



# North Carolina Medicaid Bulletin

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

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

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## Attention: All Providers

### Clinical Coverage Policies

The following new or amended clinical coverage policies are now available on the Division of Medical Assistance's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm>:

**1A-15** – Surgery for Clinically Severe Obesity

**4A** – Dental Services

**5** – Durable Medical Equipment

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

**Gina Rutherford, Clinical Policy and Programs**  
**DMA, 919-855-4260**

## Attention: All Providers

### Medicaid Provider Survey Provider Input Requested!

The Office of Medicaid Management Information System Services (OMMISS) has prepared a survey to identify opportunities to better serve providers who participate in Medicaid and other DHHS reimbursement programs that will be replaced by the new *NCLeads* system in 2006.

This survey is intended to identify the provider community's current access to systems and the Internet, along with technical support availability. It is also important for us to understand and track your claims submittal process and satisfaction levels with the current MMIS+.

You are encouraged to complete the survey located at <http://ncleads.dhhs.state.nc.us/survey> to ensure the new *NCLeads* system will address your access requirements and system education preferences. Survey participants can be assured that their responses will be considered for *NCLeads* improvement opportunities as well as to tailor provider education and communication about the *NCLeads* solution.

If you have any questions about the survey, please e-mail [NCMMIS.Provider@ncmail.net](mailto:NCMMIS.Provider@ncmail.net). Thank you for your participation in this effort!

**Tom Liverman, OMMISS Provider Relations**  
**919-647-8315**  
**[NCMMIS.Provider@ncmail.net](mailto:NCMMIS.Provider@ncmail.net)**

## Attention: All Providers

# Reimbursement Rate and HCPCS Code Changes for the Physician's Drug Program

Effective with date of service January 1, 2005, the N.C. Medicaid program covers the individual HCPCS codes for the drugs listed in the following table. Claims submitted on or after January 1, 2005 using the discontinued codes for these drugs will deny.

OLD CODE	DESCRIPTION	UNIT	NEW CODE	DESCRIPTION	UNIT	MAXIMUM REIMBURSEMENT RATE
J3395	Verteporfin (Visudyne)	15 mg	J3396	Verteporfin (Visudyne)	0.1 mg	\$10.13
S0115	Bortezomib (Velcade)	3.5 mg	J9041	Bortezomib (Velcade)	0.1 mg	\$30.76
S0163	Risperidone, long acting	12.5 mg	J2794	Risperidone, long acting	0.5 mg	\$5.12
S0159	Agalsidase Beta (Fabrazyme)	35 mg	J0180	Agalsidase Beta (Fabrazyme)	1 mg	\$128.57
S0158	Laronidase (Aldurazyme)	0.58 mg/1 ml	J1931	Laronidase (Aldurazyme)	0.1 mg	\$24.13
S0107	Omalizumab (Xolair)	25 mg	J2357	Omalizumab (Xolair)	5 mg	\$17.05
S0116	Bevacizumab (Avastin)	100 mg	J9035	Bevacizumab (Avastin)	10 mg	\$61.88
J9999	Cetuximab (Erbix)	100 mg/50 ml	J9055	Cetuximab (Erbix)	10 mg	\$54.00
J9999	Pemetrexed (Alimta)	500 mg	J9305	Pemetrexed (Alimta)	10 mg	\$43.88
J3490	Palonosetron (Aloxi)	0.25 mg/5 ml	J2469	Palonosetron (Aloxi)	25 mg	\$30.62
J9999	Abarelix, (Plenaxis)	100 mg	J0128	Abarelix, (Plenaxis)	10 mg	\$88.54
J9999	Azacitidine (Vidaza)	25 mg	S0168	Azacitidine (Vidaza)	100 mg	\$428.63

**Note:** The unit of coverage and fees on these drugs has changed. Effective with date of service January 1, 2005, the maximum reimbursement rate for sargramostim (GM-CSF) 50 mcg (**Leukine**) has been increased from \$27.53 to \$29.04. Add these changes to the list of injectable drugs published in the November 2004 general Medicaid bulletin.

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

**Attention: All Dental Providers Including Health Department Dental Clinics**

**C**orrections to ADA Code Updates Published in the January 2005 General Medicaid Bulletin

The following fees were reported incorrectly in the January 2005 general Medicaid bulletin. The dental procedure codes and fees listed below were added effective with date of service January 1, 2005 for the N.C. Medicaid Dental Program. These additions were a result of the CDT (Current Dental Terminology) 2005 ADA code updates.

