North Carolina Medicaid Bulletin

An Information Service of the Division of Medical Assistance

Published by EDS, fiscal agent for the North Carolina Medicaid Program

Number 1 *January 1999*

Attention: All Providers

Holiday Observance

The Division of Medical Assistance (DMA) and EDS will be closed on Friday, January 1, 1999, in observance of New Year's Day and Monday, January 18, 1999, in observance of Martin Luther King Jr.'s Day.

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

Attention: Personal Care Providers (excluding Adult Care Homes)

Reimbursement Rate Increase

Effective with date of service beginning January 1, 1999, the Medicaid maximum reimbursement rate for personal care service is $3.08 per 15 minute unit ($12.32/hour). No adjustments will be made to previously filed claims.

The providers' customary charges to the general public must be shown in form locator 47 on each UB-92 claim form filed. Public providers with nominal charges that are less than 50 percent of cost should report the cost of the service in form locator 47. The payment of each claim will be based on the lower of the billed charges or the maximum allowable rate.

Debbie Barnes, Financial Operations
DMA, 919-857-4165

Attention: Home Health Services Providers

The guide on the following page was created to help Home Health Services providers determine the homebound status of children.

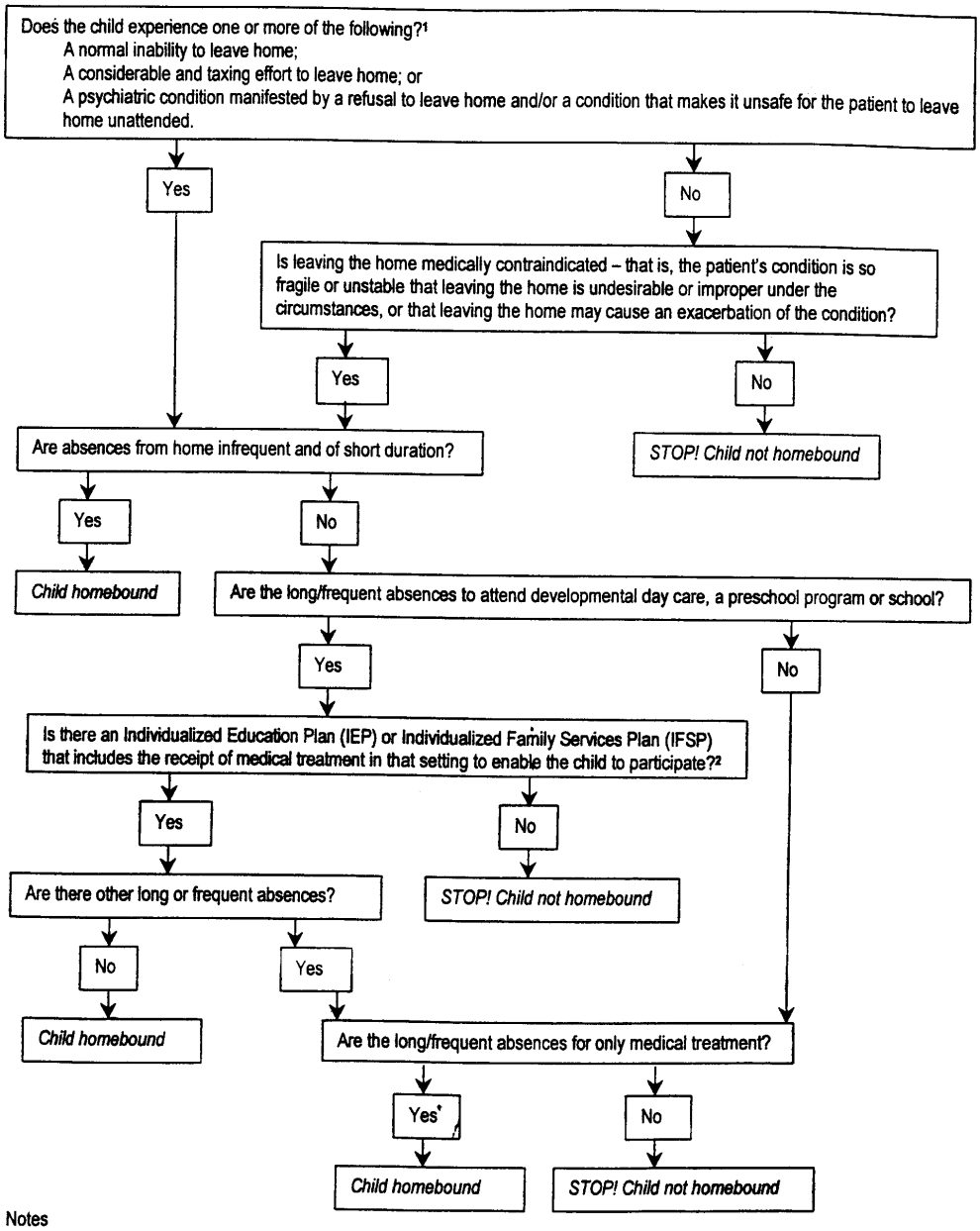
Dot Ling, Medical Policy
DMA, 919-857-4021

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

Index Page Number

Guide to Medicaid Homebound Status of Children

The homebound status of a child may be determined by using this decision tree in conjunction with Medicaid policy in Section 5.2.4 of the Medicaid Community Care Manual. When using the tree, please remember that it is only a guide. Consult the Community Care Manual for a full statement of the policy and examples of its application.



