The PERM SCHIP measurement is on hold until publication of the new final rule.

CMS is using two 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. Providers will be required to furnish the records requested by Livanta, within a timeframe indicated by Livanta.

It is anticipated that Livanta will begin requesting medical records for North Carolina's sampled claims in January 2010. Providers are urged to respond to these requests promptly with timely submission of the requested documentation.

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

Program Integrity
DMA, 919-647-8002

Attention: All Providers

Flu Testing: CPT Codes 87400 and 87804

Providers can bill for one unit of flu A and one unit of flu B by using CPT procedure code 87400 (infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; influenza, A or B, each) for a total of two units per day. Or, providers can bill two units of CPT procedure code 87804 (infectious agent antigen detection by immunoassay with direct optical observation; influenza) with the QW modifier.

Providers who received a denial with EOB 5201 (Diagnostic procedure allowed once per day unless billed with appropriate modifier) when billing for more that one flu test on the same date of service may correct and resubmit the denied claim for payment if they have filed their claims timely.

HP Enterprise Services
1-800-688-6696 or 919-855-8888

Attention: All Providers

Submitting Secondary and Tertiary Claims Electronically/837 Transaction

Effective with date of processing October 2, 2009, all providers must file claims electronically. Only claims that comply with the list of exceptions to the requirement for electronic claim submissions may be submitted on paper. The list of electronic claims submission (ECS) exceptions can be found on DMA's ECS Exceptions web page at http://www.ncdhhs.gov/dma/provider/ECSExceptions.htm.

Secondary and tertiary claims may be required to be submitted electronically depending on the status of the primary claim(s). Refer to the following instructions to ensure claims are submitted correctly.

When the Primary Payer Makes a Payment

For all claim types including professional, institutional and dental, the claims should be submitted to Medicaid electronically. Providers have various options when submitting electronic claims via the 837 transaction. The N.C. Electronic Claim Submission/Recipient Eligibility Verification Web Tool (NCECSWeb) is the State-supplied web-based option for submitting claims electronically free of charge. Providers may also contract with a vendor or clearinghouse or they may also have in-house software. If there are questions regarding placement of information on contracted software, providers are advised to consult with their vendor/clearinghouse or the ECS department at HP Enterprise Services. To contact HP Enterprise Services, providers should call 1-800-688-6696, option 1. Online assistance is also available in the HIPAA companion guides on DMA's website at http://www.ncdhhs.gov/dma/hipaa/compguides.htm.

When a payment is not made on the primary claim, the secondary claim should be submitted to Medicaid in accordance with the claim type.

If it is on a **professional** claim or a **dental** claim, it should be submitted on paper using the Medicaid Resolution Inquiry Form. All documents supporting the override request should be included with the form. However on a **professional** claim, if there is a Medicare Part B primary claim that applies 100% of the payment to the deductible, it should be submitted electronically. Medicaid will recognize the deductible amount and pay the appropriate percent based on the provider type and specialty.

If it is on an **institutional** claim, the secondary claim should be submitted electronically using occurrence and/or condition codes to override third-party insurance and/or Medicare Part A or B.

Note: Providers can override Medicare electronically. When billing on the professional or the institutional claim form, please refer to the August 2009 bulletin article titled *Electronic Medicare Overrides* for specific instructions.

Institutional Billing for Medicare Primary Claims Reporting a Zero or Negative Medicare Payment

To submit claims when Medicare Part A or B has paid zero (i.e., 0.00), which results in the Medicare payment completely applied to the deductible and coinsurance, the claim must be submitted on paper with a Resolution Inquiry form and a copy of the Medicare EOB. In the remarks field please note "Medicare zero paid claim – submit as a special batch."

To submit claims when Medicare's EOB describe a negative payment, submit the claim on paper with a Resolution Inquiry form and a copy of the Medicare EOB. In the remarks field please note "Medicare negative paid claim – submit as a special batch."

For claim specific questions, providers can call Provider Services for assistance at 1-800-688-6696, option 3.

Please refer to Section 5 of the *Basic Medicaid Billing Guide* (http://www.ncdhhs.gov/dma/basicmed/) for information regarding the submission of Medicare HMO secondary claims.

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

Attention: All Providers

Prior Authorization for Non-emergency High-tech Outpatient Radiology and Ultrasound Procedures: Updates

Prior authorization (PA) is required for non-emergency, high-tech outpatient radiology and ultrasound procedures. The ordering physician should obtain the PA; however, rendering facilities and reading radiologists can obtain the PA. Please use the ordering physician's **individual** NPI number. **Do not use a group NPI number.** Only an individual provider can request the PA. The PA should be obtained before the testing is scheduled. The PA number should be provided to the facility performing the test. The PA is good for 30 days following its issuance.

Prior authorization is not required for recipients in the benefit categories listed below. MedSolutions refers to these recipients as non-delegated.

- Recipients that are dually eligible for Medicare and Medicaid
- Recipients with third-party insurance
- Recipients with PACE
- Recipients with Health Choice
- Recipients with Family Planning Waiver
- Recipients in the Health Insurance Premium Payments Program
- Recipients with emergency coverage for approved dates of services
- Undocumented or documented aliens
- Refugees
- Recipients incarcerated or confined in a mental institutions
- Recipients enrolled in Aid to the Aged, Special Assistance to the Blind, and Special Assistance to the Aged

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

Providers submitting claims in an institutional format:

Type of Stay	Billing Instruction
Inpatient stay	Enter Bill Type 11x in Form Locator 4
Emergency department visit	Enter Revenue Code 450 in Form Locator 42
Observation stay	Enter Revenue Code 762 in Form Locator 42
Hospital emergency department referral	Enter appropriate CPT code with modifier U2 in Form Locator 44.