<b>CDT 2005 Code</b>	<b>Description</b>	<b>Reimbursement Rate</b>
D2932	Prefabricated resin crown * limited to recipients under age 21 * limited to primary and permanent anterior teeth	\$163.01
D2934	Prefabricated esthetic coated stainless steel crown – primary tooth * limited to recipients under age 21 * limited to primary anterior teeth	\$175.00

The following procedure code was **not** end-dated effective with date of service December 31, 2004 as previously stated in the January 2005 general Medicaid bulletin. Coverage and reimbursement for this procedure has not changed.

<b>Procedure Code</b>	<b>Description</b>	<b>Reimbursement Rate</b>
D2933	Prefabricated stainless steel crown with resin window * limited to recipients under age 21 * limited to primary anterior teeth	\$181.77

Providers are reminded to bill their usual and customary charges rather than the Medicaid rate. For coverage criteria and additional billing guidelines, please refer to Clinical Coverage Policy #4A, at <http://www.dhhs.state.nc.us/dma/dental/1dental.pdf>.

**Darlene Baker, Dental Policy Analyst  
DMA, 919-855-4280**

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## Attention: Dialysis Facilities

### Erythropoietin (EPO) Billing Instructions

Effective February 1, 2005, dialysis facilities now have an **option** to bill EPO claims on paper with attached medical documentation when the number of units of EPO billed exceeds 14 units per date of service or when HCPCS codes Q9937 through Q9940 are billed. This may be done instead of filing an adjustment.

#### **Paper Claims Billed Using Q9920 through Q9936**

Claims submitted on paper with HCPCS codes Q9920 through Q9936 and more than 14 units of EPO on the same date of service, may be submitted with laboratory reports indicating a 90-day average hematocrit level of 36.5% or less and other documentation to support the need for the units billed. If medical documentation supports that more than 14 units of EPO were required, the allowed units will be paid. An adjustment will not be required.

#### **Paper Claims Billed Using Q9937 through Q9940**

Claims submitted on paper with HCPCS codes Q9937 through Q9940 will be reviewed when laboratory reports and other documentation are attached. The laboratory reports must indicate a 90-day average hematocrit level of 36.5% or less. If medical documentation supports that the units of EPO were required, the allowed units will be paid. An adjustment will not be required.

Submitting the claims on paper with the appropriate medical documentation will expedite payment to the provider, in lieu of waiting for a denial and then initiating an adjustment.

#### **Claims Submitted Electronically**

Claims submitted electronically with HCPCS codes Q9920 through Q9936 and greater than 14 units of EPO will continue to be cut back to 14 units. Units exceeding 14 per day will deny with EOB 792: "Epogen units exceeded. Please resubmit as an adjustment with lab results and documentation to support payment for additional units." When filing an adjustment, providers must provide laboratory documentation indicating a 90-day average hematocrit level of 36.5% or less. Providers must remember this is a two step process. The claim must be adjusted after the electronic claim is denied with EOB 792.

Claims submitted electronically with HCPCS codes Q9937 through Q9940 will deny with EOB 3004: "Refile claim as an adjustment with documentation to support medical necessity," regardless of the number of EPO units billed.

#### **Billing Reminders**

Effective with date of service October 1, 2004, claims submitted for EPO must include the following or the claim will deny with EOB 082, "Service is not consistent with/or not covered for this diagnosis/ or description does not match diagnosis":

- ICD-9-CM diagnosis code 585, Chronic renal failure, must be entered on the claim as the primary diagnosis.

AND

- One of the following additional diagnosis codes:  
285.8, Other specified anemia
- ◆ 285.9, Anemia, unspecified
- ◆ 285.21, Anemia in end stage renal disease
- EPO must be billed with revenue code 634 and an appropriate procedure code.
- All EPO charges for the same date of service must be billed as one detail on the claim. If EPO charges are billed on two or more details on the claim for the same date of service, each of the details will deny with EOB 1198 “Service billed multiple times. If on this claim, combine units on single detail and resubmit new claim. If paid on previous claim, combine units and file as an adjustment.”
- Recipient’s hematocrit must be 36.5% or less for EPO to be covered.