Notes

1. An infant or child who, because of only his age, must rely on an adult to leave the home would not be considered confined to the home.
2. During school vacations such a child is still considered homebound.

Attention: All Providers

Important Tax Information: Corrected 1099 Processing - Action Required by March 1, 1999

Providers receiving Medicaid payments of more than $600 annually will receive a 1099 MISC tax form from Electronic Data Systems Corporation (EDS). This 1099 MISC tax form is generated as required by IRS guidelines. It will be mailed no later than January 31, 1999 to each provider. The 1099 MISC tax form will reflect the tax information on file with Medicaid as of the last Medicaid Checkwrite cycle date, December 18, 1998. If the tax name or tax identification number on the annual 1099 MISC you receive are **incorrect,** a correction to the 1099 MISC can be requested. Requesting a correction is in your best interest. Correction ensures 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 **31 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 by March 1, 1999** as follows:

- include a copy of original 1099 MISC
- complete the Special W-9 (included in this bulletin) clearly indicating the correct tax identification number and tax name or a complete IRS W-9 form - ensure all fields are completed as required
- sign and date the Special W-9 or IRS W-9 certifying the tax information provided is correct
- fax both documents to (919) 854-2328 Attention: Corrected 1099 Request

  or

- mail both documents to:

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

Upon receipt of the fax or mailed correction request, tax information on file with Medicaid will be updated according to the Special W-9 or IRS W-9. Tax information updates can be verified by checking the last page of each Medicaid Remittance and Status Report (RA) which reflects both provider tax name and tax identification number on file. Additionally, a copy of the corrected 1099 will be generated and mailed to you for record retention. All corrected 1099 requests will be summarized and reported to the IRS as required. Thank you.

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

Special W-9

Complete all four parts below and return to EDS. Incomplete forms will be returned to you for proper completion.

Provider Name: Provider Number:

Part I. Provider Taxpayer Identification Number:

Your tax identification number should be reflected below exactly as the IRS has on file for you and/or your business. Please verify the number on file (per the last page of your most recent RA) and update as necessary in the correction fields listed below:

Correction Field (please write clearly in black ink):

Employer Identification Number/Taxpayer Identification Number

Social Security Number **If you do not have an employer ID then indicate social security number if you are an individual or sole proprietor only.

Part II. Provider Tax Name:

Your tax name should be reflected below exactly as the IRS has on file for you and/or your business. Individuals and sole proprietors must use their proper personal names as their tax name. Please verify the name on file (per the last page of your most recent RA) and update as necessary in the correction fields listed below:

Correction Field:

Part III. Type of Organization - Indicate below:

____ Corporation/Professional Association _____ Individual/Sole Proprietor _____ Partnership

____ Other: _____ _____ Government: _____

Part IV. Certification

Certification - Under the penalties of perjury, I certify that the information provided on this form is true, correct, and complete.

_____

Signature Title Date

EDS Office Use Only

Date Received:_____ Name Control: _____Date Entered: _____

Attention: Adult Care Home Providers

Increase in Reimbursement Rates:

Effective with date of service October 1,1998, the per diem rates paid by Medicaid for Adult Care Home Personal Care Service are:

W8251	Basic ACH/PC	$9.15
W8252	Enhanced ACH/PC (Basic/Eating)	$18.12
W8253	Enhanced ACH/PC (Basic/Toileting)	$12.35
W8254	Enhanced ACH/PC (Basic/Eating & Toileting)	$21.32

Providers paid at the old rate for October may complete a claim adjustment form. Attach a corrected claim and a copy of your RA and resubmit claim to EDS for adjustment. A blank copy of an adjustment form is located in Appendix M of the North Carolina Medicaid Adult Care Home Services Manual dated March 23, 1998. Any further questions relating to the adjustment process should be directed to EDS.

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

Attention: CAP Providers

Reimbursement Rate Increases

Effective with date of service January 1, 1999 the maximum allowable rate for the following CAP services are increased. Providers must bill their usual and customary charges. If a provider's charge is more than the Medicaid allowable, reimbursement will be the maximum allowable amount.