Providers submitting claims in a professional format:

Type of Stay	Billing Instruction
Inpatient stay	Enter appropriate CPT code with modifier U2 in field 24D.
Emergency department visit	Enter appropriate CPT code with modifier U2 in field 24D.
Observation stay	Enter appropriate CPT code with modifier U2 in field 24D.
Hospital emergency department referral	Enter appropriate CPT code with modifier U2 in field 24D.

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

Date	Procedures	Instructions for Providers
November 1, 2009	CT, CTA, MR, MRA, PET	Institutional and professional claims submitted to HP Enterprise Services (EDS) for testing performed on November 1, 2009, and after will require PA on file. Outpatient claims will require Revenue Codes and CPT codes on the UB-04 detail.
December 15, 2009	Ultrasounds	All ordering providers will begin requesting PA for tests scheduled January 1, 2010, and after.
January 1, 2010	Ultrasounds	Institutional and professional claims submitted to HP Enterprise Services (EDS) for testing performed on January 1, 2010, and after will require PA on file. Outpatient claims will require Revenue Codes and CPT codes on the UB-04 detail.

The following procedure codes require prior approval. **Note: CPT codes 70482, 70486, 70487, 70488, and 70490 were inadvertently omitted from previous articles.**

Positron Emission Tomography (PET) Scans

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

Computed Tomography Angiography (CTA)

CPT Code	Description
70496	Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing
70498	Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing
71275	Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing
72191	Computed tomography angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing

CPT Code	Description
73206	Computed tomographic angiography, upper extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing
73706	Computed tomographic angiography, lower extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing
74175	Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing
75635	Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed and image postprocessing

Computed Tomography (CT) Scans

Note: CPT codes 70482, 70486, 70487, 70488, and 70490 were inadvertently omitted from previous articles.

CPT Code	Description
70450	Computed tomography, head or brain; without contrast material
70460	Computed tomography, head or brain; with contrast material(s)
70470	Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections
70480	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material
70481	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material
70482	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material, followed by contrast material(s) and further sections
70486	Computed tomography, maxillofacial area; without contrast material
70487	Computed tomography, maxillofacial area; with contrast material
70488	Computed tomography, maxillofacial area; without contrast material, followed by contrast material(s) and further sections
70490	Computed tomography, soft tissue neck; without contrast material
70491	Computed tomography, soft tissue neck; with contrast material
70492	Computed tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections
71250	Computed tomography, thorax; without contrast material
71260	Computed tomography, thorax; with contrast material(s)
71270	Computed tomography, thorax, without contrast material, followed by contrast material(s) and further sections
72125	Computed tomography, cervical spine; without contrast material
72126	Computed tomography, cervical spine; with contrast material(s)

CPT Code	Description
72127	Computed tomography, cervical spine; without contrast material, followed by contrast material(s) and further sections
72128	Computed tomography, thoracic spine; without contrast material
72129	Computed tomography, thoracic spine; with contrast material(s)
72130	Computed tomography, thoracic spine; without contrast material, followed by contrast material(s) and further sections
72131	Computed tomography, lumbar spine; without contrast material
72132	Computed tomography, lumbar spine; with contrast material(s)
72133	Computed tomography, lumbar spine; without contrast material, followed by contrast material(s) and further sections
72192	Computed tomography, pelvis; without contrast material
72193	Computed tomography, pelvis; with contrast material(s)
72194	Computed tomography, pelvis; without contrast material, followed by contrast material(s) and further sections
73200	Computed tomography, upper extremity; without contrast material
73201	Computed tomography, upper extremity, with contrast material(s)
73202	Computed tomography, upper extremity, without contrast material, followed by contrast material(s) and further sections
73700	Computed tomography, lower extremity; without contrast material
73701	Computed tomography, lower extremity, with contrast material(s)
73702	Computed tomography, lower extremity, without contrast material, followed by contrast material(s) and further sections
74150	Computed tomography, abdomen; without contrast material
74160	Computed tomography, abdomen; with contrast material(s)
74170	Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections
76380	Computed tomography, limited or localized follow-up study
76497	Unlisted computed tomography procedure (eg, diagnostic, interventional)
77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)
77079	Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)

Magnetic Resonance Angiography (MRA)

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

Magnetic Resonance Imaging (MRI)

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

CPT Code	Description
72142	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s)
72146	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material
72147	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material(s)
72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material
72149	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material(s)
72156	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical
72157	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic
72158	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar
72195	Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s)
72196	Magnetic resonance (eg, proton) imaging pelvis; with contrast material(s)
72197	Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s), followed by contrast material(s) and further sequences
73218	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s)
73219	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; with contrast material(s)
73220	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s), followed by contrast material(s) and further sequences
73221	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)
73222	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; with contrast material(s)
73223	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s), followed by contrast material(s) and further sequences
73718	Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s)
73719	Magnetic resonance (eg, proton) imaging, lower extremity other than joint; with contrast material(s)
73720	Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s), followed by contrast material(s) and further sequences

