North Carolina Medicaid Bulletin

Published as an Informational Service to Medicaid Providers by the Division of Medical Assistance and EDS, Fiscal Agent for the N.C. Medicaid Program

Number 1 **January 2004**

In This Issue . . .

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

Attention: All Providers

Corrected 1099 Requests – Action Required by March 1, 2004

Providers receiving Medicaid payments of more than $600 annually receive a 1099 MISC tax form from EDS. The 1099 MISC tax form is generated as required by IRS guidelines. It will be mailed to each provider no later than January 31, 2004. The 1099 MISC tax form will reflect the tax information on file with Medicaid as of the last Medicaid checkwrite cycle date, December 29, 2003.

If the tax name or tax identification number on the annual 1099 MISC you receive is **incorrect**, a correction to the 1099 MISC must be requested. This ensures that accurate tax information is on file with Medicaid and sent to the IRS annually. When the IRS receives incorrect information on your 1099 MISC, it may require backup withholding in the amount of **28 percent of future Medicaid payments**. The IRS could require EDS to initiate and continue this withholding to obtain correct tax data.

A correction to the original 1099 MISC must be **submitted to EDS by March 1, 2004** and must be accompanied by the following documentation:

- a copy of the original 1099 MISC
- a signed and completed IRS W-9 form clearly indicating the correct tax identification number and tax name. (Additional instructions for completing the W-9 form can be obtained at http://www.irs.gov under the link "Forms and Pubs.")

Fax both documents to 919-816-4399, Attention: Corrected 1099 Request - Financial

Or

Mail both documents to:

EDS
Attention: Corrected 1099 Request - Financial
4905 Waters Edge Drive
Raleigh, NC 27606

A copy of the corrected 1099 MISC will be mailed to you for your records. All corrected 1099 MISC requests will be reported to the IRS. In some cases, additional information may be required to ensure that the tax information on file with Medicaid is accurate. Providers will be notified by mail of any additional action that may be required to complete the correction to their tax information.

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

Form **W-9**
(Rev. January 2003)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type See **Specific Instructions** on page 2.

Name

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ► ..... ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.) | Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). **However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3.** For other entities, it is your employer identification number (EIN). If you do not have a number, see **How to get a TIN** on page 3.

Note: *If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.*

Social security number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

or

Employer identification number ___ ___ - ___ ___ ___ ___ ___ ___ ___

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item **2** above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item **2** does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here Signature of U.S. person ► Date ►

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee.

Note: *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

Foreign person. If you are a foreign person, use the appropriate Form W-8 (see **Pub. 515,** Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Cat. No. 10231X Form **W-9** (Rev. 1-2003)

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a **nonresident alien or a foreign entity** not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 30% of such payments (29% **after** December 31, 2003; 28% **after** December 31, 2005). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will **not** be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or

2. You do not certify your TIN when required (see the Part II instructions on page 4 for details), or

3. The IRS tells the requester that you furnished an incorrect TIN, or

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under **4** above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate **Instructions for the Requester of Form W-9.**

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your **individual** name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, **enter the owner's name on the "Name" line.** Enter the LLC's name on the "Business name" line.

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note: *You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).*

Exempt From Backup Withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note: *If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.*

Exempt payees. Backup withholding is **not required** on any payments made to the following payees:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2);

2. The United States or any of its agencies or instrumentalities;

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities;

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities; or

5. An international organization or any of its agencies or instrumentalities.

Other payees that **may be exempt** from backup withholding include:

6. A corporation;

7. A foreign central bank of issue;

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States;

9. A futures commission merchant registered with the Commodity Futures Trading Commission;

10. A real estate investment trust;

11. An entity registered at all times during the tax year under the Investment Company Act of 1940;

12. A common trust fund operated by a bank under section 584(a);

13. A financial institution;

14. A middleman known in the investment community as a nominee or custodian; or

15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt recipients listed above, **1** through **15.**

If the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt recipients except for **9**
Broker transactions	Exempt recipients **1** through **13.** Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt recipients **1** through **5**
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt recipients **1** through **7** [2]

[1] See **Form 1099-MISC**, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are **not exempt** from backup withholding: medical and health care payments, attorneys' fees; and payments for services paid by a Federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a **resident alien** and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see **How to get a TIN** below.

If you are a **sole proprietor** and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-owner **LLC** that is disregarded as an entity separate from its owner (see **Limited liability company (LLC)** on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

Note: *See the chart on page 4 for further clarification of name and TIN combinations.*

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get **Form SS-5,** Application for a Social Security Card, from your local Social Security Administration office or get this form on-line at **www.ssa.gov/online/ss5.html**. You may also get this form by calling 1-800-772-1213. Use **Form W-7,** Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or **Form SS-4,** Application for Employer Identification Number, to apply for an EIN. You can get Forms W-7 and SS-4 from the IRS by calling 1-800-TAX-FORM (1-800-829-3676) or from the IRS Web Site at **www.irs.gov**.

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: *Writing "Applied For" means that you have already applied for a TIN* ***or*** *that you intend to apply for one soon.*

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 3, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see **Exempt from backup withholding** on page 2.

Signature requirements. Complete the certification as indicated in **1** through **5** below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item **2** in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item **2** of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA or Archer MSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or single-owner LLC	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Sole proprietorship or single-owner LLC	The owner [3]
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] **You must show your individual name,** but you may also enter your business or "DBA" name. You may use either your SSN or EIN (if you have one).

[4] List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note: *If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.*

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA or Archer MSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, or to Federal and state agencies to enforce Federal nontax criminal laws and to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 30% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

Attention: All Providers

CPT Code Update 2004

New 2004 CPT codes are covered by N.C. Medicaid effective with date of service January 1, 2004. Claims with codes deleted for 2004 by the American Medical Association (AMA) will deny effective with dates of service on or after April 1, 2004.

The following table lists the new CPT codes that **may be billed**.

00529	01173	01958	21685	31632	31633	34805	35510	35512
35522	35525	35697	36555	36556	36557	36558	36560	36561
36563	36565	36566	36568	36569	36570	36571	36575	36576
36578	36580	36581	36582	36583	36584	36585	36589	36590
36595	36596	36597	36838	43237	43238	53500	57425	61537
61540	61566	61567	61863	61864	61867	61868	63101	63102
63103	64449	64517	64681	67912	70557	70558	70559	75998
76082	76083	76514	76937	76940	78804	79403	84156	84157
85055	85396	87269	87329	87660	88112	88361	89220	89225
89230	89235	89240		90734	91110	95991		

The following table lists the Medicaid covered CPT codes that will be **end-dated** effective March 31, 2004.