Procedure Code	Description	Reimbursement Rate
W8111	CAP-MR/DD Personal Care	$3.08/Unit
W8116	CAP/DA Respite Care-In Home	$3.08/Unit
W8119	CAP-MR/DD Respite Care Community Based	$3.08/Unit
W8141	CAP/DA In-Home Aide Level II	$3.08/Unit
W8142	CAP/DA In-Home Aide Level III-Personal Care	$3.08/Unit
W8143	CAP/C Personal Care	$3.08/Unit
W8144	CAP-MR/DD In-Home Aide Level I	$3.08/Unit
W8167	CAP/AIDS Respite Care-In-Home/Aide Level	$3.08/Unit
W8172	CAP/AIDS In-Home Aide II	$3.08/Unit
W8173	CAP/AIDS In-Home Aide III-Personal Care	$3.08/Unit

No adjustments will be made for claims already processed. Contact the EDS Provider Services Unit for detailed billing instructions.

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

THIS DOCUMENT IS A YEAR 2000 READINESS DISCLOSURE

UNDER UNITED STATES FEDERAL LAW.

Year 2000 Special Bulletin

Additional Information as of 18 Dec 98

In a March 1998 Special Bulletin we gave providers basic information about the effort involved with the Year 2000 or Y2K project. In that bulletin we detailed the record layouts concerning four digit years for the various claim forms and the tape RA.

DMA has developed its final methodology for the claims acquisition aspects of the Y2K project. The MMIS is currently internally Y2K capable. The effort left now is to describe to providers how and when they will submit Y2K compliant claims. These claims are those which have the appropriate eight digit date fields. What follows are summaries of the plan for the various methods of submitting claims to EDS. The chart at the end of this article gives the current planning dates for submission of Y2K compliant claims. **These dates will be firmed up once a final schedule is established and providers will be notified of these final dates.**

It is DMA's intention to accept claims in their current non Y2K compliant form until the end of the transition period for various indicated methods of submission. This capability will allow DMA to make the decision to accept non compliant claims for those situations where it feels that capability will best serve the provider community and the needs of DMA. This capability provides a high degree of comfort and flexibility as providers make the transition to Y2K compliant formats. However, all providers are reminded that they will be required to make the conversion to Y2K claims compliance. Details applicable to the various submission forms is provided below.

NECS submitters

The current NECS software will be replaced by a windows like software to be re-named the North Carolina Electronic Claims Submission (NCECS) software. This software can be used on a wide variety of current computers. As an added feature this software will output a file or diskette of claims that is not only Y2K compliant, but will also be in the ANSI 837 format. You may have read that the federal government in the Health Insurance Portability and Accountability Act (HIPAA) legislation of 1996 will require all electronic claims to be submitted in that format sometime in the next few years. Use of the NCECS software will provide that capability. Training classes on use of the NCECS software will be offered by EDS at times to be announced. EDS will send providers new NCECS software in September 1999 with providers having September to December of 1999 to implement the changes. It is expected then that claims in the new formats will begin arriving at EDS in the September 1999 to April of 2000 timeframe. NCESC providers will not require testing by EDS prior to accepting claims since the software will be internally tested by EDS and providers will simply key data enter claims into the software.

Tape Submitters

As indicated in the March 1998 bulletin, submitters will begin to provide claims using new formats. EDS will send providers specifications for that format in the February 1999 timeframe with providers having February 1999 to June 1999 to implement the changes. It is expected then that claims in the new formats will begin arriving at EDS in the April to June 1999 timeframe. All tape submitters will need to pass testing with EDS before Y2K compliant claims will be accepted. Providers are reminded to give as much notice as possible to their vendors or data processing support staff so that these changes can be made in a timely basis.

ECS Submitters

As indicated in the March 1998 bulletin, submitters will begin to provide claims using new formats. EDS will send providers specifications for that format in the March 1999 timeframe with providers having March 1999 to June 1999 to implement the changes. It is expected then that claims in the new formats will begin arriving at EDS in the April to May 1999 timeframe. All ECS submitters will need to pass testing with EDS before Y2K compliant claims will be accepted. Providers are reminded to give as much notice as possible to their vendors or data processing support staff so that these changes can be made in a timely basis.

Paper Submitters

There will be no changes to the various paper claim forms. As space permits on the forms providers should input a four digit year. Where only a two digit year is indicated by the provider, EDS' data entry staff will enter a four digit year that is appropriate. For example, an 00 will be keyed as 2000, a 99 will be keyed as 1999. We anticipate that providers may be sending in claims with four digit years at anytime in the future and for planning purposes by August 1999.

ANSI 837 Submitters

It is anticipated that some providers will want to start submitting claims in the ANSI 837 format once EDS is capable of accepting them. As was noted the new NCECS software will provide claims in that format. EDS will use translator software to accept any ANSI 837 compliant claim. It is anticipated that EDS can start to accept these claims in the July to August 1999 timeframe. Each ANSI submitter not using NCECS software will be individually tested and then allowed to submit the ANSI format.