CPT Code	Description
73721	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material
73722	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; with contrast material(s)
73723	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material(s), followed by contrast material(s) and further sequences
74181	Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)
74182	Magnetic resonance (eg, proton) imaging, abdomen; with contrast material(s)
74183	Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences
76498	Unlisted magnetic resonance procedure (eg, diagnostic, interventional)
77058	Magnetic resonance imaging, breast, without and/or with contrast material(s); unilateral
77059	Magnetic resonance imaging, breast, without and/or with contrast material(s); bilateral

Ultrasound

CPT Code	Description
76506	Echoencephalography, real time with image documentation (gray scale) (for determination of ventricular size, delineation of cerebral contents, and detection of fluid masses or other intracranial abnormalities), including A-mode encephalography as secondary component where indicated
76510	Ophthalmic ultrasound, diagnostic; B-scan and quantitative A-scan performed during the same patient encounter
76511	Ophthalmic ultrasound, diagnostic; quantitative A-scan only
76512	Ophthalmic ultrasound, diagnostic; B-scan (with or without superimposed non-quantitative A-scan)
76513	Ophthalmic ultrasound, diagnostic; anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy
76514	Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)
76516	Ophthalmic biometry by ultrasound echography, A-scan:
76519	Ophthalmic biometry by ultrasound echography, A-scan: with intraocular lens power calculation
76529	Ophthalmic ultrasonic foreign body localization
76536	Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid) real time with image documentation
76604	Ultrasound, chest (includes mediastinum), real time with image documentation
76645	Ultrasound, breast(s) (unilateral or bilateral), real time with image documentation
76700	Ultrasound, abdominal, real time with image documentation; complete
76705	Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)

CPT Code	Description
76770	Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; complete
76775	Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited
76776	Ultrasound, transplanted kidney, real time and duplex Doppler with image documentation
76800	Ultrasound, spinal canal and contents
76801	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; single or first gestation
76802	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; each additional gestation
76805	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or + 14 weeks 0 days), transabdominal approach; single or first gestation
76810	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or + 14 weeks 0 days), transabdominal approach; each additional gestation
76811	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation
76812	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation
76813	Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation
76814	Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; each additional gestation
76815	Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses
76816	Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal
76818	Fetal biophysical profile; with non-stress testing
76819	Fetal biophysical profile; without non-stress testing
76820	Doppler velocimetry, fetal; umbilical artery
76821	Doppler velocimetry, fetal; middle cerebral artery
76825	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording;
76826	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording; follow-up or repeat study
76827	Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; complete

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

CPT Code	Description
93965	Noninvasive physiologic studies of extremity veins, complete bilateral study (eg, Doppler waveform analysis with responses to compression and other maneuvers, phleborheography, impedance plethysmography)
93970	Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study
93971	Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study
93975	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study
93976	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study
93978	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study
93979	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; unilateral or limited study
93990	Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)

Other

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

Revenue Codes

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

RC Code	Description
616	Magnetic Resonance Technology (MRT) – MRA Lower Extremities
618	Magnetic Resonance Technology (MRT) – MRA Other
619	Magnetic Resonance Technology (MRT) – Other MRT

For assistance with requesting prior approval, refer to the following table:

Issue	Who to Contact
Provider information incorrect in the system	1. Go to http://www.ncdhhs.gov/dma/WebNPI/default.htm to verify the address that Medicaid has on file. 2. If the address or other information needs to be updated, go to the CSC NC Tracks website at http://www.nctracks.nc.gov/provider/cis.html.
Trouble locating the recipient or the provider in the system	Fill in one identifier and search for the provider or recipient. Do not fill in all the blanks. For example: for recipient, fill in only the name and date of birth; for provider, fill in only the name or the individual NPI number. The MedSolutions Call Center is available from 8:00 a.m. to 9:00 p.m. (EST) at 1-888-693-3211. For continuing issues, contact the Provider Assistance Desk at 1-800-575-4517, option 2.
For denials	MedSolutions will fax the PA and denial letters to the ordering and the rendering provider within five business days of the request. Providers may initiate a **peer-to-peer discussion** with a MedSolutions physician about any PA decision by calling MedSolutions at 1-888-693-3211 during normal business hours, or the provider may elect to provide additional supporting clinical information in support of a **reconsideration request** of the original denial decision. Requests for a peer-to-peer consultation or the reconsideration request and the complete additional clinical information will be accepted for **three business days following the date of MedSolutions' adverse decision.** MedSolutions shall schedule the peer-to-peer consultation within one business day. MedSolutions will provide a decision either to uphold or to overturn the initial adverse decision within two business days following the consultation or reconsideration. The provider will be notified in writing of the decision.
Accuracy Management for providers	• To obtain a questionnaire about becoming a participating rendering provider, go to http://www.accuracymgmt.com and apply. • To contact the Accuracy Management department regarding completion, credentialing, or appealing a decision, send requests to accuracymgmt@medsolutions.com. • The Accuracy Management department phone number is 1-800-457-2759.
Medicaid contact	Diane Holder, R.N. 910-355-1883

Practitioner and Clinic Services
DMA, 910-355-1883

Attention: All Providers

Piedmont Cardinal Health Plan

DMA, in collaboration with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, is in the process of requesting approval from CMS for a mental health, developmental disabilities, substance abuse (MH/DD/SA) services waiver program. The model will be based upon the waiver that has been operating in Cabarrus, Davidson, Rowan, Stanly, and Union counties since April 2005. The existing waiver is currently administered by the State through Piedmont Behavioral HealthCare (PBH), a local management entity (LME) for the delivery of publicly funded MH/DD/SA services.