36488	36489	36490	36491	36493	36530	36531	36532	36533
36534	36535	36536	36537	47134	61862	76085	76490	89350
89355	89360	89365	89399					

The following table lists the new 2004 CPT codes that are **noncovered pending further review**.

20982	22532	22533	22534	37765	37766	47140	47141	47142
59070	59074	59076	59897	65780	65781	65782	68371	0001F
0002F	0003F	0004F	0005F	0006F	0007F	0008F	0009F	0010F
0011F								

The following table lists the new 2004 CPT codes that are **noncovered**.

59072	89268	89272	89280	89281	89290	89291	89335	89342
89343	89344	89346	89352	89353	89354	89356	90698	90715
97755	99601	99602	0045T	0046T	0047T	0048T	0049T	0050T
0051T	0052T	0053T	0054T	0055T	0056T	0057T	0058T	0059T
0060T	0061T							

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

Attention: All Providers

EOB Code Crosswalk to HIPAA Standard Codes

With the implementation of standards for electronic transactions mandated by the Health Insurance Portability and Accountability Act, providers now have the option to receive an Electronic Remittance Advice (ERA) in addition to the paper version of the Remittance and Status Report (RA).

The EOB codes that providers currently receive on a paper RA are not used on the ERA. Because the EOB codes on the paper RA provide a greater level of detail on claim denials, all providers will continue to receive the paper version of the RA, even if they choose to receive the ERA transaction.

A list of standard national codes used on the ERA has been cross-walked to EOB codes as an informational aid to adjudicated claims listed on the RA. The list is available online at http://www.dhhs.state.nc.us/dma/prov.htm. The list is current as of the date of publication. Providers will be notified of changes to the list through the general Medicaid bulletin.

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

Attention: All Providers

Influenza - New Diagnosis Code V04.81

Effective with date of service October 1, 2003, the N.C. Medicaid program covers the new diagnosis code for influenza, V04.81. Diagnosis code V04.8 is no longer a valid diagnosis code. Providers who have had claims denied with V04.81 may resubmit them for payment.

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

Attention: All Providers

FluMist Influenza Vaccine (CPT Code 90660) – Billing Guidelines

Effective with date of service December 15, 2003, the N.C. Medicaid program began coverage of the intranasal FluMist vaccine for healthy recipients ages 5 years through 49 years. These Medicaid recipients must be household contacts of Medicaid recipients who are at high risk for complications from influenza. Information regarding the risk categories pertinent to influenza according to the guidelines from the Advisory Committee on Immunization Practices (ACIP) can be accessed online at http://www.cdc.gov/nip/ACIP/default.htm. This policy will remain in effect through March 31, 2004.

Medicaid covers the FluMist vaccine only when dispensed by local health departments. FluMist should be administered according to the ACIP guidelines. Providers must use CPT code 90660, influenza virus vaccine, live, for intranasal use when billing for FluMist. The appropriate diagnosis code for the influenza vaccine is ICD-9-CM diagnosis code V04.81. An administration fee will not be reimbursed in addition to the cost of the vaccine.

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

Attention: All Providers

ICD-9-CM Code Changes for 2004

Effective October 1, 2003, the following list of ICD-9-CM diagnosis codes became invalid. A three-month grace period allowed providers to bill these codes until December 31, 2003. After December 31, 2003, claims submitted with the following codes will deny.

Code	Description
255.1	Hyperaldosteronism
277.8	Other specified disorder of metabolism
282.4	Thalassemias
289.8	Other specified diseases of blood and blood-forming organs
331.1	Pick's disease
348.3	Encephalopathy, unspecified
358.0	Myasthenia gravis
458.2	Iatrogenic hypotension
530.2	Ulcer of esophagus
600.0	Hypertrophy (benign) of prostate
600.1	Nodular prostate
600.2	Benign localized hyperplasia of prostate
600.9	Hyperplasia of prostate, unspecified
719.70	Difficulty in walking, unspecified
719.75	Difficulty in walking, pelvic region and thigh
719.76	Difficulty in walking, lower leg
719.77	Difficulty in walking, ankle and foot
719.78	Difficulty in walking, other specified sites
719.79	Difficulty in walking, multiple sites
752.8	Other specified anomalies of genital organs
766.2	Post term infant, not "heavy for dates"
767.1	Birth trauma, injuries to scalp
790.2	Abnormal glucose tolerance test
799.8	Other ill-defined conditions
850.1	Concussion, with brief loss of consciousness
959.1	Injury, trunk
V04.8	Need for prophylactic vaccination and inoculation against certain viral disease, Influenza
V43.2	Status, organ or tissue replaced by other means, Heart
V53.9	Fitting and adjustment of other device, Other and unspecified device
V54.0	Aftercare involving removal of fracture plate or other internal fixation device
V64.4	Laparoscopic surgical procedure converted to open procedure
V65.1	Person consulting on behalf of another person

Most of these codes have been replaced with more diagnosis-specific five-digit codes. Providers must use current national codes from the 2004 ICD-9-CM manual when submitting claims to N.C. Medicaid.

Deborah Ireland, R.N.C., Medical Policy Section
DMA, 919-857-4020

Attention: All Providers

Inpatient Hospital Claims

In order to comply with regulations mandated by the Health Insurance Portability and Accountability Act (HIPAA) and with Medicaid regulations, effective February 1, 2004, ICD-9-CM procedure codes will only be accepted on claims submitted for inpatient hospital services. Other claim types (i.e., outpatient claims) must be billed using CPT procedure codes or HCPCS procedure codes. These other types of claims will deny if they are billed with ICD-9-CM procedure codes.

Deborah Ireland, R.N.C., Medical Policy Section
DMA, 919-857-4020

Attention: Ambulatory Surgical Centers

CPT Code Update 2004 for Ambulatory Surgical Centers

The following table lists the new CPT codes that **may be billed** by ambulatory surgical centers effective with date of service January 1, 2004.

36555	36556	36557	36558	36560	36561	36563	36565	36566
36568	36569	36570	36571	36575	36576	36578	36580	36581
36582	36583	36584	36585	36589	36590			

The following table lists the Medicaid covered CPT codes that have been **deleted** for ambulatory surgical centers.

36489	36491	36530	36531	36532	36533	36534	36535

Claims submitted with codes deleted for 2004 by the American Medical Association (AMA) will deny effective with dates of service on or after April 1, 2004.