	Current formats	**NCECS**	**Tape**	**ECS / Vendors**	**Paper**
Providers Install		9/29/99 - 12/23/99	2/17/99 - 6/24/99	3/3/99 - 6/17/99	
EDS Accepting Claims	until transition by DMA	10/13/99- 4/3/00	4/15/99 - 6/8/99	4/7/99 - 5/18/99	8/2/99

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

Attention: All Providers

Medicaid for Poor Aged, Blind, and Disabled Individuals

The General Assembly authorized Medicaid coverage for aged, blind and disabled individuals with income up to 100% of the federal poverty level (Session Law 1998-212 (Senate Bill 1366), Section 12.12D). This coverage is effective January 1, 1999. Prior to this date the income limit was the Supplemental Security Income limit which is approximately 73% of the federal poverty level. These persons will be entitled to "full Medicaid benefits" and will receive a blue Medicaid ID card. Resource limits remain $2,000 for an individual and $3,000 for a couple.

MONTHLY INCOME LIMIT*

Single Individual	$671
Married Couple	$905

RESOURCE LIMIT

Single Individual	$2,000	Married Couple	$3,000

*When a person lives in the home of another person and does not pay his proportionate share of the household's expenses, the monthly income limit may be reduced by one-third.

Many of these persons will already be eligible for Medicaid to pay Medicare premiums, deductibles and coinsurance. This new coverage will give them coverage for prescription medicine as well.

This change does not affect the income limit used to compute a person's Medicaid deductible. An individual whose countable monthly income exceeds the income limits in the table above will have to meet a Medicaid deductible to be eligible. That deductible will continue to be based on the amount by which his monthly income exceeds $242 ($317 for a couple).

Medicaid Eligibility Unit
DMA, 919-857-4019

Attention: Home Health Agencies, Private Duty Nursing Providers, and Community Alternatives Program (CAP) Case Managers

Use of HCPCS Code W4655 – "Covered Supplies Not Elsewhere Classified"

The Home Health fee schedule includes HCPCS Code W4655 (covered supplies not elsewhere classified) to allow Home Health and PDN providers to bill for non-listed items that meet Medicaid's coverage criteria. Though the list is periodically updated, it cannot include every covered supply item. When using this code, providers must first determine that the item is a covered supply and that it is not elsewhere classified. The following guidance should be applied when the W4655 code is used:

- "Covered supplies" are those that meet the Medicaid criteria in 5.1.6 of the Community Care Manual. Remember, the criteria require that:
  - The supply is medically reasonable and necessary for treatment of a patient's illness or injury. The supply has a therapeutic or diagnostic purpose for a specific patient. This requirement excludes billing for items furnished for comfort or convenience. Items that are often used by persons who are not ill or injured – such as soaps, shampoos, lotions and skin conditioners – are also not covered.
  - The supply is specifically ordered by the physician in the plan of care. Note that a physician's order in itself does not make an item "medically necessary" in the context of Medicaid coverage. The order allows the provider to bill for the item if it meets Medicaid requirements.
  - The supply is an item that is not routinely furnished as part of patient care. Minor medical and surgical supplies routinely used in patient care, such as alcohol wipes, applicators, lubricants, thermometers and thermometer covers are not billed individually to Medicaid. These items are considered part of an agency's overhead costs.
- "Covered supplies" also means that the item is considered a Home Health supply by Medicaid. Items such as drugs and biologicals, medical equipment, orthotics and prosthetics, and nutritional supplements are not covered Home Health supplies.
- "Not elsewhere classified" also means that the supply is not on the Durable Medical Equipment (DME) fee schedule (including DME-related supplies) or the Home Infusion Therapy (HIT) fee schedule, and does not have an existing code on the Home Health fee schedule.

Following are some of the most commonly asked questions and the answers concerning the use of W4655:

1. **Q:** The physician ordered a "Sween Cream" type of protective skin barrier for the patient. May we bill this to W4655?

   A: No. Skin creams and lotions are not covered by Medicaid.

2. **Q:** My patient had knee replacement surgery and the physician ordered compression hose. May these be billed to W4655?

   A: Yes, when there is documented medical necessity.

3. **Q:** The physician ordered an enteral nutrition supplement for my patient. Is it okay to bill this to W4655?

   A: Enteral nutrition products may not be billed as a Home Health supply. These products are covered by Medicaid under the DME and HIT programs.

4. **Q:** May Proderm be billed to W4655?

   A: No. Proderm is already listed under "Skin Care (Decubitus) Supplies." Supplies must be billed using their assigned codes.

5. **Q:** I have a patient who has difficulty brushing his teeth. Are glycerin swabs and toothettes billable?

   A: No. Glycerin swabs and toothettes are considered comfort or convenience items that lack medical necessity.

6. **Q:** What if the patient is a CAP participant? Doesn't that make a difference in Home Health supplies that are covered?

   A: No. CAP participants must meet the same coverage requirements for Home Health supplies. There are no exceptions for CAP participants.

