North Carolina Medicaid Bulletin
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Attention: All Providers

Clinical Coverage Policies

The following new or amended clinical coverage policies are now available on DMA’s website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm:

1A–7 – Neonatal and Pediatric Critical and Intensive Care Services
1A–8 – Hyperbaric Oxygenation Therapy
1A–10 – Panniculectomy
1A–11 – Extracorporeal Shockwave Lithotripsy
1A–15 – Surgery for Clinically Severe Obesity
1A–18 – Screening Laser Glaucoma Test
A2 – Over the Counter Medications

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

Gina Rutherford, Clinical Policy and Programs Section
DMA, 919-857-4020

Attention: All Providers

Clinical Policy and Programs

The Division of Medical Assistance (DMA) has changed the name of the Medical Policy Section to the Clinical Policy and Programs Section. This new title more accurately reflects the various clinical specialties within DMA’s program policy area.

The mission of the Clinical Policy and Programs Section is to structure benefits available to Medicaid clients in a manner that promotes access to medically necessary and cost effective care. This section is responsible for:

- Behavioral Health Services
- Clinical Policy Development
- Community Alternatives Program Services
- Dental Services
- Facility and Community Care Services
- Pharmacy and Ancillary Services
- Practitioner and Clinic Services

Along with the new title comes a change in the section’s leadership. Marcia Rao joins DMA as the Assistant Director for Clinical Policy and Programs. Ms. Rao brings with her a wealth of knowledge and experience as she has worked in broad areas of medical policy for the Medicaid program in the State of New York for more than twenty years. She has worked in systems design, overseen the State Plan, and developed and implemented many programs, including waivers. She has particular interest in community care and in children's needs.

Gina Rutherford, Clinical Policy and Programs
DMA, 919-857-4020
Attention: All Providers

EDS Address List

This is a reminder of the addresses to use when mailing correspondence or claims to EDS.

<table>
<thead>
<tr>
<th>Adjustment/Medicaid Resolution Inquiries</th>
<th>ADA Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>EDS</td>
<td>EDS</td>
</tr>
<tr>
<td>PO Box 300009</td>
<td>PO Box 300011</td>
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<td>Raleigh, NC 27622</td>
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<tr>
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<th>Hysterectomy Statements</th>
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<tr>
<td>(Name of EDS Employee)</td>
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<td>PO Box 300009</td>
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<table>
<thead>
<tr>
<th>Medicare Crossovers (Part A Only)</th>
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</table>

When sending Certified mail, UPS or Federal Express, send to:
EDS (Name of EDS Employee or Department)
4905 Waters Edge Drive
Raleigh, NC 27606

EDS, 1-800-688-6696 or 919-851-8888
Attention: All Providers

The New NCMMIS Commitment to North Carolina Providers

On July 1, 2004, Carmen Hooker Odom, Secretary of the Department of Health and Human Services, created the Office of Medicaid Management Information System (MMIS) Services to ensure a successful transition to the new NCLeads system. The Office of MMIS Services reports directly to the Office of the Secretary and will work with Affiliated Computer Services (ACS) State Healthcare LLC on the implementation of the new NCLeads system. Staff from the Division of Medical Assistance; the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; and the Division of Public Health as well as the Division of Facility Services have been reassigned to the Office of MMIS Services to assist with the transition.

The Office of MMIS Services Provider Relations Team is developing a website for providers to access information about the new NCLeads system and for updates about the transition to the new system. Providers will be notified through the general Medicaid bulletin when the website is available.

Providers may contact the Provider Relations Team with questions or comments by calling 919-855-3112 or by e-mail at ncmmis.provider@ncmail.net.

Tom Liverman, Provider Relations
Office of MMIS Services
919-855-3112

Attention: All Providers

Medicare Crossovers

On September 6, 2004, the N.C. Medicaid program will return to processing all crossover claims billed on a CMS-1500 form or as an 837 professional transaction as direct crossovers from Medicare.