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

- Bill Revenue Code 634 in form locator 42
- Enter description in form locator 43
- Bill appropriate \*HCPCS “Q” code (Q9920-Q9940) that reflects the recipient’s hematocrit (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	43	44	45	46	47	48
Rev Code	Description	HCPCS/Rates	Serv Date	Serv Units	Total Charges	Noncovered Charges
634	EPO 9000U	Q9934	01152005	25	135.00	

Select the “Q” code that reflects the recipient’s current 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

**Q codes, continued**

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

**N.C. Medicaid will implement use of HCPCS code Q4055 for billing EPO in order to comply with the end –dating of HCPCS codes in the range Q9920 through Q9940. Billing instructions and the effective date of the change will be published in a future Medicaid Bulletin when the system is ready to receive claims.**

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

**Attention: Durable Medical Equipment Providers**

**2005 HCPCS Code Deletions and Crosswalks**

The following codes were end-dated effective with date of service **January 31, 2005**, and removed from the fee schedule:

K0059	K0655	E0176	W4126
K0060	K0656	E0177	W4128
K0061	K0657	E0178	W4129
K0081	K0660	E0179	W4134
K0650	K0661	E1091	W4135
K0651	K0662	W4122	W4136
K0652	K0663	W4123	W4137
K0653	K0664	W4124	
K0654	K0665	W4125	

Effective with date of service **February 1, 2005**, the following codes were added to the DME fee schedule:

Old Code(s)	New Code	Description	Modifier	Maximum Reimbursement Rate	Life Expectancy
W4134 W4135 W4136 W4137	<b>E0960*</b>	Wheelchair accessory, shoulder harness/straps or chest strap including any type mounting hardware	Rental: New Purchase: Used Purchase:	9.10 90.98 68.24	3yrs/ 2 yrs 000-020
	E1025*	Lateral thoracic support, non-contoured, for pediatric wheelchair, each (includes hardware)	Rental: New Purchase: Used Purchase:	41.32# 413.25# 309.94#	2 yrs
	E1026*	Lateral thoracic support, contoured, for pediatric wheelchair, each (includes hardware)	Rental: New Purchase: Used Purchase:	41.32# 413.25# 309.94#	2 yrs
W4134 W4135 W4136 W4137	E1027	Lateral/anterior support for pediatric wheelchair, each (includes hardware)	Rental: New Purchase: Used Purchase:	41.32# 413.25# 309.94#	2 yrs
E1091 W4122 W4123 W4124	E1229*	Wheelchair, pediatric size, not otherwise specified	Rental: New Purchase: Used Purchase:	Individually Priced	3 yrs
W4125 W4126	E1239*	Power wheelchair, pediatric size, not otherwise specified	Rental: New Purchase: Used Purchase:	Individually Priced	4 yrs
K0059 K0060 K0061	<b>E2205</b>	Manual wheelchair accessory, handrim without projections, any type, replacement only, each	Rental: New Purchase: Used Purchase:	3.25 32.67 24.52	3 yrs

## Codes, continued

Old Code(s)	New Code	Description	Modifier	Maximum Reimbursement Rate	Life Expectancy
K0081	<b>E2206</b>	Manual wheelchair accessory, wheel lock assembly, complete, each	Rental: New Purchase: Used Purchase:	4.06 40.68 30.50	3 yrs
W4128	E2291*	Back, planar, for pediatric size wheelchair including fixed attaching hardware	Rental: New Purchase: Used Purchase:	44.46 444.56 333.42	2yrs/000-020
W4129	E2292*	Seat, planar for pediatric size wheelchair including fixed attaching hardware	Rental: New Purchase: Used Purchase:	42.06 420.55 315.42	2yrs/000-020
W4128	E2293*	Back, contoured, for pediatric size wheelchair including fixed attaching hardware	Rental: New Purchase: Used Purchase:	44.46 444.56 333.42	2yrs/000-020
W4129	E2294*	Seat, contoured, for pediatric size wheelchair including fixed attaching hardware	Rental: New Purchase: Used Purchase:	42.06 420.55 315.42	2yrs/000-020
K0108 W4005	<b>E2368*</b>	Power wheelchair component, motor, replacement only	Rental: New Purchase: Used Purchase:	51.67 516.57 387.44	2 yrs
K0108 W4005	<b>E2369*</b>	Power wheelchair component, gear box, replacement only	Rental: New Purchase: Used Purchase:	45.00 449.94 337.45	2 yrs
K0108 W4005	<b>E2370*</b>	Power wheelchair component, motor and gear box, replacement only	Rental: New Purchase: Used Purchase:	80.29 802.84 602.12	2 yrs
K0650	<b>E2601</b>	General use wheelchair seat cushion, width less than 22 inches, any depth	Rental: New Purchase: Used Purchase:	8.86 88.65 66.49	3yrs/2yrs 000-020