The expansion will allow other LMEs to apply to the State to operate in the same capacity as PBH as a prepaid health plan for the delivery of MH/DD/SA services. All Medicaid recipients residing in the selected LME catchment areas who are approved for participation will be required to obtain MH/DD/SA services through their respective LMEs.

The State plans to release a request for applications in the spring of 2010. The State will initially select one or two waiver entities to begin operation in July of 2010 or at a date approved by CMS. The request for applications will provide details on requirements for participation. Additional information will be provided through the Medicaid Bulletin as it becomes available.

Waiver Development and Demonstrations Unit
DMA, 919-855-4260

Attention: All Providers

Medicaid Credit Balance Reporting

All providers participating in the Medicaid Program are required to submit a quarterly **Credit Balance Report** to the DMA Third-Party Recovery Section identifying balances due to Medicaid. Providers must report any **outstanding** credits owed to Medicaid that have not been reported previously on a Medicaid Credit Balance Report. However, hospital and nursing facility providers are required to submit a report every calendar quarter even if there are no credit balances. The report must be submitted no later than 30 days following the end of the calendar quarter (March 31, June 30, September 30, and December 31).

The Medicaid Credit Balance Report is used to monitor and recover "credit balances" owed to the Medicaid Program. A credit balance results from an improper or excess payment made to a provider. For example, refunds must be made to Medicaid if a provider is paid twice for the same service (e.g., by Medicaid and a medical insurance policy, by Medicare and Medicaid, by Medicaid and a liability insurance policy) or if the patient liability was not reported in the billing process or if computer or billing errors occur.

For the purpose of completing the report, a Medicaid Credit Balance is the amount determined to be refundable to the Medicaid Program. When a provider receives an improper or excess payment for a claim, it is reflected in the provider's accounting records (patient accounts receivable) as a "credit." However, credit balances include money due to Medicaid regardless of its classification in a provider's accounting records. If a provider maintains a credit balance account for a stipulated period (e.g., 90 days) and then transfers the account or writes it off to a holding account, this does not relieve the provider of liability to the Medicaid Program. The provider is responsible for identifying and repaying all monies owed the Medicaid Program.

The Medicaid Credit Balance Report requires specific information for each credit balance on a claim-by-claim basis. The reporting form provides space for 15 claims but may be reproduced as many times as necessary to accommodate all the credit balances being reported. Specific instructions for completing the report are on the reverse side of the reporting form.

Submitting the Medicaid Credit Balance Report does not result in the credit balances automatically being reimbursed to the Medicaid Program. **Electronic adjustments are the preferred method of satisfying the credit balances and can be performed through the North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool. Refer to the September 2009 Special Bulletin, *North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool Instruction Guide*, on DMA's website at http://www.ncdhhs.gov/dma/bulletin/ for specific filing instructions.**

In the event, a billing error caused an individual provider to be paid for a service in which a provider group should have been paid, a refund check will need to be sent to HP Enterprise Services (EDS) to correct the error as it is unlikely the individual provider will have future claims to adjust. In these circumstances only, a check must be made payable to HP Enterprise Services (EDS) and sent to HP Enterprise Services (EDS) using the **Medicaid Provider Refund Form** (http://www.ncdhhs.gov/dma/provider/forms.htm). The information on the form must be complete and accurate in order to process the provider refund check.

Submit the Medicaid Credit Balance Report Form to:	Electronic Adjustments using the North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool	Submit Refund Checks to:
Third Party Recovery Section Division of Medical Assistance 2508 Mail Service Center Raleigh NC 27699-2508	**Refer to the September 2009 Special Bulletin, *North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool Instruction Guide* (http://www.ncdhhs.gov/dma/bulletin/)**	HP Enterprise Services Refunds P.O. Box 300011 Raleigh NC 27622-3011 (**Do not** send these refund checks to DMA or to the Controller's Office.)

Submit **only** the completed Medicaid Credit Balance Report to DMA. **Failure to submit a Medicaid Credit Balance Report to DMA will result in the withholding of Medicaid payment until the report is received.**

Send to DMA:

- The **original** completed Medicaid Credit Balance Report.
- Please circle "Adjustment" at bottom of original credit balance report to indicate an electronic adjustment has been performed. (**Note:** You may circle "Refund" in the event a check must be sent due to the reason stated above).

Send to HP Enterprise Services Refunds Department:

- Always send **live credit balance refund check(s)** to the HP Enterprise Services (EDS) refunds address listed in this bulletin.
- Enclose a copy of the Medicaid Credit Balance Report associated with the refund.
- Include a completed **Medicaid Provider Refund Request Form** to ensure that HP Enterprise Services (EDS) can appropriately document individual refund amounts.
- Please circle "Refund" at the bottom of the copy of the Medicaid Credit Balance Report.

A copy of the Medicaid Credit Balance Report form follows this article. The Medicaid Provider Refund Form and the Medicaid Credit Balance Report form are also available on DMA's website at http://www.ncdhhs.gov/dma/provider/forms.htm.