In anticipation of this change, providers should verify that their Medicare provider numbers are cross-referenced to their Medicaid provider numbers. Providers can verify this by contacting EDS Provider Services at 1-800-688-6696 or 919-851-8888.

If your Medicaid and Medicare provider numbers are not cross-referenced, please complete and submit the following form by fax or mail to EDS at the address indicated on the form. Additional information on crossover claims will be published in upcoming general Medicaid bulletins.


EDS, 1-800-688-6696 or 919-851-8888
Medicare Crossover Reference Request

Provider Name: ________________________________
Contact Person (required): _____________________  Telephone (required): ____________

Select the appropriate Medicare Carrier/Intermediary/DMERC from the following listing, the Action to be taken, and your Medicare and Medicaid provider numbers. **If this section is not completed, the form will not be processed.** These are the only carriers for which EDS can currently cross-reference provider numbers.

### Medicare Part A Intermediaries
- □ Riverbend GBA Medicare Part A (Tennessee) [http://www.riverbendgba.com](http://www.riverbendgba.com)
- □ Palmetto GBA Medicare Part A. Effective November 1, 2001, Palmetto GBA assumed the role of North Carolina Part A intermediary from Blue Cross/Blue Shield of NC. (North Carolina) [http://www.palmettogba.com](http://www.palmettogba.com)
- □ Trailblazer Medicare Part A (Colorado, New Mexico and Texas) [http://www.the-medicare.com](http://www.the-medicare.com)
- □ United Government Services Medicare Part A (Wisconsin) [http://www.ugsmedicare.com](http://www.ugsmedicare.com)
- □ Palmetto Medicare Part A (South Carolina) [http://www.palmettogba.com](http://www.palmettogba.com)
- □ Carefirst of Maryland Medicare Part A (Maryland) [http://www.marylandmedicare.com/pages/mdmedicare/mdmedicaremain1.htm](http://www.marylandmedicare.com/pages/mdmedicare/mdmedicaremain1.htm)
- □ Veritus Medicare Part A (Pennsylvania) [http://www.veritusmedicare.com](http://www.veritusmedicare.com)
- □ First Coast Service Options Medicare Part A, subsidiary of BCBS of Florida (Florida) [http://www.floridamedicare.com](http://www.floridamedicare.com)

### Medicare Part B Carrier
- □ CIGNA Medicare Part B (Tennessee, North Carolina, and Idaho) [http://www.cignamedicare.com](http://www.cignamedicare.com)
- □ AdminaStar Medicare Part B (Indiana and Kentucky) [http://www.adminastar.com](http://www.adminastar.com)
- □ Palmetto Medicare Part B (South Carolina) [http://www.palmettogba.com](http://www.palmettogba.com)

**Palmetto Region C DMERC** (Alabama, Arkansas, Colorado, Florida, Georgia, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas and the Virgin Islands): [http://www.palmettogba.com](http://www.palmettogba.com)

*Trading Partners currently in testing phase.

### Action to be taken:
- □ **Addition** - This is used to add a new provider number (Medicare or Medicaid) to the crossover file.
  
  Medicare Provider number: _______________  Medicaid Provider number: _______________

- □ **Change** - This is used to change an existing provider number (Medicare or Medicaid) on the crossover file.

  Medicare Provider number: _______________  Medicaid Provider number: _______________

**Mail completed form to:**

P.O. Box 300009
Raleigh, NC  27622
FAX: 1-919-851-4014
1-800-688-6696

PVS002 Revised 07/04
**Attention: Anesthesia Providers**

**Adjustments to Anesthesia Claims**

Anesthesia modifiers QK, QX, QY, QZ, and AA were implemented for all anesthesia claims processed on or after May 16, 2004. These modifiers allow better definition of services rendered by the certified registered nurse anesthetist (CRNA) and anesthesiologist and allows proper payment when anesthesia services are rendered by the CRNA and medically directed by the anesthesiologist. One of these modifiers is required on all claims filed for anesthesia service. This includes claims filed for anesthesia for obstetrical services and for anesthesia services that are reimbursed based on the fee schedule instead of time units.