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

Attention: Area Mental Health Centers

End-Dated HCPCS Code for Behavioral Health

HCPCS procedure codes W9906, Clozaril lab and counseling, was end-dated effective with date of service December 1, 2003. This action was taken due to non-usage of the code.

Carol Robertson, Medical Policy Section
DMA, 919-857-4020

Attention: Area Mental Health Centers, Federally Qualified Health Centers, Health Departments, Nurse Practitioners, Physicians, and Rural Health Clinics

Risperidone (Risperdal Consta, J3490) – Billing Guidelines

Effective with date of service January 1, 2004, the N.C. Medicaid program covers injectable risperidone (Risperdal Consta) for use in the Physician's Drug Program. The FDA states that risperidone, a benzisoxazole antipsychotic agent, is indicated for the treatment of schizophrenia. Risperdal Consta is available in dosage strengths of 25 mg, 37.5 mg, and 50 mg for intramuscular administration every two weeks. One of the ICD-9-CM diagnosis codes in the range **295.0 through 295.9** must be entered on the CMS-1500 claim form when billing for Risperdal Consta.

Providers must bill J3490, the unclassified drug code, with an invoice attached to the claim form. **An invoice must be submitted with each claim**. The paper invoice must indicate the name of the recipient, the recipient's Medicaid identification (MID) number, the name of the medication, the dosage given, the National Drug Code (NDC) number from the vial(s) used, the number of vials used, and the cost per dose. Providers must indicate the number of units given in block 24G on the claim form. The maximum reimbursement rate is $249.84 for the 25 mg vial, $374.77 for the 37.5 mg vial, and $499.69 for the 50 mg vial. Providers must bill their usual and customary charge.

Add this drug to the lists of injectable drugs published in the June 2002 and August 2002 general Medicaid bulletins.

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

Attention: Children's Development Service Agencies and Developmental Evaluation Centers

Conversion to National Codes

Effective with date of service January 1, 2004, national HCPCS codes replaced state-created codes as indicated below. This change is being made to comply with the implementation of standard national codes mandated by the Health Insurance Portability and Accountability Act (HIPAA). Claims billed after January 1, 2004 using these state-created codes will deny.

New HCPCS Code	Old State-Created Code
H0031 (1 unit = 15 minutes)	Y2104, Social/Family Diagnosis and Assessment
96110 and 96111	Y2110, Educational/Developmental Testing
T1023	Y2136, Intermediate Assessment (not time based)

Monica Teasley, Medical Policy Section
DMA, 919-857-4020

Attention: Durable Medical Equipment Providers

HCPCS Code Changes for Durable Medical Equipment

The following HCPCS codes were changed effective with date of service January 1, 2004. The DME Fee Schedule has been updated to reflect this change. The changes were made to comply with code changes from the Centers for Medicare and Medicaid Services (CMS).

Old Code	New Code	Description	Quantity Limitation or Lifetime Expectancy	Maximum Reimbursement Rate
A4621	A7525	Tracheostomy mask, each	N/A	Purchase: $ 1.34
A4622	A7520	Tracheostomy/laryngectomy tube, non-cuffed, polyvinylchloride (PVC), silicone or equal, each	N/A	Purchase: 52.13
	A7521	Tracheostomy/laryngectomy tube, cuffed, polyvinylchloride (PVC), silicone or equal, each	N/A	Purchase: 52.13
	A7522	Tracheostomy/laryngectomy tube, stainless steel or equal (sterilizable and reusable), each	N/A	Purchase: 52.13
K0016	E0973*	Wheelchair accessory, adjustable height, detachable armrest, complete assembly, each	3 years	Rental: 10.24 New Purchase: 107.61 Used Purchase: 80.71
K0022 K0026 K0027	E0982	Wheelchair accessory, back upholstery, replacement only, each	1 year for ages 0 through 20 2 years for ages 21 and older	Rental: 4.47 New Purchase: 44.72 Used Purchase: 33.53
K0025	E0966*	Manual wheelchair accessory, headrest extension, each	1 year for ages 0 through 20 2 years for ages 21 and older	Rental: 6.56 New Purchase: 65.55 Used Purchase: 49.16
K0028	E1226*	Manual wheelchair accessory, fully reclining back, each	1 year for ages 0 through 20 2 years for ages 21 and older	Rental: 44.68 New Purchase: 434.11 Used Purchase: 325.56
K0029 K0032 K0033	E0981	Wheelchair accessory, seat upholstery, replacement only, each	1 year for ages 0 through 20 2 years for ages 21 and older	Rental: 4.54 New Purchase: 45.37 Used Purchase: 34.02

HCPCS Code Changes for Durable Medical Equipment, continued

Old Code	New Code	Description	Quantity Limitation or Lifetime Expectancy	Maximum Reimbursement Rate
K0030	E0992*	Manual wheelchair accessory, solid seat insert	1 year for ages 0 through 20 2 years for ages 21 and older	Rental: $ 8.66 New Purchase: 89.05 Used Purchase: 66.80
K0031	E0978	Wheelchair accessory, safety belt/pelvic strap, each	1 year for ages 0 through 20 2 years for ages 21 and older	Rental: 3.88 New Purchase: 38.81 Used Purchase: 29.12
K0035	E0951	Heel loop/holder, with or without ankle strap	2 years	Rental: 2.42 New Purchase: 24.03 Used Purchase: 18.02
K0036	E0952	Toe loop/holder, each	2 years	Rental: 1.84 New Purchase: 17.63 Used Purchase: 13.23
K0048	E0990*	Wheelchair accessory, elevating legrest, complete assembly, each	3 years	Rental: 10.52 New Purchase: 103.12 Used Purchase: 77.35
K0049	E0995	Wheelchair accessory, calf rest/pad, each	2 years	Rental: 2.69 New Purchase: 27.00 Used Purchase: 20.26
K0062 K0063	E0967*	Manual wheelchair accessory, hand rim with projections, each	1 year for ages 0 through 20 2 years for ages 21 and older	Rental: 6.71 New Purchase: 67.07 Used Purchase: 50.28
K0079	E0961	Manual wheelchair accessory, wheel lock brake extension (handle), each	1 year for ages 0 through 20 2 years for ages 21 and older	Rental: 4.95 New Purchase: 47.35 Used Purchase: 23.68
K0080	E0974	Manual wheelchair accessory, anti-rollback device, each	1 year for ages 0 through 20 2 years for ages 21 and older	Rental: 13.24 New Purchase: 124.75 Used Purchase: 94.27
K0082	E2360	Power wheelchair accessory, 22 NF non-sealed lead acid battery, each	1 year	Rental: 10.57 New Purchase: 105.16 Used Purchase: 78.87