Debbie Odette, Third Party Recovery Section
DMA, 919-647-8100

Instructions for Completing Medicaid Credit Balance Report

Complete the "Medicaid Credit Balance Report" as follows:

- **Full name of facility as it appears on the Medicaid Records**
- **The facility's Medicaid provider number**. If **the facility has more than one provider number, use a separate sheet for each number. DO NOT MIX**
- **Circle the date quarter end**
- **Enter year**
- The name and telephone number of the person completing the report. This is needed in the event DMA has any questions regarding some item in the report

Complete the date fields for each Medicaid balance by providing the following information:

Column 1 – The last name and first name of the Medicaid recipient (e.g., Doe, Jane)

Column 2 – The individual Medicaid identification (MID) number

Column 3 – The month, day, and year of beginning service (e.g., 12/05/03)

Column 4 – The month, day, and year of ending service (e.g., 12/10/03)

Column 5 – The R/A date of Medicaid payment (not your posting date)

Column 6 – The Medicaid ICN (claim) number

Column 7 – The amount of the credit balance (not the amount your facility billed or the amount Medicaid paid)

Column 8 – The reason for the credit balance by entering: "81" if it is a result of a Medicare payment; "83" if it is the result of a health insurance payment; "84" if it is the result of a casualty insurance/attorney payment or "00" if it is for another reason. Please explain "00" credit balances on the back of the form.

After this report is completed, total column 7 and mail to **Third Party Recovery, DMA, 2508 Mail Service Center, Raleigh, NC 27699-2508.**

MEDICAID CREDIT BALANCE REPORT

PROVIDER NAME:_____ CONTACT PERSON: _____
PROVIDER NUMBER: _____ TELEPHONE NUMBER: _____
QUARTER ENDING: (Circle one) 3/31 6/30 9/30 12/31 YEAR: _____

(1) RECIPIENT'S NAME	(2) MEDICAID NUMBER	(3) FROM DATE OF SERVICE	(4) TO DATE OF SERVICE	(5) DATE MEDICAID PAID	(6) MEDICAID ICN	(7) AMOUNT OF CREDIT BALANCE	(8) REASON FOR CREDIT BALANCE
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							

Circle one: Refund Adjustment

Return form to: **Third Party Recovery**
DMA
2508 Mail Service Center
Raleigh, NC 27699-2508

Revised 10/07

Attention: CAP/DA Case Managers and CAP/DA Service Providers

Participation in the Community Alternatives Program for Disabled Adults: Freeze Update

In response to the Joint Conference Committee Report on the Continuation, Expansion, and Capital Budgets, Section G, Item 170 of the 2009 Appropriation Act (SL 2009-451) (http://www.ncleg.net/Sessions/2009/Bills/Senate/PDF/S202v8.pdf), each county, as of October 2009, was assigned a new slot allocation. This new slot allocation allows compliance with the proposed freeze as well as allowing lead agencies to continue to serve citizens in their catchment area. Please direct questions about the new slot allocation to the CAP/DA Unit in the Facility and Community Care Section by calling 919-855-4340 or faxing 919-715-2372.

Facility and Community Care Section
DMA, 919-855-4340

Attention: Enhanced Behavioral Health (Community Intervention) Services Providers

Provider Verification and Credentialing Activities

Community Intervention Services (CIS) agencies have now received the re-verification packets that must be completed and returned to CSC immediately to ensure uninterrupted enrollment as a CIS provider. For detailed information, please review Implementation Update #63 (http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/), the November 2009 Medicaid Bulletin (http://www.ncdhhs.gov/dma/bulletin/) or contact the CSC EVC Call Center at 1-866-844-1113.

Behavioral Health Section
DMA, 919-855-4290

Attention: Pharmacists

Drug Utilization Review Early Refill Alert

DMA is continuing to see a large number of claims that are denied with the early refill alert and are subsequently being rebilled by overriding the denial at the point of sale. In accordance with Clinical Coverage Policy 9, *Outpatient Pharmacy Program*, pharmacy providers are reminded that there is no provision for payment by N.C. Medicaid for early refills on controlled substances except in the event that a recipient's therapy has changed. Providers are cautioned to carefully consider the appropriateness of overriding the Drug Utilization Review (DUR) early refill alert. When using 05 to designate a therapy change, the provider should verify that indeed a therapy change did occur.

Program Integrity will monitor the use of the early refill override codes. Claims billed with the incorrect override code, overridden for an invalid reason, or otherwise not in compliance with policy will be subject to recoupment.

Pharmacy Review Unit
DMA, 919-647-8000

Attention: Pharmacists and Prescribers

New Prior Authorization Requirements for Brand-name Fibrates and Lovaza

Effective with date of service of November 17, 2009, the N.C. Outpatient Pharmacy Program will begin requiring prior authorization (PA) for brand-name fibrates and Lovaza. Prescribers can request prior authorization by contacting ACS at 866-246-8505 (telephone) or 866-246-8507 (fax).

The criteria and PA request form for these medications are available on the N.C. Medicaid Enhanced Pharmacy Program website at http://www.ncmedicaidpbm.com. Medications that now require prior authorization include Antara, Fenoglide, Lipofen, Lofibra, Lopid, Tricor, Triglide, Trilipix, and Lovaza.

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

Attention: Personal Care Services Providers

Implementation of PCS PACT Reviews and Independent Assessments

In response to Session Law 2009-451 (Senate Bill 202), Section 10.68A.(a)(3) (http://www.ncga.state.nc.us/Sessions/2009/Bills/Senate/PDF/S202v8.pdf), DMA is implementing changes in the Medicaid In-Home Personal Care Services (PCS) Program. The required changes are being implemented in two stages.

