



North Carolina Medicaid Bulletin

*An Information Service of the Division of Medical Assistance
Published by EDS, fiscal agent for the North Carolina Medicaid Program*

Visit DMA on the Web at: <http://www.dhhs.state.nc.us/dma>

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

Bold, italicized material is excerpted from the American Medical Association Current Procedural Terminology (CPT) Codes. Descriptions and other data only are copyrighted 2001 American Medical Association. All rights reserved.

Attention: Independent Practitioners and Local Education Agencies
Correction to December 2002 Special Bulletin VII, *HIPAA Code Conversion*

The billing instructions for completing the CMS-1500 claim form published in the December 2002 Special Bulletin VII, *HIPAA Code Conversion*, has been corrected as follows:

Block 24C-Type of Service: enter a 15. Do not enter a 01 or leave this block blank.

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

Attention: All Providers
Medical Coverage Policies

Updated policies for the following programs are now located on the Division of Medical Assistance's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm>:

- 1A Physicians
 - 1A-5 Case Conference for Sexually Abused Children
 - 1A-6 Electrical Osteogenic Stimulators
 - 1A-7 Neonatal Intensive Care Services

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: All Providers
Update to Regional Managed Care Consultant List

The Regional Managed Care Consultant list has been updated to reflect the new telephone number and fax number for the southeastern regional consultant, Rosemary Long. The new numbers are:

Telephone: 910-738-7399
Fax: 910-738-7349

The list is also available online at <http://www.dhhs.state.nc.us/dma/ca/mcc.pdf>.

Managed Care Section
DMA, 919-857-4022

Jerry Law PH: 252-321-1806 FAX: 252-321-1876 Jerry.Law@ncmail.net	Rosemary Long PH: 910-738-7399 FAX: 910-738-7349 Rosemary.Long@ncmail.net	Lisa Gibson PH: 919-319-0301 FAX: 919-319-0551 Lisa.Gibson@ncmail.net	Julia McCollum PH: 919-857-4219 FAX: 919-715-0844 Julia.McCollum@ncmail.net	Darryl Frazier PH: 919-857-4233 FAX: 919-715-0844 Darryl.Frazier@ncmail.net	Lisa Catron PH: 828-683-8812 FAX: 828-683-8814 Lisa.Catron@ncmail.net
Beaufort Bertie Camden Chowan Currituck Dare Edgecombe Gates Halifax Hertford Hyde Martin Nash Northhampton Pasquotank Perquimans Pitt Terrell Warren Washington	Bladen Brunswick Carteret Columbus Craven Cumberland Duplin Greene Harnett Hoke Johnston Jones Lenoir New Hanover Onslow Pamlico Pender Robeson Sampson Scotland Wayne Wilson	Alamance Anson Caswell Davie Davidson Forsyth Guilford Lee Montgomery Moore Person Randolph Richmond Rockingham Rowan Stanley Stokes Surry Yadkin	Chatham Durham Franklin Granville Orange Vance Wake	Cabarrus Gaston Iredell Lincoln Mecklenburg Union	Alexander Alleghany Ashe Avery Buncombe Burke Caldwell Catawba Cherokee Clay Cleveland Graham Haywood Henderson Jackson Macon Madison McDowell Mitchell Polk Rutherford Swain Transylvania Watauga Wilkes Yancey

Attention: All Providers

Mecklenburg County Managed Care Update

Effective December 1, 2002, United Healthcare of North Carolina, Inc. discontinued participation as a Medicaid health maintenance organization (HMO). SouthCare is now the only Medicaid HMO provider available in Mecklenburg County.

Carolina ACCESS providers, Carolinas Medical Center ACCESS II, and Metrolina Comprehensive (formerly C.W. Williams) are also available to provide services to Mecklenburg County Medicaid recipients in addition to SouthCare.

**Darryl Frazier, Managed Care Section
DMA, 919-857-4022**

Attention: All Providers

HIPAA Implementation Training Seminars

Seminars on the implementation of the Health Insurance Portability and Accountability Act (HIPAA) transaction sets are scheduled for Spring 2003. Dates and site locations for the seminars will be published in the March general Medicaid bulletin.