HCPCS Code Changes for Durable Medical Equipment, continued

Old Code	New Code	Description	Quantity Limitation or Lifetime Expectancy	Maximum Reimbursement Rate
K0083	E2361	Power wheelchair accessory, 22 NF sealed lead acid batter, each, (e.g. gel cell, absorbed glassmat)	1 year	Rental: 13.06 New Purchase: 130.54 Used Purchase: 97.92
K0084	E2362	Power wheelchair accessory, Group 24 non-sealed lead acid battery, each	1 year	Rental: $ 8.62 New Purchase: 86.09 Used Purchase: 64.57
K0085	E2363	Power wheelchair accessory, Group 24 sealed lead acid battery, each, (e.g. gel cell, absorbed glassmat)	1 year	Rental: 17.42 New Purchase: 174.10 Used Purchase: 130.57
K0086	E2364	Power wheelchair accessory, U-1 non-sealed lead acid battery, each	1 year	Rental: 10.57 New Purchase: 105.16 Used Purchase: 78.87
K0087	E2365	Power wheelchair accessory, U-1 sealed lead acid battery, each (e.g. gel cell, absorbed glassmat)	1 year	Rental: 10.50 New Purchase: 104.99 Used Purchase: 78.76
K0088	E2366*	Power wheelchair accessory, battery charger, single mode, for use with only one battery type, sealed or non-sealed, each	2 years	Rental: 21.03 New Purchase: 209.73 Used Purchase: 157.30
K0089	E2367*	Power wheelchair accessory, battery charger, dual mode, for use with either battery type, sealed or non-sealed, each	2 years	Rental: 39.22 New Purchase: 392.25 Used Purchase: 294.19
K0100	E0959	Manual wheelchair accessory, adapter for amputee, each	1 year for ages 0 through 20 2 years for ages 21 and older	Rental: 8.00 New Purchase: 79.99 Used Purchase: 60.00
K0103	E0972	Wheelchair accessory, transfer board or device, each	1 year for ages 0 through 20 2 years for ages 21 and older	Rental: 5.25 New Purchase: 51.59 Used Purchase: 37.78
K0107	E0950	Wheelchair accessory, tray, each	1 year for ages 0 through 20 2 years for ages 21 and older	Rental: 9.74 New Purchase: 97.30 Used Purchase: 72.98
K0268	E0561	Humidifier, non-heated, used with positive airway pressure device	2 years	Rental: $ 13.16 New Purchase: 131.57 Used Purchase 96.68

HCPCS Code Changes for Durable Medical Equipment, continued

Old Code	New Code	Description	Quantity Limitation or Lifetime Expectancy	Maximum Reimbursement Rate
K0531	E0562	Humidifier, heated, used with positive airway pressure device	2 years	Rental: 79.72 New Purchase: 797.23 Used Purchase 597.93
K0532	E0470*	Respiratory assist device, bi-level pressure capability, without back-up rate feature, used with non-invasive interface, e.g. nasal or facial mask (intermittent assist device with continuous positive airway pressure device)	5 years	Rental: 247.24 New Purchase: 2,472.42 Used Purchase 1,854.31
K0533	E0471*	Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with non-invasive interface, e.g. nasal or facial mask (intermittent assist device with continuous positive airway pressure device)	N/A	Rental: 580.30
K0538	E2402*	Negative pressure wound therapy electrical pump, stationary or portable	N/A	Rental: 1,654.77
K0539	A6550	Dressing set for negative pressure wound therapy electrical pump, stationary or portable, each	15 per month	Purchase: 26.42
K0540	A6551	Canister set for negative pressure wound therapy electrical pump, stationary or portable, each	10 per month	Purchase: 23.66
K0549	E0303*	Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress	5 years	Rental: 436.14 New Purchase: 6,341.28 Used Purchase 4,003.74
K0550	E0304*	Hospital bed, extra heavy duty, with weight capacity greater than 600 pounds, with any type side rails, with mattress	5 years	Rental: 767.43 New Purchase: 7.694.23 Used Purchase: 5,801.80
S8181	A7526	Tracheostomy tube collar/holder, each	12 per month	Purchase: 4.07
W4113 W4114 W4687	E0240	Bath/shower chair, with or without wheels, any size	3 years	New Purchase: 64.11 Used Purchase: 40.98
W4115	E0247	Transfer bench for tub or toilet with or without commode opening	3 years	New Purchase: 91.00 Used Purchase: 68.25
W4685 W4686	E0248	Transfer bench, heavy duty, for tub or toilet with or without commode opening	3 years	New Purchase: 248.08 Used Purchase: 186.06

Note: HCPCS codes with an asterisk require prior approval.

The coverage criteria for these items have not changed. Refer to Medical Coverage Policy #5, Durable Medical Equipment, on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex for detailed coverage information. A Certificate of Medical Necessity and Prior Approval form must be completed for all items regardless of the requirement for prior approval.

Melody B. Yeargan, P.T., Medical Policy Section
DMA, 919-857-4020

Attention: Durable Medical Equipment Providers

HCPCS Code Deletions for Durable Medical Equipment

Effective with dates of service January 1, 2004, the following codes were end-dated and deleted from the DME Fee Schedule. This action is being taken because the Centers for Medicare and Medicaid Services (CMS) has deleted these codes.

Code	Description
E0165	Commode chair, stationary, with detachable arms
K0054	Seat width of 10", 11", 12", 15", 17", or 20" for a high strength, lightweight or ultralightweight wheelchair
K0055	Seat depth of 15", 17", or 18" for a high strength, lightweight or ultralightweight wheelchair
K0057	Seat width 19" or 20" for heavy duty or extra heavy duty chair
K0058	Seat depth 17" or 18" for motorized/power wheelchair

Melody B. Yeargan, P.T., Medical Policy Section
DMA, 919-857-4020

Attention: Durable Medical Equipment Providers

Place of Service for Durable Medical Equipment

Durable medical equipment (DME) providers are reminded that they may only bill for DME and related supplies when the recipient resides in a private residence or an adult care home. Therefore, DME providers may not bill N.C. Medicaid for DME or related supplies when the recipient resides in a skilled nursing facility or intermediate care facility. Remember that your designation of place of service "12" in block 24B on the CMS-1500 claim form indicates that you are have verified the recipient's place of residence as his/her home or an adult care home.