Stage I PCS PACT Reviews were implemented November 3, 2009, with a notice to all active enrolled PCS providers. The postmark deadline for all materials requested in the notice was November 23, 2009. **If you did not receive the notice and submit the required materials, refer to the PACT Review website at http://www.qireport.net for instructions and forms, and submit the required materials immediately.** Questions may be directed to the PACT Help Line at 1-800-228-3365 or by e-mail to PACTreview@thecarolinascenter.org.

After you have responded to the initial PACT Review notice, continue to conduct new referral assessments, annual reassessments, and change of status reviews until you are notified that Stage II Independent Assessments have been implemented. **Until you receive further notice, also complete and submit weekly assessment and discharge updates using the Weekly Summary Form at http://www.qireport.net.**

Implementation of Stage II Independent Assessments will occur as early as possible in calendar year 2010. Watch http://www.qireport.net and future bulletin articles for important announcements and updates.

Facility and Community Care Section
DMA, 919-855-4340

Attention: Health Departments, Nurse Midwives, Nurse Practitioners, and Physicians

Lidocaine for Topical Anesthesia and Saline/Water Codes: Billing Guidelines

Effective with date of service November 1, 2009, the N.C. Medicaid Program covers lidocaine anesthetic agent (including formulations) when it is used to block pain sensation during outpatient procedures and it is billed using HCPCS code J3490. National Drug Codes (NDCs) are **required** on the claim.

Note: The HCPCS code appropriate for billing lidocaine administered **intravenously** is J2001. For providers billing on professional claims, the maximum reimbursement rate for lidocaine will depend on the NDC that is billed.

Effective with date of service November 1, 2009, codes for sterile water/saline and/or dextrose (diluent flush), 10 ml (HCPCS code A4216), and for sterile water/saline, 500 ml (HCPCS code A4217), are also covered when used as flushes and irrigations or to dilute medications prior to administration. For providers billing on professional claims, the maximum reimbursement rate for A4216 is $0.42 and the maximum reimbursement rate for A4217 is $2.64. For multi-dose vials, only the amount administered to the recipient may be billed. When single-dose vials are used, the entire vial may be billed.

HCPCS codes A4216 and A4217 do NOT require NDCs to be reported. Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III*, on DMA's website (http://www.ncdhhs.gov/dma/bulletin/) and to general Medicaid bulletin articles for additional instructions regarding the NDC requirements.

The Physicians Drug Program fee schedule (HCPCS code J3490) and the Physician Services fee schedule (HCPCS codes A4216 and A4217) on DMA's website at http://www.ncdhhs.gov/dma/fee/.

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

Attention: All Providers

Medicaid Recipient Appeal Process/Early and Periodic Screening, Diagnosis, and Treatment

Medicaid **Recipient** Appeal Process/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) seminars are scheduled for the month of February 2010. Seminars are intended to address Medicaid **recipient** appeal process when a Medicaid service is denied, reduced or terminated. The seminar will also focus on an overview of EPDST – Medicaid for Children.

The seminar sites and dates will be announced in the January 2010 Medicaid Bulletin (http://www.ncdhhs.gov/dma/bulletin/). Pre-registration will be required. Due to limited seating, registration will be limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

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

Attention: Nurse Practitioners and Physicians

Golimumab (50 mg per 0.5 ml) for Injection (Simponi, HCPCS Code J3590): Billing Guidelines

The following article from the July 2009 Medicaid bulletin is being republished to correct the maximum allowable reimbursement rate. Systematic adjustments will be made to previously paid claims for dates of service on or after July 1, 2009.

Effective with date of service July 1, 2009, the N.C. Medicaid Program covers golimumab injectable (Simponi) for use in the Physician's Drug Program when billed with HCPCS code J3590 (unclassified biologics). Simponi is available as either single-dose, 50 mg per 0.5 ml pre-filled syringes or single-dose, 50 mg per 0.5 ml pre-filled SmartJect autoinjectors.

Simponi is a human monoclonal antibody that is indicated for the treatment of adults with active moderate to severe rheumatoid arthritis (RA), active psoriatic arthritis (PsA), and active ankylosing spondylitis (AS).

Simponi is administered as a subcutaneous (SC) injection once a month. The recommended dose for Simponi is 50 mg.

Prior to initiating Simponi and periodically during therapy, patients should be evaluated for active tuberculosis and tested for latent infection. For patients with RA, Simponi should be given in combination with methotrexate and for patients with PsA or AS, Simponi may be given with or without methotrexate or other non-biologic disease-modifying antirheumatic drugs (DMARDs). For patients with RA, PsA, or AS, corticosteroids, non-biologic DMARDs, and/or non-steroidal anti-inflammatory drugs (NSAIDs) may be continued during treatment with Simponi.

For Medicaid Billing

- The ICD-9-CM diagnosis codes required for billing Simponi are:
  - ♦ 714.0 through 714.9 (rheumatoid arthritis)

  OR

  - ♦ 696.0 (psoriatic arthritis [severe])

  OR

  - ♦ 720.0 (ankylosing spondylitis)
- Providers should bill Simponi with HCPCS code J3590 (unclassified biologics).
- One Medicaid unit of coverage is 50 mg. The maximum reimbursement rate, per unit (50 mg), is $1,701.00.
- Providers must indicate the number of HCPCS units used.
- Providers must bill with National Drug Codes (NDCs). The NDC units should be reported as "ML." For example, each 50 mg administered (0.5 ml from either the disposable pen or the disposable syringe), the NDC units should be reported as "ML0.5." Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III,* on DMA's website (http://www.ncdhhs.gov/dma/bulletin/) for additional instructions.
- Medicaid covers only rebatable NDCs.
- Providers must bill their usual and customary charge.