7. **Q:** None of the ostomy pouches on the supply list are suitable for the preemie patients I see. May we bill a smaller pouch and use W4655?

   A: Yes, as long as there is supporting documentation showing that the smaller pouch is medically necessary.

8. **Q:** We have several insulin-dependent diabetics that need cotton balls when they inject. May we bill these to W4655?

   A: No. Cotton balls are considered an overhead cost and may not be billed separately.

9. **Q:** The supply list includes disposable diapers and pullups. May we use W4655 to bill for "Poise Pads" or panty liners?

   A: No. These items are considered a comfort or convenience item and are not billable.

10. **Q:** The physician ordered Ensure pudding and bars for the patient. May we bill them to W4655?

    A: No. Oral nutritional supplements in any form are not billable as a Home Health supply.

11. **Q:** Our agency makes up a "venipuncture kit" consisting of a biohazard bag, lab tube, two alcohol wipes, a butterfly needle, and a Band-Aid. May this be billed to the miscellaneous supply code?

    A: No. Contents of kits vary greatly among agencies and frequently contain items that are not covered by Medicaid. The only covered supply in your agency's kit is the butterfly needle which already has a code of its own. The non-covered items are considered overhead costs.

When using W4655, providers must bill their usual and customary rates. Billing Medicaid for supplies that do not meet coverage requirements may result in recoupment of payments.

Dot Ling, Medical Policy
DMA, 919-857-4021

Attention: All Physicians

Injectable Drugs Administered in a Physician's Office

Effective October 20, 1998, Synagis is no longer reimbursable through the physician's program but instead covered through the pharmacy program. The recipient should take the prescription (see prescription requirements below) to the pharmacy to obtain the medication and to the physician's office for administration.

The physician cannot bill for the cost of the drug, but can bill for "injectable drug administration" using code Q0124 on a HCFA-1500 when the following conditions are met:

- The injection is the sole purpose for the visit to the physician's office.
- The recipient is age 21 or over. (Recipients under age 21 are governed by the Health Check policies).
- The injectable drug administration is not given in conjunction with chemotherapy agents.
- The fee is not billed in conjunction with an office visit (CPT codes 99201-99215).

Only one vial per recipient per month will be routinely covered for children under two years of age who meet the criteria for use. The physician must write the weight and date of birth of the baby (in his/her own handwriting) on the face of the prescription.

One vial is adequate for a baby who weighs up to 6.7 kg or 15 lbs. If the baby weighs more than 15 lbs., and is receiving oxygen mechanically and/or suffering from BPD (bronchopulmonary dysplasia), the physician must obtain prior authorization to receive two vials for the patient.

Prior authorization can be obtained by sending a letter documenting the patient's status and need for two vials per month to:

N.C. Division of Medical Assistance
Attention: Benny Ridout, R.Ph
P.O. Box 29529
Raleigh, North Carolina 27626-0529
FAX (919) 733-2796

An authorization code will be assigned to all prior authorizations. This code must be included on the prescription to notify the pharmacist that the prescription has been approved for dispensing.

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

Attention: Durable Medical Equipment Providers

Supplies for Use with Suction Pumps

Codes E0600, portable suction pump, and W4004, 12 volt D.C. suction pump, were moved from the Frequently Serviced category of the Durable Medical Equipment (DME) Fee Schedule to the Capped Rental category on August 1, 1998. In order to provide the supplies for use with this equipment when the monthly rentals accrue to the purchase price and become the property of the recipient, we are adding codes for the supplies to the DME Fee Schedule. The following codes will be effective with date of service January 1, 1999:

Code	Description	Rate	Limitation
A4628	oropharyngeal suction catheter	$3.57	4 per month
K0190	canister, disposable, used with suction pump	$8.94	1 per month
K0191	canister, non-disposable, used with suction pump	$27.37	2 per year
K0192	tubing, used with suction pump	$3.10	2 per month
W4678	replacement battery for portable suction pump	$69.33	1 per 2 years

Providers are reminded that these supplies are covered only with patient-owned suction pumps. Refer to Section 6.1 of the DME Manual. In addition, please note that, as with all DME items, a Certificate of Medical Necessity and Prior Approval form must be completed, but prior approval is not required. Providers are also reminded to bill their usual and customary fees.