Melody B. Yeargan, P.T., Medical Policy Section
DMA, 919-857-4020

Attention: Durable Medical Equipment Providers

HCPCS Code Changes for Orthotics and Prosthetics

The following HCPCS codes were changed effective with date of service January 1, 2004. The Orthotic and Prosthetic Fee Schedule has been updated to reflect this change. The changes were made to comply with code changes from the Centers for Medicare and Medicaid Services (CMS).

Old Code	New Code	Description	Maximum Reimbursement Rate
K0556	L5673	Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, Elastomeric or equal, for use with locking mechanism	Purchase: $ 564.04
K0557	L5679	Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, Elastomeric or equal, for use with locking mechanism	Purchase: 470.02
K0558	L5681	Addition to lower extremity, below knee/above knee, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, Elastomeric or equal, for use with or without locking mechanism, initial only	Purchase: 999.64
K0559	L5683	Addition to lower extremity, below knee/above knee, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, Elastomeric or equal, for use with or without locking mechanism, initial only	Purchase: 999.64

All of these codes require prior approval. The coverage criteria for these items have not changed. Refer to Medical Coverage Policy #5, DME, on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex for detailed coverage information. A Certificate of Medical Necessity and Prior Approval form must be completed for all items regardless of the requirement for prior approval.

Melody B, Yeargan, P.T., Medical Policy Section
DMA, 919-857-4020

Attention: Durable Medical Equipment Providers

End-Dated HCPCS Code for Orthotics and Prosthetics

Effective with date of service January 1, 2004, HCPCS code L2122, knee ankle foot orthosis, fracture orthosis, femoral fracture cast orthosis, plaster type casting material, custom-fabricated, was end-dated and deleted from the Orthotic and Prosthetic Fee Schedule. This action is being taken because the Centers for Medicare and Medicaid Services (CMS) has deleted this code.

Melody B. Yeargan, P.T., Medical Policy Section
DMA, 919-857-4020

Attention: Federally Qualified Health Centers, Health Departments, Nurse Practitioners, Physicians, and Rural Health Clinics

Arsenic Trioxide, 1 mg (Trisenox, J9017) – Billing Guidelines

Effective with date of service October 1, 2003, the N.C. Medicaid program covers injectable arsenic trioxide (Trisenox) for use in the Physician's Drug Program when billed with HCPCS code J9017. The FDA states that arsenic trioxide, an antineoplastic agent, is indicated for induction of remission and consolidation in patients with acute promyelocytic leukemia (APL) who are refractory to, or have relapsed from, retinoid and anthracycline chemotherapy, and whose APL is characterized by the presence of the t (15; 17) translocation or PML/RAR-alpha gene expression. It is recommended that Trisenox be infused intravenously over a period of one to two hours.

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

- **V58.1** – Admission or encounter for chemotherapy;
  AND EITHER
- **205.00** – Myeloid leukemia, acute; promyelocytic leukemia, acute: without mention of remission;
  OR
- **205.01** – Myeloid leukemia, acute; promyelocytic leukemia, acute: in remission

For Medicaid billing, one unit of coverage is 1 mg. Providers must indicate the number of units given in block 24G on the CMS-1500 claim form. The maximum reimbursement rate per unit is $35.10. Providers must bill their usual and customary charge.

Add this drug to the lists of injectable drugs published in the June 2002 and August 2002 general Medicaid bulletins.

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

Attention: Federally Qualified Health Centers, Health Departments, Nurse Practitioners, Physicians, and Rural Health Centers

Omalizumab (Xolair, J3490) – Billing Guidelines

Effective with date of service January 1, 2004, the N.C. Medicaid program covers injectable omalizumab (Xolair) for use in the Physician's Drug Program. The FDA states that Xolair, an anti-asthmatic monoclonal antibody, is indicated for adults and adolescents (12 years of age and older) with moderate to severe persistent asthma who have a positive skin test or in vitro reactivity to a perennial aeroallergen and whose symptoms are inadequately controlled with inhaled corticosteroids. One of the following ICD-9-CM diagnosis codes must be entered on the CMS-1500 claim form when billing for Xolair:

- **493.00** – Unspecified extrinsic asthma
- **493.01** – Unspecified extrinsic asthma with status asthmaticus
- **493.02** – Unspecified extrinsic asthma with acute exacerbation

Providers must bill J3490, the unclassified drug code, with an invoice attached to the claim form. **An invoice must be submitted with each claim**. The paper invoice must indicate the name of the recipient, the recipient's Medicaid identification (MID) number, the name of the medication, the dosage given, the National Drug Code (NDC) number from the vial(s) used, and the cost per dose. For Medicaid billing, one unit of coverage is the 150 mg vial for subcutaneous injection. Providers must indicate the number of units given in block 24G on the claim form. The maximum reimbursement rate is $487.13 for the 150 mg vial. Providers must bill their usual and customary charge.

Add this drug to the lists of injectable drugs published in the June 2002 and August 2002 general Medicaid bulletins.

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

Attention: Home Infusion Therapy Providers

End-Dated Codes for Low Profile Gastrostomy Kits

Effective with date of service December 31, 2003, the following HCPCS procedure codes were end-dated and deleted from the Home Infusion Therapy Fee Schedule due to limited usage. These supplies are still available to Medicaid recipients through durable medical equipment (DME) providers. If you are currently providing these kits to clients, after January 1, 2004, please refer them to a DME supplier.

W4210	Low profile gastrostomy kit
W4211	Low profile gastrostomy extension replacement kit for continuous feeding
W4212	Low profile gastrostomy extension replacement kit for bolus feeding

Beth Karr, Medical Policy Section
DMA, 919-857-4021

Attention: Federally Qualified Health Centers, Health Departments, Nurse Practitioners, Physicians, and Rural Health Clinics

Palonosetron 0.25 mg (Aloxi, J3490) – Billing Guidelines

Effective with date of service January 1, 2004, the N.C. Medicaid program covers injectable palonosetron (Aloxi) for use in the Physician's Drug Program. The FDA states that palonosetron, a selective 5-HT3 receptor antagonist and antiemetic, is indicated for the prevention of acute nausea and vomiting associated with initial and repeat courses of moderately and highly emetogenic cancer chemotherapy. It is also indicated for the prevention of delayed nausea and vomiting associated with initial and repeat courses of moderately emetogenic cancer chemotherapy. It is given intravenously.