EDS, 1-800-588-6696 or 919-851-8888

Attention: All Providers

Revised Health Insurance Information Referral Form (DMA 2057)

The Health Insurance Information Referral form (DMA 2057) has been revised by the Third Party Recovery (TPR) Section. The revised form is effective immediately. This form should be used when insurance information on the TPR database must be updated. A copy of an Explanation of Benefits (EOB) from the insurance carrier **or** a copy of the insurance card must be attached to the form. Forms indicating only verbal verifications by an insurance carrier will be returned to the provider.

A copy of the revised DMA 2057 form is also available online at <http://www.dhhs.state.nc.us/dma>.

**Third Party Recovery Section
DMA, 919 733 6294**

**Division of Medical Assistance
Health Insurance Information Referral Form**

Recipient Name: _____

Recipient ID No: _____ Date of Birth: _____

Health Ins. Co. Name (1) _____ Policy/Cert No. _____

(2) _____ Policy/Cert No. _____

Reason For Referral

- 1. _____ Recipient never covered by or added to above policy(s) (**EOB attached**)
- 2. _____ Recipient's insurance coverage terminated (**EOB attached**)
- 3. _____ New policy not indicated on Medicaid ID card (**EOB or copy of insurance card attached**)
Indicate type coverage:

(Do not include Medicare)

- | | | |
|---------------------|---------------------|----------------------|
| _____ Major Medical | _____ Hosp/Surgical | _____ Basic Hospital |
| _____ Dental | _____ Cancer | _____ Accident |
| _____ Indemnity | _____ Nursing Home | |

Attach original claim, a copy of the EOB **or** a copy of the insurance card and submit to: DMA - TPR, 2508 Mail Service Center, Raleigh, North Carolina 27699-2508. The Third Party Recovery (TPR) Section will update the system and forward claims to EDS within 10 working days after receipt.

Provider Name: _____ Provider Number: _____

Submitted By: _____ Date Submitted: _____

Telephone Number: _____

Attention: All Providers

Corrected 1099 Requests – Action Required by March 1, 2003

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, 2003. The 1099 MISC tax form reflects the tax information on file with Medicaid as of the last Medicaid checkwrite cycle date, December 27, 2002.

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 **30 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, 2003** 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
4905 Waters Edge Drive
Raleigh, NC 27606
Attention: Corrected 1099 Request - Financial

A copy of the corrected 1099 MISC will be mailed to you for your records. All corrected 1099 MISC requests are 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. December 2000)
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.

Please print or type

Name (See **Specific Instructions** on page 2.)

Business name, if different from above. (See **Specific Instructions** on page 2.)

Check appropriate box: Individual/Sole proprietor Corporation Partnership Other ▶

Address (number, street, and apt. or suite no.)

City, state, and ZIP code

Requester's name and address (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 2.** 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 2.

Note: If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.

Social security number
or
Employer identification number

List account number(s) here (optional)

Part II For U.S. Payees Exempt From Backup Withholding (See the instructions on page 2.)

Part III Certification

Under penalties of perjury, I certify that:

- 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**
- 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**
- 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 2.)

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 get 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.

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

- Certify the TIN you are giving is correct (or you are waiting for a number to be issued).
- Certify you are not subject to backup withholding, or
- Claim exemption from backup withholding if you are a U.S. exempt payee.

If you are a foreign person, use the appropriate Form W-8. See Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Corporations.

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.

What is backup withholding? Persons making certain payments to you must withhold and pay to the IRS 31% of such payments under certain conditions. 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.

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 not be subject to backup withholding. **Payments you receive will be subject to backup withholding if:**

- You do not furnish your TIN to the requester, or
- You do not certify your TIN when required (see the Part III instructions on page 2 for details), or
- The IRS tells the requester that you furnished an incorrect TIN, or
- 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

- 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 Part II instructions 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 enter 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.

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

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.

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 an LLC that is disregarded as an entity separate from its owner (see **Limited liability company (LLC)** above), and are owned by an individual, enter your SSN (or "pre-LLC" EIN, if desired). If the owner of a disregarded LLC is a corporation, partnership, etc., enter the owner's EIN.

Note: See the chart on this page 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. Get **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's Internet Web Site at www.irs.gov.

If you 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.