Overpayments of anesthesia services for dually eligible recipients were made due to Medicare processing with the medical direction modifiers that were not recognized by Medicaid. These overpayments will be resolved with the processing of these adjustments.

N.C. Medicaid will begin initiating adjustments of anesthesia claims that were either denied or paid incorrectly at 100 percent of the allowed amount for the service.

**Adjustments for claims submitted under the following scenario will be initiated immediately and will occur on-going for future claim submissions:**

If a claim was submitted by both the anesthesiologist and the CRNA and the first claim was processed and paid at 100 percent and the second claim was submitted with either modifier QX, QY or QK, denoting medical direction, but has not yet been processed:

- The first claim (paid at 100 percent) will be recouped with an EOB instructing the provider to rebill services using a medical direction modifier.
- The second claim will be processed and paid at 50 percent of the allowed amount for the service.

**Adjustments for claims submitted under the following scenario will be initiated in the future. (Providers will be notified through the general Medicaid bulletin prior to the reprocessing of these claims):**

1. If a claim was submitted by either the anesthesiologist or the CRNA for the same service and both claims have been processed, and if the first claim was paid and the second claim was denied:
   - The paid claim will be adjusted and repaid at 50 percent of the total allowed amount for the service.
   - The denied claim will be reprocessed and paid at 50 percent of the allowed amount for the service.

2. If a claim was submitted by both the anesthesiologist and the CRNA for the same service and both claims were processed and paid at 100 percent of the total allowed amount, both claims will be adjusted and repaid at 50 percent of the allowed amount for the service.

Providers will not be required to file adjustments or refund overpayments. Recoupments will be done when the claims are reprocessed.

**EDS, 1-800-688-6696 or 919-851-8888**
Attention: All Providers

Change in Billing Requirements for Anesthesia Codes 01961, 01968, and 01969

Effective with date of service September 1, 2004, providers billing for the following anesthesia codes must now bill with unit of time. For Medicaid billing, one minute = one unit. The time plus base units will be used in calculating the reimbursement.

- 01961, Anesthesia for cesarean delivery only
- 01968, Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia
- 01969, Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia

For additional information on billing for anesthesia services using anesthesia modifiers, refer to the April 2004 general Medicaid bulletin.

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

Attention: Hospice Providers

Hospice Nursing Facility Room and Board Billing Guidelines

Hospice providers currently bill Hospice Nursing Facility Room and Board according to the level of care determined by the FL-2 approval. If the level of care is Intermediate (ICF), the Hospice providers bill using RC658. If the level of care is Skilled (SNF), the Hospice providers bills using RC659. If a claim is billed using a revenue code that does not match the level of care on the FL-2, the claim will deny with EOB 2229 “There is not an approved FL-2 for the billed Nursing Facility level of care for the date of service”.

Effective with date of service June 1, 2004 all prior approvals will be granted at one level of care, Nursing Facility (NF) level of care. This action is being taken to comply with the change in level of care for nursing facilities from two levels to one level of care. (Refer to the August 2004 general Medicaid bulletin on DMA’s website at http://www.dhhs.state.nc.us/dma/bulletin.htm for more information). Hospice claims for the facility charge approved at the new NF level of care must be billed using RC659. If the level of care was approved prior to June 1, 2004 at the ICF level of care, the provider should continue using RC658 as long as the ICF approval is valid. If the level of care was approved prior to June 1, 2004 at the SNF level of care, providers will continue to bill using RC659. Hospice providers should bill accordingly to avoid receiving a denial with EOB 2229.