Providers must bill J3490, the unclassified drug code, with an invoice attached to the CMS-1500 claim form. **An invoice must be submitted with each claim**. The paper invoice must indicate the name of the recipient, the recipient's Medicaid identification (MID) number, the name of the medication, the dosage given, the National Drug Code (NDC) number from the vial(s) used, the number of vials used, and the cost per dose. For Medicaid billing, one unit of coverage is .25 mg/5 ml. Providers must indicate the number of units given in block 24G on the claim form. The maximum reimbursement rate is $291.60 per 5 ml vial. Providers must bill their usual and customary charge.

Add this drug to the lists of injectable drugs published in the June 2002 and August 2002 general Medicaid bulletins.

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

Attention: Health Departments and Physicians

Breast and Cervical Cancer Medicaid Procedures

Applications for Breast and Cervical Cancer Medicaid (form DMA-5079) and the Breast and Cervical Cancer Medicaid Verification form for Screening, Diagnosis, and Treatment (form DMA-5081) must be completed and returned to the county department of social services in the county where the resident resides. Do not send the forms to the Division of Medical Assistance (DMA).

Providers must complete every item on the forms and ensure that they are using the most current version of the forms. The current version of the DMA-5079 is August 2003; the most current version of the DMA-5081 is July 2003. The date is located in the lower left-hand corner of the forms. Current version of the forms are available on DMA's website at http://www.dhhs.state.nc.us/dma/forms.html.

At recertification many providers are returning the verification form with tamoxifen indicated as treatment. Tamoxifen is not covered through the BCCM program. Do not submit the verification form with tamoxifen indicated as the treatment.

Susan Ryan, Medicaid Eligibility Unit
DMA, 919-857-4019

Attention: Home Infusion Therapy Providers

HCPCS Code Change for Pediatric Enteral Formulae

Effective with date of service January 1, 2004, HCPCS code W9934, pediatric enteral formulae, was end-dated and deleted from the Home Infusion Therapy Fee Schedule due to limited usage. To bill for enteral formulae, either adult or pediatric, use one of the following HCPCS codes.

HCPCS Code	Description	Maximum Allowable Rate
B4150	Category I: semi-synthetic intact protein/protein isolates	$0.58 per 100 cal.
B4151	Category I: natural intact protein/protein isolates.	1.37 per 100 cal.
B4152	Category II: intact protein/protein isolates (calorically dense)	0.49 per 100 cal.
B4153	Category III: hydrolyzed protein/amino acids	1.66 per 100 cal.
B4154	Category IV: defined formula for special metabolic need	1.07 per 100 cal.
B4155	Category V: modular components	0.83 per 100 cal.
B4156	Category VI: standardized nutrients	1.18 per 100 cal.

To determine the appropriate HCPCS code for a specific product name, refer to the Enteral Nutrition Product Classification List located online at http://www.palmettogba.com.

Providers must bill their usual and customary charges.

Beth Karr, Medical Policy Section
DMA, 919-857-4021

Attention: All Providers

Medical Coverage Policies

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

1A14 – Gender Transformation
1A17 – Stereotactic Pallidotomy
5 – Durable Medical Equipment
8J – Children's Development Service Agencies

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

Darlene Creech, Medical Policy Section
DMA, 919-857-4020

Attention: Durable Medical Equipment Providers

Conversions to National Miscellaneous Codes

The N.C. Medicaid program will <u>not</u> convert to national miscellaneous codes effective with date of service January 1, 2004 as announced in the December 2003 general Medicaid bulletin article titled *Conversions to National Miscellaneous Codes.* Therefore, DME providers must continue to use the state-created codes listed in that article.

Note: The following codes listed in that article have now been converted to national standard codes effective with date of service January 1, 2004.

Old Code	New Code	Description	Quantity Limitation or Lifetime Expectancy	Maximum Reimbursement Rate
W4113 W4114 W4687	E0240	Bath/shower chair, with or without wheels, any size	3 years	New Purchase: 64.11 Used Purchase: 40.98
W4115	E0247	Transfer bench for tub or toilet with or without commode opening	3 years	New Purchase: 91.00 Used Purchase: 68.25
W4685 W4686	E0248	Transfer bench, heavy duty, for tub or toilet with or without commode opening	3 years	New Purchase: 248.08 Used Purchase: 186.06

For dates of service from January 1, 2004 through February 29, 2004, only those state-created codes listed on the DME Fee Schedule with an asterisk beside them require prior approval. The coverage criteria for those items has not changed. Refer to Medical Coverage Policy #5, Durable Medical Equipment, on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex for detailed coverage information.

The following state-created codes will be converted to national miscellaneous codes effective with date of service March 1, 2004.

New HCPCS Code	Old State-Created Code
A9900	W4046 Disposable electrodes W4120 Disposable bags for Inspirease inhaler system, set of 3 W4153 Tracheostomy ties, twill W4651 Blood glucose test strips W4670 Sterile saline, 3cc vial W4672 Gray adapter for use w/ external insulin pump W4673 Piston rod for use w/ external insulin pump W4678 Replacement battery for portable suction pump
B9998	**Low profile gastrostomy equipment:** W4210 Low profile gastrostomy kit W4211 Low profile gastrostomy extension/replace kit for continuous feed W4212 Low profile gastrostomy extension/replace kit for bolus feed