Part II—For U.S. Payees Exempt From Backup Withholding

Individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends. For more information on exempt payees, see the separate Instructions for the Requester of Form W-9.

If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding. Enter your correct TIN in Part I, write "Exempt" in Part II, and sign and date the form.

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

Part III—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).

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 state tuition program payments, IRA or MSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to give 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 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.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 31% 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.

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 The minor ²
3. Custodian account of a minor (Uniform Gift to Minors Act)	The grantor-trustee ¹
4. a. The usual revocable savings trust (grantor is also trustee)	The actual owner ¹
b. So-called trust account that is not a legal or valid trust under state law	The owner ³
5. Sole proprietorship	The owner ³
For this type of account:	Give name and EIN of:
6. Sole proprietorship	The owner ³
7. A valid trust, estate, or pension trust	Legal entity ⁴
8. Corporate	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership	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.



Attention: All Providers

Third Party Health Insurance and Medicaid Eligibility Policy Clarification

It has come to our attention that there may be some confusion regarding the relation of third party health insurance to Medicaid eligibility. Individuals with third party health insurance coverage may be eligible to receive Medicaid benefits. However, applicants with third party health insurance coverage are not eligible for benefits through the North Carolina Health Choice (NCHC) program. (**Note:** NCHC is available only to persons under the age of 19.)

Because Medicaid is always the payer of last resort, providers must file claims with the recipient's private health insurance before submitting claims to Medicaid. Individuals with questions about Medicaid eligibility should be referred to their local county department of social services.

Medicaid Eligibility Unit
DMA, 919-857-4019

Attention: All Providers

Proposed Medical Coverage Policies

In accordance with Session Law 2001-424, Senate Bill 1005, 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
Medical Policy Section
Division of Medical Assistance
2511 Mail Service Center
Raleigh, NC 27699-2511

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.

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

Attention: Hospitals, Anesthesiologists, and Certified Registered Nurse Anesthetists

Billing for Certified Registered Nurse Anesthetist Services

The February 1, 2003 date of service to implement the use of modifiers when billing for Certified Registered Nurse Anesthetist (CRNA) services announced in the December 2002 general Medicaid bulletin article entitled *Billing for Certified Registered Nurse Anesthetist Services* has been delayed. Providers will be notified through the general Medicaid bulletin of the new date to implement the revised billing guidelines.

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

Attention: Durable Medical Equipment Providers

HCPCS Code Changes

Effective with date of service February 1, 2003, the following codes will be end-dated and replaced with new codes.

End-Dated Code(s)	New Code	Description	Maximum Reimbursement Rate
W4669	K0409	Sterile water, 1000 ml	\$ 3.27
W4671	A4323	Sterile saline, 1000 ml	2.42
W4675 W4676 W4677	A4250	Urine test or reagent strips or tablets (100 tablets or strips)	25.00
W4201 W4202	A4927	Gloves, non-sterile, per 100	10.92
W4203 W4204	A4930	Gloves, sterile, per pair	.85

These codes do not require prior approval. However, as with all durable medical equipment (DME), a Certificate of Medical Necessity and Prior Approval form must be completed.

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

Attention: Durable Medical Equipment Providers, Home Health Agencies, and Home Infusion Therapy Providers

Fee Schedules Available on the Internet

The following fee schedules are now available on DMA’s website at <http://www.dhhs.state.nc.us/dma>:

- Durable Medical Equipment
- Orthotics and Prosthetics
- Home Health Services and Supplies
- Home Infusion Therapy

These rates, effective with dates of service January 1, 2003, represent the maximum reimbursement rate allowed by Medicaid.

Providers must bill their usual and customary charges.

Debbie Barnes, Financial Operations
DMA, 919-857-4015

Attention: Physicians, Health Departments, and Nurse Practitioners

Pegfilgrastim, 6 mg (Neulasta, S0135) – Billing Guidelines

Effective with date of service January 1, 2003, the N.C. Medicaid program covers pegfilgrastim (Neulasta) for use in the Physician’s Drug Program. Neulasta is indicated to decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia. One of the following ICD-9-CM diagnoses must be listed on the CMS-1500 claim form:

205.00	205.10	238.7	288.9	V42.9	V59.3	V66.2
205.01	205.11	288.0		V58.1	V59.8	V66.5

Providers must bill S0135, indicating the number of units given in block 24G on the claim. For Medicaid billing, one unit of coverage is 6 mg. The maximum reimbursement rate per unit is \$2,655.00. Providers must bill their usual and customary charge.