EDS, 1-800-688-6696 or 919-851-8888
Attention: Community Alternatives Program Providers

Reimbursement Rate Increase for Community Alternatives Program Services

Effective with date of service August 16, 2004, the Medicaid maximum reimbursement rate for the following Community Alternatives Program (CAP) services has been increased. This is an interim rate increase that will be effective through December 2004. Results from a pending audit of PCS providers may result in a subsequent rate change. Providers will be notified of any further rate changes in future general Medicaid bulletins.

<table>
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<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Reimbursement Rate</th>
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<tr>
<td>S5125</td>
<td>CAP/C Personal Care</td>
<td>$3.55/15 min unit</td>
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<tr>
<td>S5125</td>
<td>CAP/AIDS In-Home Aide II-Personal Care</td>
<td>3.55/15 min unit</td>
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<tr>
<td>S5125</td>
<td>CAP/AIDS In-Home Aide III-Personal Care</td>
<td>3.55/15 min unit</td>
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<tr>
<td>S5125</td>
<td>CAP/DA In-Home Aide II-Personal Care</td>
<td>3.55/15 min unit</td>
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<tr>
<td>S5125</td>
<td>CAP/DA In-Home Aide III-Personal Care</td>
<td>3.55/15 min unit</td>
</tr>
<tr>
<td>S5125</td>
<td>CAP-MR/DD Personal Care</td>
<td>3.55/15 min unit</td>
</tr>
<tr>
<td>S5120</td>
<td>CAP-MR/DD In-Home Aide Level I</td>
<td>3.55/15 min unit</td>
</tr>
<tr>
<td>S5150</td>
<td>CAP/C Respite Care In-Home</td>
<td>3.55/15 min unit</td>
</tr>
<tr>
<td>S5150</td>
<td>CAP/AIDS Respite Care In-Home, Aide Level</td>
<td>3.55/15 min unit</td>
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<tr>
<td>S5150</td>
<td>CAP/DA Respite Care-In Home</td>
<td>3.55/15 min unit</td>
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<tr>
<td>S5150</td>
<td>CAP-MR/DD Respite Care Community Based</td>
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</tr>
</tbody>
</table>

Robyn Slate, Rate Setting
DMA, 919-857-4015

Attention: Personal Care Providers (excluding Adult Care Homes)

Reimbursement Rate Increase for Personal Care Services

Effective with date of service August 16, 2004, the Medicaid maximum reimbursement rate for In-Home Personal Care Services (PCS) is $3.55 per 15-minute unit ($14.20/hour). This is an interim rate increase that will be effective through December 2004. Results from a pending audit of PCS providers may result in a subsequent rate change. Providers will be notified of any further rate changes in future general Medicaid bulletins.

Robyn Slate, Rate Setting
DMA, 919-857-4015
Attention: Area Mental Health Programs, CAP-MR/DD Providers, and Local Management Entities

Medicaid Determination of Eligibility for New CAP-MR/DD Recipients

When determining eligibility for potential CAP-MR/DD coverage for a person who is applying for Medicaid, the lead agency or provider must follow the county department of social services (DSS) time standards for processing applications. For Medicaid recipients applying for CAP-MR/DD, the lead agency or provider must follow the guidelines in the CAP-MR/DD Manual found at http://www.dhhs.state.nc.us/mhddsas.

According to the Code of Federal Regulations, 42CFR435.911, Timely Determination of Eligibility for Medicaid for DSS, the “agency must establish time standards for determining eligibility.” These standards may not exceed “a) Ninety days for applicants who apply for Medicaid on the basis of disability; and b) Forty-five days for all other applicants.”

As indicated on page 5-10, section 5.4 of the CAP-MR/DD Manual: “For a person to get CAP-MR/DD benefits and for provider agencies, including the lead agency, to get paid, activities must be coordinated with the DSS Medicaid staff. Promptly processing the Plan of Care to get an approval from the local lead agency as quickly as possible is important for the person as well as DSS. DSS has strict time limits to act on application. If the Plan is not approved within the time limit, DSS may have to deny the Medicaid application. This means a person may have to reapply for Medicaid. Getting the Plan approved within the designated DSS and CAP-MR/DD timeframes benefits the person.” The manual further states on page 8-2, section 8.2.1a: “For new Medicaid applicants, the Plan of Care approval date must be coordinated with the DSS Medicaid Office so the plan is approved within the time standards required for Medicaid applicants.” Contact the county DSS to determine which application processing time standard applies.