HCPCS Code Conversions, continued

New HCPCS Code	Old State-Created Code
E1399	**Ambulatory devices:** W4688 Single point cane for weights 251# to 600# W4689 Quad point cane for weights 251# to 600# W4690 Crutches for weights 251# to 600# W4691 Fixed height forearm crutches for weights to 600# W4695 Glides/skis for use w/ walker **Bariatric replacement mattresses for hospital beds:** W4733 Replacement overszd innerspring matt for hosp bed w/ width to 39” W4734 Replacement overszd innerspring matt for hosp bed w/ width to 48” W4735 Replacement overszd innerspring matt for hosp bed w/ width to 54” W4736 Replacement overszd innerspring matt for hosp bed w/ width to 60” W4737 Trapeze bar, freestanding w/ grab bar for weights 451# to 750# **Bariatric hospital beds:** W4726 Total electric hosp bed weights 351# to 450# w/ matt and side rails W4730 Total elec hosp bed 451# to 1000# w/ width 39”w/ matt & side rails W4731 Total elec hosp bed 451# to 1000# w/ width 48”w/ matt & side rails W4732 Total elec hosp bed 451# to 1000# w/ width 54”w/ matt & side rails **Other equipment:** W4001 CO/2 saturation monitor w/ accessories, probes W4002 Manual ventilation bag W4016 Bath seat, pediatric W4047 Miscellaneous pediatric equipment W4633 Eggcrate mattress pad
K0009	**Manual pediatric wheelchairs**: W4122 Pediatric wheelchair, lightweight manual W4123 Pediatric wheelchair, lightweight manual w/ growth system W4124 Pediatric wheelchair, ultra lightweight manual **Manual bariatric wheelchairs:** W4696 Manual wheelchair for weights 451# to 600# W4697 Manual wheelchair for weights 651# and greater
K0014	**Power pediatric wheelchairs:** W4125 Pediatric wheelchair, power, rigid frame W4126 Pediatric wheelchair, power, folding frame **Power bariatric wheelchairs:** W4704 Power wheelchair for weights 251# to 600# W4705 Power wheelchair for weights 651# to 1000# W4706 Power wheelchair for weights 1001# and greater
K0108	W4117 Wheelchair seat width, cost added option from manufacturer W4118 Wheelchair seat depth, cost added option from manufacturer W4119 Wheelchair seat height, cost added option from manufacturer W4128 Solid back equipment with hardware (ea) W4129 Solid seat equipment with hardware (ea)

HCPCS Code Conversions, continued

New HCPCS Code	Old State-Created Code	
K0108, continued	W4130	Contoured or 3-piece head/neck supports with hardware (ea)
	W4131	Basic head/neck support w/ hardware (ea)
	W4132	Contoured or 3-piece head/neck supports with adj. hardware (ea)
	W4133	Basic head/neck support w/ adj. hardware (ea)
	W4134	Shoulder stabilizers w/ hardware, including pads (pr)
	W4135	Shoulder stabilizers w/ hardware, including H-strap (ea)
	W4136	Fixed thoracic supports w/ hardware (pr)
	W4137	Adjustable thoracic supports w/ hardware (pr)
	W4138	Hip/thigh supports w/ hardware (pr)
	W4139	Sub-asis bars w/ hardware (ea)
	W4140	Abductor pads w/ hardware (pr)
	W4141	Knee blocks w/ hardware (pr)
	W4143	Shoe holders w/ hardware (pr)
	W4144	Foot/legrest cradle (ea)
	W4145	Manual tilt-in-space option (ea)
	W4146	Power tilt-in-space option (ea)
	W4147	Power recline (ea)
	W4148	Modular back w/ hardware (ea)
	W4150	Multi-adj. tray (ea)
	W4151	Specialty controls w/ hardware (ea)
	W4152	Growth kit (ea)
	W4155	Abductor pads w/ hardware (pr)
	Bariatric wheelchair components:	
	W4698	Seat width 21” and 22” for oversized manual wheelchair
	W4699	Seat width 23” and 24” for oversized manual wheelchair
	W4700	Seat width 25” and greater for oversized manual wheelchair
	W4701	Seat depth 19” and 20” for oversized manual wheelchair
	W4702	Seat depth 21” and 22” for oversized manual wheelchair
	W4703	Seat depth 23” and greater for oversized manual wheelchair
	W4707	Seat width 21” and 22” for oversized power wheelchair
	W4708	Seat width 23” and 24” for oversized power wheelchair
	W4709	Seat width 25” and greater for oversized power wheelchair
	W4710	Seat depth 19” and 20” for oversized power wheelchair
	W4711	Seat depth 21” and 22” for oversized manual wheelchair
	W4712	Seat depth 23”and greater for oversized power wheelchair
	W4713	Oversized full support footboard

HCPCS Code Conversions, continued

New HCPCS Code	Old State-Created Code	
K0108, continued	W4714	Swingaway special footrests for weight 401# and greater (pr)
	W4715	Swingaway reinforced legrest elevating for weight 301# to 400# (pr)
	W4716	Swingaway footrests, elevating for weight 401# and greater (pr)
	W4717	Oversized calf pads (pr)
	W4718	Oversized footplates for weights 301#
	W4719	Oversized solid seat
	W4720	Oversized solid back
	W4721	Oversized 2" cushion
	W4722	Group 27 Gel cell battery
	W4723	Oversized full support calfboard

Providers are not required to enter the service review number (SRN) on claim submitted for dates of service from January 1, 2004 through February 29, 2004. Additional instructions regarding prior approval and submitting claims will be published in the general Medicaid bulletin prior to the date of conversion for these codes.

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

Attention: Providers of Services for the Community Alternatives Program for Children

HCPCS Code Change for Pediatric Enteral Formulae

Effective with date of service January 1, 2004, HCPCS code W9934, pediatric enteral formulae, was end-dated and deleted from the CAP/C Fee Schedule due to limited usage. To bill for pediatric enteral formulae, use one of the following HCPCS codes from the CAP/C Fee Schedule with the modifier "BO" to indicate that it is administered orally.

HCPCS Code	Description	Maximum Allowable Rate
B4150 BO	Category I: semi-synthetic intact protein/protein isolates	$0.58 per 100 cal.
B4151 BO	Category I: natural intact protein/protein isolates.	1.37 per 100 cal.
B4152 BO	Category II: intact protein/protein isolates (calorically dense)	0.49 per 100 cal.
B4153 BO	Category III: hydrolyzed protein/amino acids	1.66 per 100 cal.
B4154 BO	Category IV: defined formula for special metabolic need	1.07 per 100 cal.
B4155 BO	Category V: modular components	0.83 per 100 cal.
B4156 BO	Category VI: standardized nutrients	1.18 per 100 cal.

To determine the appropriate HCPCS code for a specific product name, refer to the Enteral Nutrition Product Classification List located online at http://www.palmettogba.com. Providers must bill their usual and customary charges.

Beth Karr, Medical Policy Section
DMA, 919-857-4021

Attention: All Dental Providers

Conversion from CPT to CDT-4 Codes for Dental Services

To assure compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the Medicaid program will no longer be able to accept dental claims with *Current Procedural Terminology* (CPT) codes filed on the American Dental Association (ADA) claim form. Federal regulations recognize only the *Current Dental Terminology* (CDT) code set published by the ADA as being HIPAA-compliant for dental claims. As a result, Medicaid is making the following changes to the dental program to assure continued coverage for the small percentage of oral health services that typically have been billed as covered CPT codes in any given year.