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

Attention: Physicians, Health Departments, and Nurse Practitioners

Fulvestrant, 250 mg/5 ml (Faslodex, J9999) – Billing Guidelines

Effective with date of service May 1, 2002, the N.C. Medicaid program covers fulvestrant (Faslodex) for use in the Physician's Drug Program. Faslodex is an injectable estrogen receptor antagonist for the treatment of hormone receptor positive metastatic breast cancer in postmenopausal women with disease progression following antiestrogen therapy. Medicaid policy states that if a drug is available in both oral and injectable forms, the oral form should be used unless there is medical justification for using the injectable form. The medical record should reflect why oral anastrozole was not used. ICD-9-CM diagnoses appropriate to bill with Faslodex are 174.0 through 174.9.

Providers must bill J9999, the unclassified drug code for antineoplastic agents, 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 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. For Medicaid billing, one unit of coverage is 250 mg/5 ml. The maximum reimbursement rate per unit is \$832.00. Providers must bill their usual and customary charge. Previously denied claims for dates of service beginning May 1, 2002 may be resubmitted.

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

Attention: Physicians, Health Departments, and Nurse Practitioners

Leuprolide Acetate Implant, 65 mg (Viadur, J9219) – Billing Guidelines

Effective with date of service January 1, 2003, the N.C. Medicaid program covers the leuprolide acetate (Viadur) implant for use in the Physician's Drug Program. Providers must bill J9219 for the implant on the CMS-1500 claim form. ICD-9-CM diagnosis 185, malignant neoplasm of prostate, must be listed on the claim. For Medicaid billing, one unit of coverage is one 65 mg implant. The maximum reimbursement rate per implant is \$5,129.81. One implant is allowed per year. The year begins with the insertion date. CPT codes 11981, 11982, and 11983 are covered for the insertion, removal, and removal and reinsertion of the implant. Providers are expected to bill their usual and customary charge.

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

Attention: Physicians, Health Departments, and Nurse Practitioners

Factor VIIa (Coagulation Factor, Recombinant) per 1.2 mg (Novoseven, Q0187) – Billing Guidelines

Effective with date of service February 1, 2003, the N.C. Medicaid program covers factor VIIa (NovoSeven) for use in the Physician’s Drug Program. Providers must bill Q0187, indicating the number of units given in block 24G on the CMS-1500 claim form. One of the following ICD-9-CM diagnoses must be listed on the claim:

286.0	286.3	286.7
286.1	286.5	287.1

For Medicaid billing, one unit of coverage is 1.2 mg. The maximum reimbursement rate per unit is \$1,516.20. Providers are expected to bill their usual and customary charge.

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

Attention: Prescribers and Pharmacists

"Medically Necessary" Replaces "Dispense as Written"

Effective January 1, 2003, the words "medically necessary" handwritten on a prescription by the prescriber is required to dispense a trade or brand name drug. “Dispense as written” is no longer valid. Senate Bill 1115, Section 21.19(h) Dispensing of Generic Drugs mandates this change.

Section 21.19(h) Dispensing of Generic Drugs. – Notwithstanding G.S. 90-85.27 through G.S. 90-85.31, or any other law to the contrary, under the Medical Assistance Program (Title XIX of the SSA), and except as otherwise provided in this subsection for atypical antipsychotic drugs and drugs listed in the narrow therapeutic index, a prescription order for a drug designated by a trade or brand name shall be considered to be an order for the drug by its established or generic name, except when the prescriber has determined, at the time the drug is prescribed, that the brand name drug is medically necessary and has written on the prescription order the phrase "medically necessary." An initial prescription order for an atypical antipsychotic drug or a drug listed in the narrow therapeutic drug index that does not contain the phrase "medically necessary" shall be considered an order for the drug by its established or generic name, except that a pharmacy shall not substitute a generic or established name prescription drug for subsequent brand or trade name prescription orders of the same prescription drug without explicit oral or written approval of the prescriber given at the time the order is filled. Generic drugs shall be dispensed at a lower cost to the Medical Assistance Program rather than trade or brand name drugs. As used in this subsection, "brand name" means the proprietary name the manufacturer places upon a drug product or on its container, label, or wrapping at the time of packaging; and "established name" has the same meaning as in section 502(e) (3) of the Federal Food, Drug, and Cosmetic Act as amended, 21 U.S.C. § 352 (e) (3).