If there is no approved plan of care by the end of the 45-day/90-day timeframe, DSS will process the application as a regular non-CAP-MR/DD case applying regular Medicaid eligibility rules. If this creates a denial before the approved plan of care is received by DSS, the process must start over with the application for Medicaid.

EDS, 1-800-688-6696 or 919-851-8888
Attention: Area Mental Health Programs, CAP-MR/DD Providers, and Local Management Entities

Submission of MR-2 for Level of Care Determination

Session Law 437 1.2 (c) repealed G.S. 122C-3 (34) and (35) regarding Single Portal Services in area mental health programs. Therefore, it is no longer a Medicaid requirement to have the Single Portal Coordinator sign the MR-2 for ICF-MR level of care before it is submitted to EDS. However, the physician’s signature and the signature of the case manager are still required on the MR2.

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

Attention: Dental Providers and Health Departments Dental Clinics

2002 American Dental Association (ADA) Claim Form

The Division of Medical Assistance (DMA) and EDS currently are updating the Medicaid claims processing system to accept the 2002 ADA claim form. The planned implementation date for the new form is October 1, 2004. Once the system has been updated, providers will be given a three-month transition period to begin using the 2002 claim form. During the three-month transition period, both the 1999 and 2002 ADA forms will be accepted. After the transition period, claims filed using the 1999 ADA form will be returned to the provider. Please refer to upcoming general Medicaid bulletins for notification of the official implementation date.

Claim forms can be ordered directly from the ADA. Listed below are the web address, toll-free telephone number, and contact address for the ADA.

http://www.ada.org/ada/prod/catalog/index.asp

1-800-947-4746

American Dental Association
Attn: Salable Materials Office
211 E. Chicago Avenue
Chicago, IL 60611

The claim form is available as a single or two-part form. The single form must be used when submitting claims for payment. The two-part form must be used when requesting prior approval. The original is returned to the provider and serves as the prior approval/claim copy. The second page is retained by EDS.

Dr. Ron Venezie, Dental Director
DMA, 919-857-4033
## AOA Dental Claim Form

### Header Information
- Type of Transaction (Check all applicable boxes)
- Payment of All Services - DB - Rejection for Preauthorization/Payment Authorization

### Primary Subscriber Information
- Name, Address, City, State, Zip Code
- Date of Birth (MM/DD/YYYY)
- Gender
- Subscription Identifier (SSN or ID)

### Other Coverage
- Other Dental or Medical Coverage
- Subscriber Name (First, Middle Initial, Last)

### OBJECT INFORMATION
- Patient Information
- Relationship to Primary Subscriber

### Record of Services Provided
- Procedure Code
- Name
- Date

### Missing Teeth Information
- Anterior
- Posterior
- History
- Other

### Ancillary Claim/Treatment Information
- Place of Treatment (Check applicable box)
- Number of Procedures (00 to 99)
- Other

### Billing Dentist or Dental Entity
- Name, Address, City, State, Zip Code
- Procedure Code

### Treatment Dentist and Treatment Location Information
- Procedure Code
- License Number
- Specialty

### Example

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<th>Value</th>
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Attention: Dental Providers and Health Departments Dental Clinics

Dental Seminar Schedule

Seminars for dental providers are scheduled for September 2004. This seminar will focus on upcoming changes to the clinical coverage policy for dental services and will include guidelines for completing the ADA claim form, changes in covered procedure codes, the most common denials for dental claims, and other general Medicaid issues. Medicaid billing personnel, supervisors, and office managers are encouraged to attend.