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

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

Attention: Adult Care Homes, Adult Day Health Care Centers, Health Departments, Nurse Practitioners, Nursing Facilities, and Physicians

Clarification of the Two-Step Tuberculosis (TB) Test Process and Billing

There has been much confusion regarding the two-step tuberculosis (TB) test – what is it and how can a physician's office get paid for administering both parts of the test?

Two-step testing reduces the likelihood of interpreting a "boosted" reaction as a true conversion or a new infection; it is recommended in situations where there will be repeat testing on a regular basis.

Two-step testing is required for residents of long-term care facilities upon admission. **If the resident has had a documented TB skin test (TST) within the last 12 months, that TST can be counted as the first step in two-step testing.**

1. If the reaction to the first test is positive, consider the individual infected.
2. If the reaction to the first test is negative, a second test should be given 1 to 3 weeks later.
    a. If the second test is positive, consider the individual infected.
    b. If the second test is negative, consider the individual not infected, record reactions, and document dates of reading and signature(s) of person(s) reading the tests.

    Source: NCTB Control Program Policy Manual (Rev 01/09 11-11) at http://www.epi.state.nc.us/epi/tb

Physicians should bill Medicaid for the two-step TB test as follows:

1. Bill the first part of the test using CPT procedure code 86580. This code can be billed only one time per day.
2. For the second part of the test that is administered 1 to 3 weeks after the first test, bill using the same CPT procedure code, 86580. No modifier is required.

Two-step testing is required for staff in long-term care facilities, as well as for staff in adult day health care centers who provide care for HIV/AIDS clients (see Chapter XI, 10A NCAC 41A.0205 (b) 4 and 5). TB skin testing is not covered by Medicaid for job requirements. Another payment source will need to be identified when the test is administered to staff to meet these requirements.

Julie Budzinski, MA
Clinical Policy and Programs
DMA, 919-855-4368

Margaret Comin, RN, BSN, MPA
Clinical Policy and Programs
DMA, 919-855-4355

Attention: Pharmacists and Prescribers

Removal of Cough and Cold Medications from Coverage

Effective **December 1, 2009**, N.C. Medicaid will stop covering prescription medications used to treat the symptoms of cough and colds. The cough and cold medications that will no longer be covered are those that contain a cough suppressant or a cough expectorant. Products that do not have a cough suppressant or an expectorant will continue to be covered.

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

Attention: Home Health Agencies and Private Duty Nursing Providers

Using National Drug Codes for the Billing of Diabetic Supplies

Effective November 15, 2009, Prodigy Diabetes Care, LLC, became N.C. Medicaid's designated preferred manufacturer for glucose meters, diabetic test strips, control solutions, lancets, lancing devices, and syringes. This change to a preferred manufacturer means that only Prodigy test strips, control solutions, lancets, lancing devices, and syringes will be covered by N.C. Medicaid.

Effective with date of service February 1, 2010, home health agencies and private duty nursing (PDN) providers who provide diabetic supplies must also comply with this requirement. Beginning February 1, 2010, only Prodigy test strips, lancets, lancing devices, and syringes will be covered by N.C. Medicaid. Diabetic supplies billed for Medicaid reimbursement must be obtained from Prodigy Diabetes Care, LLC.

Billing Instructions for Submitting Claims for Medicaid Reimbursement of Diabetic Supplies

Claims for diabetic test strips, lancets, lancing devices, and insulin syringes must be billed using the National Drug Code (NDC) for the product. The following table lists the HCPCS codes affected by this requirement along with the corresponding NDC. The codes listed below are the only diabetic supply codes affected.

HCPCS Code	Product Description	NDC
A4253	Blood glucose test or reagent strips (1 unit = 50 strips)	08484-9902-50
A4259	Lancets (1 unit = 100 lancets)	08484-9903-28
A4258	Lancing Device (1 unit = 1 box)	08484-9903-55

Home health agencies must complete the following fields on the UB-04 claim form when billing for these supplies. Providers using the 837I transaction or other electronic claims submission should enter the information in the comparable blocks.

The following fields are required when reporting NDCs with the UB-04:

- **FL42:** Revenue code
- **FL43:** Enter the NDC qualifier of N4, followed by the 11-digit NDC number
  - ♦ Do not enter spaces between the NDC data elements.
  - ♦ Do not enter hyphens within the NDC number.
  - ♦ Enter UN immediately following the NDC.
- **FL44:** Enter the appropriate HCPCS procedure code.

PDN providers using the CMS-1500 claim form or electronic equivalent are also required to use the NDC in addition to the HCPCS code to bill the codes listed above. Enter the information as follows.

- **Field 24 A:**
  - ♦ Begin by left justifying the N4 qualifier. Immediately follow it with the 11-digit NDC.
  - ♦ Insert three (3) spaces
  - ♦ Enter the code UN (describes the unit of measure)
- **Field 24 B:** Enter the quantity

For information on billing with the NDC, please refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III,* on DMA's website (http://www.ncdhhs.gov/dma/bulletin/).
For additional information, providers may call Prodigy Diabetic Care, LLC, at 1-866-540-4816.