**Melissa Weeks, Medical Policy Section
DMA, 919-857-4020**

Attention: Personal Care Services (in Private Residences) Providers, Home Health Agencies, Durable Medical Equipment Providers, Home Infusion Therapy Providers, Private Duty Nursing Providers, and Adult Care Home Providers

Amended Implementation of Transfer of Assets Policy for Specified Home Care Services

Effective with date of service February 1, 2003, payments for specified home care services may be affected by a new transfer of assets policy that applies to certain Medicaid recipients. The implementation of the policy was announced in the January 2003 general Medicaid bulletin in an article entitled, *Implementation of Transfer of Assets Policy for Specified Home Care Services*. The amended implementation removes the provision to suspend claims while awaiting a transfer of assets determination. It also eliminates the possibility of a retroactive sanction period for an individual who is a Medicaid recipient at the time of the review. This article updates the information in the January 2003 article and should be read in its entirety.

Transfer of Assets Determinations and Sanctions

If an applicant/recipient has transferred assets in a manner contrary to the policy, he will not qualify for payment for any of the specified services provided during the sanction period. Sanction periods are by calendar month.

- **Medicaid Applicants:** The county department of social services (DSS) makes a transfer of assets determination as part of the Medicaid eligibility process. A sanction period may be in a period of retroactive Medicaid eligibility as well as extend through the current time period. Providers should be alert that individuals with a pending Medicaid application on the date of service may not be eligible for Medicaid payment for the service if a sanction is imposed. (Refer to ***Retroactive Eligibility*** on page 2 of the ***What is Medicaid*** section of ***Basic Medicaid Handout – April 2002*** for information about accepting retroactive eligibility. The handout is available on DMA's website at <http://www.dhhs.state.nc.us/dma/basicmed/what.pdf>.)
- **Medicaid Recipients:** The county DSS will review transfer of assets at each eligibility review. It also will review transfer of assets when it becomes aware of the receipt of one of the specified home care services. In either instance, a sanction period will not begin until after the recipient's right to an advance notice and the related appeal rights have been met. Sanction periods will not be retroactive.

The determination and any resulting sanction will apply to all of the services. A separate determination for each service is not required. This policy does not apply to transfers prior to February 1, 2003; therefore, there will be no sanction periods that begin before that date.

Services Included in the Policy

The Medicaid services included in the policy are:

- Personal Care Services (PCS) in private residences
- Home Health Services, including the supplies provided by home health agencies
- Durable Medical Equipment (DME), including the supplies provided by DME providers
- Home Infusion Therapy
- The supplies on the Home Health fee schedule provided by Private Duty Nursing (PDN) providers to PDN patients (the nursing care is not included in the policy)

Medicaid Recipients Subject to the Policy

The policy applies to individuals in the following Medicaid eligibility categories:

- Medical Assistance for the Aged (MAA)
- Medical Assistance for the Disabled (MAD)
- Medical Assistance for the Blind (MAB)
- Medicare Aid (MQB-Q)

Adult care home providers should note that this policy does not apply to their residents receiving State/County Special Assistance. It does apply to a private pay adult care home resident if the individual is in one of the four eligibility categories (MAA, MAD, MAB, and MQB-Q).

MAA, MAD, and MAB recipients have a blue Medicaid identification (MID) card with the abbreviation listed under "Program" on the card. MQB-Q recipients have a buff card labeled as a "MEDICARE-AID ID CARD."

Community Alternatives Program (CAP) participants are not subject to a transfer of assets determination for the specified services. Providers may identify a CAP participant by the entry in the "CAP" block of the MID card.

How the Policy Affects Payment

Payment for a date of service on and after February 1, 2003, depends on the information that is in the claims processing system.