The seminars will begin at 10:00 a.m. and end at 1:00 p.m. Providers are encouraged to arrive by 9:45 a.m. to complete registration. Lunch will not be provided at the seminars. Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

Providers may register for the seminars by completing and submitting the registration form on page 13 or by registering online at http://www.dhhs.state.nc.us/dma/provsem.htm. Please indicate on the registration form the session you plan to attend.

Special Bulletin V, Dental Services Coverage Policy and Billing Guidelines, available on DMA’s website at http://www.dhhs.state.nc.us/dma/bulletin.htm, will be used as the primary training document for the seminar. Please print the special bulletin and bring it to the seminar.

Because the seminar also will briefly address the general Medicaid billing guidelines, providers may wish to bring a copy of the General Medicaid Billing/Carolina ACCESS Policies and Procedures Guide (http://www.dhhs.state.nc.us/dma/medbillcaguide.htm) to the seminar.

Wednesday, September 8, 2004
Jane S. McKimmon Center
1101 Gorman Street
Raleigh, NC

Thursday, September 23, 2004
Park Inn Gateway Conference Center
909 Highway 70 SW
Hickory, NC

Tuesday, September 28, 2004
Coast Line Convention Center
501 Nutt Street
Wilmington, NC

Thursday, September 30, 2004
Holiday Inn Conference Center
530 Jake Alexander Blvd., S
Salisbury, NC

EDS, 1-800-688-6696 or 919-851-8888
Directions to the Dental Seminars

Jane S. McKimmon Center – Raleigh
Traveling East on I-40
Take exit 295 and turn left onto Gorman Street. Travel approximately one mile. The McKimmon Center is located on the right at the corner of Gorman Street and Western Boulevard.

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

Park Inn Gateway Conference Center – Hickory
Take I-40 to exit 123. Follow signs to US 321 North. Take the first exit (Hickory exit) and follow the ramp to the stoplight. Turn right at the light onto US 70. The Gateway Conference Center is on the right.

Coast Line Convention Center – Wilmington
Take I-40 east to Wilmington. Take the Highway 17 exit. Turn left onto Market Street. Travel approximately 4 or 5 miles to Water Street. Turn right onto Water Street. The Coast Line Inn is located one block from the Hilton on Nutt Street behind the Railroad Museum.

Holiday Inn Conference Center – Salisbury
Traveling South on I-85
Take exit 75. Turn right onto Jake Alexander Boulevard. Travel approximately ½ mile. The Holiday Inn is located on the right.

Traveling North on I-85
Take exit 75. Turn left onto Jake Alexander Boulevard. Travel approximately ½ mile. The Holiday Inn is located on the right.

(cut and return the registration form only)

Dental Seminar Registration Form
(No Fee)

Provider Name _______________________________ Provider Number ____________________________
Address __________________________________________________________
City, Zip Code ____________________________ County ________________________________
Contact Person ____________________________ E-mail Address ____________________________
Telephone Number ____________________________ Fax Number _____________________________
1 or 2 (circle one) person(s) will attend the seminar at ____________________________ on ________________ (date)

Return to: Provider Services
EDS
P.O. Box 300009
Raleigh, NC 27622
Attention: Dialysis Treatment Facility Providers

Erythropoietin (EPO) Billing Instructions

Effective with date of service October 1, 2004, claims submitted for erythropoietin (Epogen) must include ICD-9-CM diagnosis code 585 as the primary diagnosis and one of the additional diagnosis codes listed below to be considered for EPO reimbursement. If the primary diagnosis code and an appropriate additional diagnosis code are not listed on the claim, it will deny with EOB 082, “Service is not consistent with/or not covered for this diagnosis/or description does not match diagnosis.”

The following information is required on the claim when billing for Epogen:
- ICD-9-CM diagnosis code 585, Chronic renal failure, must be entered on the claim as the primary diagnosis for end-stage renal disease.