Changes in Procedure Codes Covered in the Dental Program

Effective with dates of service on or after February 1, 2004, the Medicaid Dental Program will no longer cover CPT codes. Effective with dates of service on or after February 1, 2004, the dental procedure codes listed below will be added to the dental program. An indicator of **"R"** means that the service is considered routine and does not require prior approval. An indicator of **"PA"** means that prior approval is needed to allow payment for the service.

CDT-4 Procedure Code	Description	Indicator	Reimbursement Rate
D7412	Excision of benign lesion, complicated	R	$ 230.00
D7413	Excision of malignant lesion up to 1.25 cm	R	182.20
D7414	Excision of malignant lesion greater than 1.25 cm	R	182.20
D7415	Excision of malignant lesion, complicated	R	230.00
D7465	Destruction of lesion(s) by physical or chemical method, by report	R	125.41
D7485	Surgical reduction of osseous tuberosity	R	234.47
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	R	243.72
D7840	Condylectomy	R	879.99
D7850	Surgical discectomy, with or without implant	R	849.11
D7858	Joint reconstruction	PA	1,009.57
D7860	Arthrotomy	R	621.89
D7865	Arthroplasty	PA	1,055.64
D7870	Arthrocentesis	R	38.37
D7872	Arthroscopy – diagnosis, with or without biopsy	R	386.27
D7873	Arthroscopy – surgical: lavage and lysis of adhesions	R	434.90
D7940	Osteoplasty – for orthognathic deformities	PA	590.37
D7941	Osteotomy – mandibular rami	PA	1,047.15
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft	PA	1,115.28
D7944	Osteotomy – segmented or subapical – per sextant or quadrant	PA	881.19
D7945	Osteotomy – body of mandible	PA	1,094.72
D7946	LeFort I (maxilla – total)	PA	1,081.11
D7947	LeFort I (maxilla – segmented)	PA	815.20
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft	PA	1,409.55
D7949	LeFort II or LeFort III – with bone graft	PA	1,946.33

CDT-4 Procedure Codes, continued

CDT-4 Procedure Code	Description	Indicator	Reimbursement Rate
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or facial bones – autogenous or nonautogenous, by report	PA	$ 893.38
D7960	Frenulectomy (frenectomy or frenotomy) – separate procedure	PA	149.71
D7972	Surgical reduction of fibrous tuberosity	R	175.37
D7991	Coronoidectomy	R	486.45

New Prior Approval Requirement for Code D7340

With the addition of coverage for code D7960, Medicaid will no longer use code D7340 to cover a labial or buccal frenectomy procedure. Code D7340 will be used exclusively as defined in the CDT-4 manual Vestibuloplasty – ridge extension (secondary epithelialization). As a result, the reimbursement rate has been adjusted (see below), and code D7340 will require prior authorization effective with dates of service on or after February 1, 2004.

Revised Dental Reimbursement Rates

Effective with dates of service on or after February 1, 2004, reimbursement rates for the following dental procedure codes have been revised to be more consistent with rates paid for comparable procedures billed as CPT codes. With the exception of code D7340, the prior approval indicator remains unchanged from that published in current the Dental Policy Manual for the dental codes listed below.

CDT-4 Procedure Code	Description	Indicator	Reimbursement Rate
D0160	Detailed and extensive oral evaluation – problem focused, by report	R	$ 59.40
D0290	Posterior-anterior or lateral skull and facial bone survey film	R	31.43
D0320	Temporomandibular joint arthrogram, including injection	R	39.11
D7260	Oroantral fistula closure	R	398.87
D7286	Biopsy of oral tissue – soft (all others)	R	113.30
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)	PA	548.59
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts)	PA	1,016.32
D7410	Excision of benign lesion up to 1.25 cm	R	169.11
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	R	370.61
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	R	370.61
D7460	Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm	R	370.61
D7461	Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm	R	370.61

Revised Dental Reimbursement Rates, continued

CDT-4 Procedure Code	Description	Indicator	Reimbursement Rate
D7510	Incision and drainage of abscess – intraoral soft tissue	EM	$ 152.62
D7520	Incision and drainage of abscess – extraoral soft tissue	EM	289.05
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	EM	179.37
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	EM	486.13
D7630	Mandible – open reduction (teeth immobilized, if present)	EM	677.24
D7640	Mandible – closed reduction (teeth immobilized, if present)	EM	388.90
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches	EM	804.38
D7730	Mandible – open reduction	EM	692.07
D7740	Mandible – closed reduction	EM	442.65
D7750	Malar and/or zygomatic arch – open reduction	EM	901.78
D7780	Facial bones – complicated reduction with fixation and multiple surgical approaches	EM	851.76
D7810	Open reduction of dislocation	EM	675.56
D7820	Closed reduction of dislocation	EM	81.20
D7910	Suture of recent small wounds up to 5 cm	EM	174.94
D7911	Complicated suture – up to 5 cm	EM	271.80
D7912	Complicated suture – greater than 5 cm	EM	337.33
D7920	Skin graft (identify defect covered, location and type of graft)	PA	468.94
D7980	Sialolithotomy	PA	319.17
D7981	Excision of salivary gland, by report	PA	441.43
D7982	Sialodochoplasty	PA	396.28
D7990	Emergency tracheotomy	EM	204.89
D9610	Therapeutic drug injection, by report	R	15.92
D9630	Other drugs and/or medicaments, by report	R	15.92

Revised Medical Coverage Policy for Dental Services

A revised version of Medical Coverage Policy #4A, Dental Services, incorporating the changes described in this article will be available on February 1, 2004, on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm.

Ronald Venezie, DDS, MS, Dental Advisor
DMA, 919-857-4025

Proposed Medical Coverage Policies

In accordance with Session Law 2003-284, proposed new or amended Medicaid medical 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.

Darlene Creech
Division of Medical Assistance
Medical 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 Thursday, January 1, 2004 in observance of New Year's Day, and on Monday, January 19, 2004 in observance of Dr. Martin Luther King's birthday.

Checkwrite Schedule

December 9, 2003	January 13, 2004	February 3, 2004
December 15, 2003	January 22, 2004	February 10, 2004
December 29, 2003	January 27, 2004	February 17, 2004

Electronic Cut-Off Schedule

December 5, 2003	January 9, 2004	January 30, 2004
December 12, 2003	January 16, 2004	February 6, 2004
December 19, 2003	January 23, 2004	February 13, 2004

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, Acting Director
Division of Medical Assistance
Department of Health and Human Services

Patricia MacTaggart
Executive Director
EDS