Melody B. Yeargan, P.T., Medical Policy
DMA, 919-857-4021

Attention: Dialysis Treatment Facility Providers

Erythropoietin (EPO) Billing Instructions

Effective with date of service February 1, 1999, the coverage guidelines for EPO administered in a dialysis treatment facility are:

- Recipient has a diagnosis of end stage renal disease (ESRD) ICD-9 CM 585 (Chronic renal failure) **and**
- has **either** 285.8 (other specified anemia) **or** 285.9 (anemia, unspecified)
- Recipient's hematocrit level of 36% or less

Dialysis treatment facility providers are reminded of the following details when filing Medicaid for EPO on the UB-92 claim:

- Bill Revenue Code 634 in form locator 42
- Enter description in form locator 43
- Bill appropriate HCPCS "Q" code that reflects the recipient's HCT level in form locator 44 (reference list below)
- Enter the service date in form locator 45
- Enter the units in form locator 46 (1000U = 1 unit)
- Enter the total charge in form locator 47

Refer to the billing example below

42 Rev Code	43 Description	44 HCPCS/Rates	45 Serv Date	46 Serv Units	47 Total Charges	48 Noncovered Charges
634	EPO 9000U	Q9934	020199	9	135.00	

Select the "Q" code that reflects the recipient's HCT level.

- Q9920 EPO, per 1000 units, Patient HCT 20 or less
- Q9921 EPO, per 1000 units, Patient HCT 21
- Q9922 EPO, per 1000 units, Patient HCT 22
- Q9923 EPO, per 1000 units, Patient HCT 23
- Q9924 EPO, per 1000 units, Patient HCT 24
- Q9925 EPO, per 1000 units, Patient HCT 25
- Q9926 EPO, per 1000 units, Patient HCT 26
- Q9927 EPO, per 1000 units, Patient HCT 27
- Q9928 EPO, per 1000 units, Patient HCT 28
- Q9929 EPO, per 1000 units, Patient HCT 29
- Q9930 EPO, per 1000 units, Patient HCT 30
- Q9931 EPO, per 1000 units, Patient HCT 31
- Q9932 EPO, per 1000 units, Patient HCT 32
- Q9933 EPO, per 1000 units, Patient HCT 33
- Q9934 EPO, per 1000 units, Patient HCT 34
- Q9935 EPO, per 1000 units, Patient HCT 35
- Q9936 EPO, per 1000 units, Patient HCT 36
- Q9937 EPO, per 1000 units, Patient HCT 37
- Q9938 EPO, per 1000 units, Patient HCT 38
- Q9939 EPO, per 1000 units, Patient HCT 39
- Q9940 EPO, per 1000 units, Patient HCT 40

Note: Providers can bill up to 14 units of EPO without submitting medical records. When filing an adjustment, providers must provide copies of actual laboratory documentation indicating a 90 day average hematocrit level of 36.5% or less. Medical records, including but not limited to the hematocrit levels, must be kept on file and available to DMA or its agents for at least 5 years from the date of service.

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

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Attention: Physicians

Erythropoietin (EPO) Billing Instructions

Effective with date of service February 1, 1999, EPO will be edited for appropriate diagnoses. Continue to bill on the HCFA-1500 claim form. EPO is covered for the following diagnoses when administered in a physician's office:

- End stage renal disease (ESRD)
  ICD-9-CM 585 (Chronic renal failure) **and** 285.8 (other specified anemia) **or** 285.9 (anemia, unspecified)
- Anemia induced by Cancer chemotherapy
  ICD-9-CM V58.1 (encounter for chemotherapy and aftercare) **and** 285.8 **or** 285.9 **or**
  140.0-203.01 (various neoplasms)
- Anemia secondary to AZT therapy for AIDS
  ICD-9-CM 042 (Human Immuno-deficiency virus infection) **and** 285.8 **or** 285.9
- Anemia secondary to Myelodysplasia when symptomatic
  ICD-9-CM 237.7 (Neoplasm, other lymphatic and hematopoietic tissues) **and** 285.8 **or** 285.9
- Anemia of prematurity
  ICD-9-CM 776.6 (anemias of prematurity)
- Anemia due to chronic disease
  ICD-9-CM 285.9 (anemia, unspecified)

Providers should select the "Q" code that best reflects the recipient's HCT level.

- Q9920 EPO, per 1000 units, Patient HCT 20 or less
- Q9921 EPO, per 1000 units, Patient HCT 21
- Q9922 EPO, per 1000 units, Patient HCT 22
- Q9923 EPO, per 1000 units, Patient HCT 23
- Q9924 EPO, per 1000 units, Patient HCT 24
- Q9925 EPO, per 1000 units, Patient HCT 25
- Q9926 EPO, per 1000 units, Patient HCT 26
- Q9927 EPO, per 1000 units, Patient HCT 27
- Q9928 EPO, per 1000 units, Patient HCT 28
- Q9929 EPO, per 1000 units, Patient HCT 29
- Q9930 EPO, per 1000 units, Patient HCT 30
- Q9931 EPO, per 1000 units, Patient HCT 31
- Q9932 EPO, per 1000 units, Patient HCT 32
- Q9933 EPO, per 1000 units, Patient HCT 33
- Q9934 EPO, per 1000 units, Patient HCT 34
- Q9935 EPO, per 1000 units, Patient HCT 35
- Q9936 EPO, per 1000 units, Patient HCT 36
- Q9937 EPO, per 1000 units, Patient HCT 37
- Q9938 EPO, per 1000 units, Patient HCT 38
- Q9939 EPO, per 1000 units, Patient HCT 39
- Q9940 EPO, per 1000 units, Patient HCT 40