**Codes, continued**

<b>Old Code(s)</b>	<b>New Code</b>	<b>Description</b>	<b>Modifier</b>	<b>Maximum Reimbursement Rate</b>	<b>Life Expectancy</b>
K0651	<b>E2602*</b>	General use wheelchair seat cushion, width 22 inches or greater, any depth	Rental: New Purchase: Used Purchase:	16.20 161.88 121.43	3yrs/2yrs 000-020
	<b>E2609*</b>	Custom fabricated wheelchair seat cushion, any size	Rental: New Purchase: Used Purchase:	Individually priced	3 yrs
K0652 E0176 E0177 E0178 E0179	<b>E2603*</b>	Skin protection wheelchair seat cushion, width less than 22 inches, any depth	Rental: New Purchase: Used Purchase:	22.31 223.04 167.28	3yrs
K0653 E0176 E0177 E0178	<b>E2604*</b>	Skin protection wheelchair seat cushion, width 22 inches or greater, any depth	Rental: New Purchase: Used Purchase:	31.56 315.76 236.83	3yrs
K0654	<b>E2605*</b>	Positioning wheelchair seat cushion, width less than 22 inches, any depth	Rental: New Purchase: Used Purchase:	32.19 321.69 241.29	3yrs
K0655	<b>E2606*</b>	Positioning wheelchair seat cushion, width 22 inches or greater, any depth	Rental: New Purchase: Used Purchase:	43.61 436.07 327.06	3yrs
K0656	<b>E2607*</b>	Skin protection and positioning wheelchair seat cushion, width less than 22 inches, any depth	Rental: New Purchase: Used Purchase:	29.56 295.60 221.70	3yrs

**Codes, continued**

<b>Old Code(s)</b>	<b>New Code</b>	<b>Description</b>	<b>Modifier</b>	<b>Maximum Reimbursement Rate</b>	<b>Life Expectancy</b>
K0657	<b>E2608*</b>	Skin protection and positioning wheelchair seat cushion, width 22 inches or greater, any depth	Rental: New Purchase: Used Purchase:	35.42 354.00 265.51	3yrs
K0660	<b>E2611</b>	General use wheelchair back cushion, width less than 22 inches, any height, including any type mounting hardware	Rental: New Purchase: Used Purchase:	31.23 312.35 234.29	3yrs
K0661	<b>E2612</b>	General use wheelchair back cushion, width 22 inches or greater, any height, including any type mounting hardware	Rental: New Purchase: Used Purchase:	42.25 422.54 316.89	3yrs
K0662	<b>E2613*</b>	Positioning wheelchair back cushion, posterior, width less than 22 inches, any height, including any type mounting hardware	Rental: New Purchase: Used Purchase:	39.31 393.04 294.78	3yrs
K0663	<b>E2614*</b>	Positioning wheelchair back cushion, posterior, width 22 inches or greater, any height, including any type mounting hardware	Rental: New Purchase: Used Purchase:	54.40 543.93 407.97	3yrs
K0664	<b>E2615*</b>	Positioning wheelchair back cushion, posterior-lateral, width less than 22 inches, any height, including any type mounting hardware	Rental: New Purchase: Used Purchase:	45.24 452.32 339.23	3yrs

**Codes, continued**

<b>Old Code(s)</b>	<b>New Code</b>	<b>Description</b>	<b>Modifier</b>	<b>Maximum Reimbursement Rate</b>	<b>Life Expectancy</b>
K0665	<b>E2616*</b>	Positioning wheelchair back cushion, posterior-lateral, width greater than 22 inches, any height, including any type mounting hardware	Rental: New Purchase: Used Purchase:	60.86 608.58 456.45	3yrs
K0664	<b>E2620*</b>	Positioning wheelchair back cushion, planar back with lateral supports, width less than 22 inches, any height, including any type mounting hardware	Rental: New Purchase: Used Purchase:	57.47 574.76 431.08	3yrs/2yrs 000-020
K0665	<b>E2621*</b>	Positioning wheelchair back cushion, planar back with lateral supports, width greater than 22 inches, any height, including any type mounting hardware	Rental: New Purchase: Used Purchase:	54.77 547.70 410.79	3yrs/2yrs 000-020
W4122 W4123 W4124 E1091	E1231*	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, with seating system	Rental: New Purchase: Used Purchase:	213.81# 2138.09# 1603.57#	3 yrs
W4122 W4123 W4124 E1091	E1232*	Wheelchair, pediatric size, tilt-in-space, folding, adjustable, with seating system	Rental: New Purchase: Used Purchase:	213.85 2138.41 1603.82	3 yrs
W4122 W4123 W4124 E1091	E1233*	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, without seating system	Rental: New Purchase: Used Purchase:	221.57 2215.73 1661.79	3 yrs