- If a date of service is in a sanction period, payment for the date of service will be denied. (Refer to *Billing the Recipient*.)
- If the date of service is not in a sanction period, the claim will continue to process for payment.

Nothing in this policy involves recouping a payment from a provider agency because of a transfer of assets by a recipient.

Transfer of Asset Information

Providers may access the Automated Voice Response (AVR) system to get a recipient's transfer of assets status as of a specified date. The AVR response provides information that is in the claims processing system at the time of the inquiry. AVR information is not a guarantee of payment.

To access transfer of assets information, the provider selects option 6 at the main menu for information about recipient eligibility. The call flow to get to transfer of assets information is as follows:

Provider Number Verification – When the provider selects option 6 from the main menu, AVR prompts the provider to enter their N.C. Medicaid provider number for verification. After the provider number is verified, the prompt will allow a caller to go in either of two directions: Recipient Eligibility and Coordination of Benefits or Hospice Eligibility. Choose selection 1.

Recipient Access Method Prompt – To obtain recipient eligibility information, the provider must enter a valid recipient MID number **OR** a combination of the recipient's date of birth and social security number, and a "FROM" date of service. AVR prompts the provider to select a method for accessing the recipient data.

“Please select one of the following recipient identification options. To enter a recipient identification number, press 1. To enter a recipient date of birth and social security number, press 2.”

Date of Service Prompt – The provider must enter either a pound sign (#) only (for the current date) or a “FROM” date of service in a MMDDCCYY format.

Host Response – After receiving a valid provider number and recipient MID number, and “FROM” date of service, AVR determines whether or not the provider is authorized to access recipient eligibility information from the eligibility file.

Eligibility/Enrollment Prompt – The AVR will give the following response asking the provider to choose one of these two options:

"For eligibility information, press 1. For enrollment information, press 2."

Choose selection 1 for eligibility information. Transfer of assets information will be the last information given. The provider will be told one of the following:

“There is no information in the system about a transfer of assets determination for the recipient related to personal care services in a private residence, home health services, durable medical equipment, home infusion therapy, and supplies furnished by a private duty nursing agency. If you are a provider of one of these services, ask the recipient to contact the county DSS to begin a transfer of assets assessment.”

“For the given date of service, the recipient is not eligible for the payment of personal care services in a private residence, home health services, durable medical equipment, home infusion therapy, and supplies furnished by a private duty nursing agency. The given date is within a transfer of assets sanction period.”

“At this time, the given date of service is not in a transfer of assets sanction period for the payment of personal care services in a private residence, home health services, durable medical equipment, home infusion therapy, or supplies furnished by a private duty nursing agency. This information is subject to change.”

Providers also may verify the recipient’s transfer of assets status by seeing the recipient’s notice about the results of a transfer of assets determination. The county DSS will provide the recipient a notice indicating that transfer of assets has been reviewed and any penalty period assessed.

Billing the Recipient

A provider may bill the recipient if Medicaid payment is denied due to a transfer of assets sanction and the provider has advised the recipient of his responsibility for payment before the services are rendered. The provider should maintain documentation that the recipient was notified of and accepted the responsibility.

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

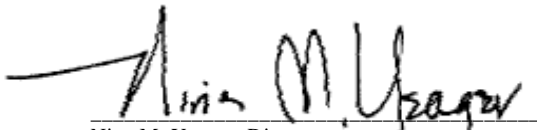
Checkwrite Schedule

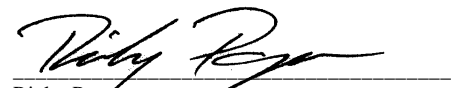
February 11, 2003	March 4, 2003	April 8, 2003
February 18, 2003	March 11, 2003	April 15, 2003
February 27, 2003	March 18, 2003	April 22, 2003
	March 27, 2003	

Electronic Cut-Off Schedule

February 7, 2003	March 7, 2003	April 4, 2003
February 14, 2003	March 14, 2003	April 11, 2003
February 21, 2003	March 21, 2003	April 17, 2003
February 28, 2003		

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.


Nina M. Yeager, Director
Division of Medical Assistance
Department of Health and Human Services


Ricky Pope
Executive Director
EDS

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