Refer to the billing example below:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E LINE)

1. 585 3. _____
2. V58.1 4. _____

24. A		B	C	D	E	F	G	H
DATE(S) OF SERVICE FROM MM/DD/YY	**TO MM/DD/YY**	**Place of Service**	**Type of Service**	**Procedures, Services, or Supplies** *CPT/HCPCS/Modifier*	**Diagnosis Code**	**Charges**	**Days/ Units**	**EPSDT Family Plan**
02/01/99	02/01/99	11	3	Q9936		192.00	12	

Note: When filing an adjustment, providers must provide copies of actual laboratory hematocrit documentation.

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

Attention: All Providers

1999 CPT Updates

Effective with date of service January 1, 1999, Medicaid providers may bill the 1999 CPT (Current Procedural Terminology) codes. Claims filed with obsolete 1998 codes for dates of service January 1, 1999 through March 31, 1999 will be accepted for processing. Dates of service on and after April 1, 1999 must be filed with the 1999 CPT codes.

The Medicine Section has numerous changes and additions addressing the Immune Globulins and Vaccine/Toxoids. The new vaccines covered at this time are:

90632 Hepatitis A vaccine, adult dosage, for intramuscular use. This is for recipients 18 years of age and over.

90633 Hepatitis A vaccine, pediatric/adolescent dosage - 2 dose schedule, for intramuscular use. This is for recipients 2 years of age to 18 years of age.

The Hepatitis A vaccines are limited to the following risk groups:

- Persons with chronic liver disease
- Persons engaging in high-risk sexual activity
- Residents of a community experiencing an outbreak of Hepatitis A
- Injectable drug users
- Persons who have clotting factor disorders (hemophiliacs and other recipients of therapeutic blood products)
- Certain institutional workers (e.g. caretakers for the developmentally challenged)
- Employees of child day-care centers
- Laboratory workers who handle live Hepatitis A virus
- Handlers of primate animals that may be harboring HAV

90680 Rotavirus vaccine, tetravalent, live, for oral use for children

The new CPT codes requiring further review by the Division of Medical Assistance are currently non covered and are:

36823 Insertion of arterial and venous cannula(s) for isolated extracorporeal circulation and regional chemotherapy perfusion to an extremity, with or without hyperthermia, with removal of cannula(s) and repair of arteriotomy and venotomy sites

56321 Laparoscopy, surgical with adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal

77380 Proton beam delivery to a single treatment area

77381 Proton beam treatment to one or two treatment areas

88240 Cryopreservation, freezing, and storage of cells

88241 Thawing and expansion of frozen cells, each aliquot

88249 Chromosome analysis, score 100 cells

88264 Chromosome analysis 20/25 cells

88271 Molecular cytogenetics, DNA probe

88272 Molecular cytogenetics, chromosomal in situ hybridization 3 - cells

88273 10 - 30 cells for microdeletions

88274 25 - 99 cells

88275 100 - 300 cells

88291 Cytogenetics and molecular cytogenetics, interpretation and report

The non covered 1999 CPT codes are:

97140	Manual therapy techniques, one or more regions, each 15 minutes
89264	Sperm identification from testis tissue; fresh or cryopreserved
94014	Patient initiated spirometric recording per 30 day period of time, includes transmitted data
94015	Patient initiated spirometric recording, includes data transmission
94016	Patient initiated spirometric recording, physician review and interpretation only

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

Attention: Private Duty Nursing (PDN) Providers

Private Duty Nursing Seminars

Seminars for PDN providers will be held in February 1999. Each provider is encouraged to send appropriate clinical, and clerical personnel. Coverage issues for PDN, service limitations, and plan of care (HCFA-485) will be discussed. In addition, procedures for filing PDN claims, common billing errors, and follow-up procedures will be reviewed.

Please select the most convenient site and return the completed registration form to EDS as soon as possible. Seminars 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. **Preregistration is strongly recommended.**

Note: Providers should bring their <u>1999</u> Community Care Manual as a reference source. Additional manuals will be available for purchase at $20.00.

Directions are available on page 19 of this bulletin.

Wednesday, February 3, 1999
Catawba Valley Technical College
Highway 64-70
Hickory, NC
Auditorium - Building 20

Tuesday, February 9, 1999
Four Points Sheraton
(Previously known as Howard Johnson)
5032 Market Street
Wilmington, NC

Tuesday, February 16, 1999
WakeMed
MEI Conference Center
3000 New Bern Avenue
Raleigh, NC
Park at East Square Medical Plaza

(cut and return registration form only)

<u>Private Duty Nursing Provider Seminar Registration Form</u>
(No Fee)

Provider Name_____ Provider Number _____

Address_____ Contact Person _____

City, Zip Code_____ County _____

Telephone Number_____ Date _____

_____ persons will attend the seminar at _____ on _____
(location) (date)

Return to: Provider Relations
EDS
P.O. Box 300009
Raleigh, NC 27622

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Attention: All Providers

Basic Medicaid Seminars

Seminars which discuss basic Medicaid subjects will be held in February 1999. The seminars are intended for new Medicaid providers and the topics will include form instructions, eligibility, Managed Care including Carolina ACCESS and HMOs. Persons inexperienced in billing North Carolina Medicaid are encouraged to attend.