AND

- One of the following additional diagnosis codes:
  - 285.8, Other specified anemia
  - 285.9, Anemia, unspecified
  - 285.21, Anemia in end stage renal disease
- Epogen must be billed with revenue code 634 and an appropriate procedure code.
- All Epogen charges for the same date of service must be billed as one detail on the claim. If Epogen charges are billed on two or more details on the claim for the same date of service, each of the details will deny with EOB 1198 “Service billed multiple times. If on this claim, combine units on single detail and resubmit new claim. If paid on previous claim, combine units and file an adjustment.”

The requirements related to hematocrit values remain unchanged. Refer to the January 1999 general Medicaid bulletin for additional information.

The procedure codes for billing Epogen will change from Q9920 through Q9940 to Q4055, Injection, epoetin alfa, 1000 units. Billing instructions and the effective date of the change will be published in a future general Medicaid bulletin when the system is ready to receive claims.

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

Attention: Pharmacists and Prescribers

Technical Correction to General Policy for Over the Counter Medications

A technical correction to clarify how over the counter medications are dispensed was made to Section 1.0 of General Coverage Policy #A2, Over the Counter Medications. The updated policy is now available on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm.

EDS, 1-800-688-6696 or 919-851-8888
Attention: Pharmacists and Physicians

Synagis Coverage for 2004-2005

For the Synagis season 2004-2005, Synagis will no longer require prior authorization. However, physicians are required to complete a Synagis for RSV Prophylaxis criteria (1, 2 or 3) form for coverage. These forms will be available on the Division of Medical Assistance’s website at http://www.dhhs.state.nc.us/dma/forms.html by September 15, 2004.

Completed forms should be sent to the physician’s pharmacy provider of choice for processing. If clinical criteria 1, 2 or 3 applies, then the pharmacy provider reviews the form to ensure that it has been completed in full and verifies the recipient’s Medicaid eligibility. The pharmacy provider ships the Synagis to the physician’s office.

In the event that a recipient does not meet the clinical criteria for coverage, the physician can request an exemption by completing a N.C. Medicaid Request for Medical Review for Synagis Outside of Criteria form and submitting it to the pharmacy provider. The pharmacy provider forwards the form to DMA for clinical review. If the request for coverage is denied, the physician may appeal to DMA.

Physicians and pharmacy providers are subject to audits of Synagis records by the DMA Program Integrity Unit. All Synagis criteria forms and requests for coverage outside of criteria must be sent by the pharmacy provider on a weekly basis to DMA for review.

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

Attention: Pharmacists and Prescribers

Removal of ADHD Drugs and Rebetron from the Prior Authorization Drug List

Effective August 5, 2004, the following drugs will no longer require prior authorization from Medicaid:

- Amphetamine Mixtures (Adderall, Adderall XR)
- Dextroamphetamine (generics, Dexedrine, Dextrostat)
- Methamphetamine (Desoxyn)
- Methylphenidate (generics, Ritalin, Methylin, Concerta)
- Methylphenidate sustained-release (generics, Ritalin SR, Ritalin LA, Methylin ER, Metadate ER, Metadate CD), Ritalin LA 20mg, 30mg, 40mg
- Pemoline (generics, Cylert, PemADD)
- Focalin (Dexamethasone HCL)
- Rebetron (Interferon Alfa-2b and Ribavirin combination pack)

Sharman Leinwand, RPh, MPH Pharmacy Program
DMA, 919-857-4020
Proposed Clinical Coverage Policies

In accordance with Session Law 2003-284, proposed new or amended Medicaid clinical coverage policies are available for review and comment on DMA’s website at http://www.dhhs.state.nc.us/dma/prov.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.

Gina Rutherford
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.

Holiday Observance

The Division of Medical Assistance and EDS will be closed on Monday, September 6, 2004 in observance of Labor Day.

Checkwrite Schedule

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Electronic Cut-Off Schedule

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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.

Gary H. Fuquay, Director
Division of Medical Assistance
Department of Health and Human Services

Cheryll Collier, Executive Director
EDS