Clinical Policies and Programs
DMA, 919-855-4380

Attention: Durable Medical Equipment Providers and Pharmacy Providers

Prodigy Diabetic Supplies Under the Durable Medical Equipment and Pharmacy Programs: Update

Effective November 15, 2009, Prodigy Diabetes Care, LLC, was designated as N.C. Medicaid's preferred manufacturer for glucose meters, diabetic test strips, control solutions, lancets, lancing devices, and syringes. Beginning on this date of service, only Prodigy test strips, control solutions, lancets, lancing devices, and syringes will be covered by N.C. Medicaid. This change applies only to Medicaid-primary recipients (dually eligible and third-party recipients are not affected). **Note:** These requirements will not apply to private duty nursing and home health providers until February 1, 2010 (see page 28).

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

Covered Product	Package Size	Unit Type	NDC-11
Prodigy Pocket™ Meter Kit - Black	1 Meter Kit	1 Meter	08484-0708-00
Prodigy Pocket™ Meter Kit - Pink	1 Meter Kit	1 Meter	08484-0708-01
Prodigy Pocket™ Meter Kit - Blue	1 Meter Kit	1 Meter	08484-0708-02
Prodigy Pocket™ Meter Kit -Green	1 Meter Kit	1 Meter	08484-0708-03
Prodigy Pocket™ Meter Kit -Camouflage	1 Meter Kit	1 Meter	08484-0708-04
Prodigy Pocket™ Meter Kit –Pink Camouflage	1 Meter Kit	1 Meter	08484-0708-05
Prodigy AutoCode® Talking Meter Kit	1 Meter Kit	1 Meter	08484-0701-20
Prodigy Voice™ Meter Kit	1 Meter Kit	1 Meter	08484-0719-50
Prodigy™ No Coding Test Strips	50 ct Bottle	1 Bottle	08484-9902-50
Prodigy Control Solution (Low)	1 Bottle	1 Bottle	08484-9903-10
Prodigy Twist Top Lancets 28G	100 ct Box	1 Box	08484-9903-28
Prodigy Lancing Device, Adj. Depth w/ Clear Cap	100 ct Box	1 Box	08484-9903-55
Prodigy Syringe 28G 12.7mm – 1 cc (100 ct)	100 ct Box	1 Box	08484-9904-30
Prodigy Syringe 31G 8mm – ½ cc (100 ct)	100 ct Box	1 Box	08484-9904-35
Prodigy Syringe 31G 8mm – ⅓ cc (100 ct)	100 ct Box	1 Box	08484-9904-38

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

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

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

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

A transition period will be in place from November 15, 2009, through February 15, 2010 (this transition period is not a postponement), in which a one-time, per-recipient, per-product override will be allowed. In addition to modifier NU, DME providers will need to place the SC modifier in block 24D of the CMS-1500 claim form to bypass the requirement to bill for Prodigy NDCs (as listed in the chart above). Following

February 15, 2010, this modifier will no longer be acceptable for use with diabetic supplies for DME and only the Prodigy NDCs referenced above will be covered.

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

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

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

For patients on insulin pumps incompatible with Prodigy products, there will be an override process available for patients who cannot use Prodigy products for clinical reasons. In these instances, the provider must be a DME provider. The following protocol, documented in Section 5.5 of Clinical Coverage Policy 5A, *Durable Medical Equipment*, needs to be followed for overrides. Submit the denial to DMA at the designated diabetic supply override fax line, 919-715-3166, along with the required medical necessity forms. Consideration will be given to the request and a written decision will be returned to the provider.

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

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

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

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

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

Durable Medical Equipment Program
DMA, 919-855-4310

Outpatient Pharmacy Program
DMA, 919-855-4300

Attention: All Providers

Top 10 Reasons a Provider Application is Deemed Incomplete

On April 20, 2009, CSC took over the provider enrollment, credentialing, and verification (EVC) functions from DMA's Provider Services unit. In just six months, the CSC EVC Call Center has handled almost 10,000 applications from providers who want to participate in North Carolina's Medicaid Program.

Most applications move smoothly through the EVC process but occasionally an application is deemed incomplete and processing is suspended until the provider submits the necessary information.

The top 10 reasons an application may be deemed incomplete are:

1. The W-9 form is not filled out correctly.
2. Sections 18 A and B of the ownership and managing employees form are not provided.
3. The indicator boxes are not marked.
4. Titles are not provided.
5. Required documents are not provided.
6. Documents that have been returned are incorrect.
7. A DMA Provider Services Business Rule requirement is not met.
8. An administrative review is needed.
9. The provider has not responded to e-mails and return letters.
10. The signer is not an authorized agent for the provider.

In even rarer instances, a provider's application is rejected. **The top three reasons an application may be rejected are:**

1. The wrong type of application is submitted.
2. The wrong version of an application is used.
3. An enrolled provider has submitted a new application instead of a change form.

We appreciate your willingness to provide services to some of our State's most vulnerable citizens. Our goal is to ensure your application is processed in a timely fashion so that you can participate in the N.C. Medicaid Program. We hope that these lists will help you avoid some common mistakes as you complete your application packet. We look forward to helping you become part of North Carolina's Medicaid community.

CSC, 1-866-844-1113

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

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

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

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

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

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

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

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

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

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

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

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

Proposed Clinical Coverage Policies

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

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

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

2009 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
December	12/3/09	12/8/09
	12/10/09	12/15/09
	12/17/09	12/23/09
January 2010	1/7/10	1/12/10
	1/14/10	1/20/10
	1/21/10	1/28/10
	1/28/10	2/2/10

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

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

Melissa Robinson
Executive Director
HP Enterprise Services