Please select the most convenient site and return the completed registration form to EDS as soon as possible. Seminars 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. **Preregistration is strongly recommended**.

Note: Please bring your Specialty Manual if you wish to reference it during the workshop. A free Basic Medicaid workshop handout will be provided.

Directions are available on page 19 of this bulletin.

Tuesday, February 2, 1999
Catawba Valley Technical College
Highway 64-70
Hickory, NC
Auditorium

Thursday, February 4, 1999
Martin Community College
Kehakee Park Road
Williamston, NC
Auditorium

Friday, February 5, 1998
Four Points Sheraton
(Previously known as Howard Johnson)
5032 Market Street
Wilmington, NC

Wednesday, February 10, 1999
A-B Technical College
340 Victoria Road
Asheville, NC
Auditorium - Building 20

Monday, February 22, 1999
WakeMed
MEI Conference Center
3000 New Bern Avenue
Raleigh, NC
Park at East Square Medical Plaza

Wednesday, February 24, 1998
Ramada Inn
3050 University Parkway
Winston-Salem, NC

(cut and return registration form only)

Basic Medicaid Provider Seminar Registration Form
(No Fee)

Provider Name_____Provider Number _____

Address_____Contact Person _____

City, Zip Code_____County _____

Telephone Number_____Date _____

_____ persons will attend the seminar at _____ on _____
(location) (date)

Return to: Provider Relations
EDS
P.O. Box 300009
Raleigh, NC 27622

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Directions to Basic Medicaid and Private Duty Nursing (PDN) Seminars

Registration forms for these workshops are on page 15 and 17 of this bulletin.

Catawba Valley Technical College, Hickory
Tuesday, February 2, 1999 - Basic Medicaid
Wednesday, February 3, 1999 - PDN

Take I-40 to exit 125 and go approximately 1/2 mile to Highway 70. Head East on Highway 70 and College is approximately 1.5 miles on the right.

Martin Community College, Williamston
Thursday, February 4, 1999 - Basic Medicaid

Take Highway 64 into Williamston. College is approximately 1-2 miles west of Williamston. The Auditorium is located in Building 2.

Four Points Sheraton, Wilmington *(Previously known as the Howard Johnson Plaza)*
Friday, February 5, 1999 - Basic Medicaid
Tuesday, February 9, 1999 - PDN

I-40 East into Wilmington to Highway 17 - just off of I-40. Turn left onto Market Street and Howard Johnson Plaza is located on the left.

A-B Technical College, Asheville
Wednesday, February 10, 1999 - Basic Medicaid

I-40 to Exit 50. Head North on Hendersonville Road to intersection with Route 25 (McDowell Street). Take a left on Route 25 to Intersection with Victoria Road. Take a left onto Victoria Road to the Administration Building. The Laurel Auditorium is located in the Laurel Building. The Auditorium is located in building 20.

WakeMed MEI Conference Center, Raleigh
Monday, February 22, 1999 - Basic Medicaid
Tuesday, February 16, 1999 - PDN

Take the I-440 Raleigh Beltline to New Bern Avenue, Exit 13A (New Bern Avenue, Downtown). Go toward WakeMed. Turn left at Sunnybrook Road and park at the East Square Medical Plaza which is a short walk from the conference facility. Vehicles will be towed if not parked in appropriate parking spaces designated for the Conference Center.

Ramada Inn Plaza, Winston-Salem
Wednesday, February 24, 1999 - Basic Medicaid

I-40 Business to Cherry Street Exit. Continue on Cherry Street for 2-3 miles. Get in the left hand turn lane and make a left at IHOP Restaurant. Pass the IHOP Restaurant and take the first driveway on the right and follow signs to the Ramada Inn Plaza.

Checkwrite Schedule

January 5, 1999	February 2, 1999	March 2, 1999
January 12, 1999	February 9, 1999	March 9, 1999
January 21, 1999	February 18, 1999	March 16, 1999
		March 25, 1999

Electronic Cut-Off Schedule *

December 31, 1998	January 29, 1999	February 26, 1999
January 8, 1999	February 5, 1999	March 5, 1999
January 15, 1999	February 12, 1999	March 12, 1999
		March 19, 1999

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

Paul R. Perruzzi, Director
Division of Medical Assistance
Department of Health and Human Services

James R. Clayton
Executive Director
EDS

EDS

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