**Codes, continued**

Old Code(s)	New Code	Description	Modifier	Maximum Reimbursement Rate	Life Expectancy
W4122 W4123 W4124 E1091	E1234*	Wheelchair, pediatric size, tilt-in-space, folding, adjustable, without seating system	Rental: New Purchase: Used Purchase	192.91 1928.95 1446.70	3 yrs
W4122 W4123 W4124 E1091	E1235*	Wheelchair, pediatric size, rigid, adjustable, with seating system	Rental: New Purchase: Used Purchase:	185.75 1857.43 1393.07	3 yrs
W4122 W4123 W4124 E1091	E1236*	Wheelchair, pediatric size, folding, adjustable, with seating system	Rental: New Purchase: Used Purchase:	163.87 1638.73 1229.05	3 yrs
W4122 W4123 W4124 E1091	E1237*	Wheelchair, pediatric size, rigid, adjustable, without seating system	Rental: New Purchase: Used Purchase:	165.30 1653.05 1239.80	3 yrs
W4122 W4123 W4124 E1091	E1238*	Wheelchair, pediatric size, folding, without seating system	Rental: New Purchase: Used Purchase:	172.37 1723.55 1292.64	3 yrs

**Note:** The pound sign (#) indicates a temporary rate, which will change when Medicare’s established rates are published. Temporary rates for Wheelchair Seat Frames and Cushions were published in the October 2004 general Medicaid bulletin. Some of those codes have now been crosswalked to new codes with appropriate rates and are listed in the table above. The codes listed in the table below have not been crosswalked to new HCPCS codes, but their rates have now been established by Medicare. Effective February 1, 2005, the rates reflect those published by Medicare.

<b>HCPCS Code</b>	<b>Description</b>	<b>Modifier</b>	<b>Maximum Reimbursement Rate</b>
<b>E2201*</b>	Manual wheelchair accessory, non-standard seat frame, width greater than or equal to 20 inches and less than 24 inches	Rental: New Purchase: Used Purchase:	37.31 373.10 279.83
<b>E2202*</b>	Manual wheelchair accessory, non-standard seat frame, width 24-27 inches	Rental: New Purchase: Used Purchase:	47.40 473.98 355.50
<b>E2203*</b>	Manual wheelchair accessory, non-standard seat frame depth , 20 to less than 22 inches	Rental: New Purchase: Used Purchase::	47.89 479.05 359.28
<b>E2204*</b>	Manual wheelchair accessory, non-standard seat frame depth , 22-25 inches	Rental: New Purchase: Used Purchase:	81.35 813.40 610.05
<b>E2340*</b>	Power wheelchair accessory, non-standard seat frame, width 20-23 inches	Rental: New Purchase: Used Purchase:	35.85 358.36 268.79
<b>E2341*</b>	Power wheelchair accessory, non-standard seat frame, width 24-27 inches	Rental: New Purchase: Used Purchase:	53.76 537.58 403.19
<b>E2342*</b>	Power wheelchair accessory, non-standard seat frame, depth 20-21 inches	Rental: New Purchase: Used Purchase:	44.80 447.98 335.99
<b>E2343*</b>	Power wheelchair accessory, non-standard seat frame, depth 22-25 inches	Rental: New Purchase: Used Purchase:	71.67 716.78 537.58

**Note:** In both of the tables above, HCPCS codes with an asterisk (\*) require prior approval and bold type indicates the item is covered by Medicare. A Certificate of Medical Necessity and Prior Approval form must be completed for all items regardless of the requirement for prior approval. The coverage criteria for these items have not changed. Refer to Clinical Coverage Policy #5, Durable Medical Equipment, on DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for detailed coverage information.

Providers are reminded that the rates listed are the maximum reimbursement rates. Rates have not changed for codes with only description changes. Providers must bill their usual and customary rate for all DME.

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

Attention: Durable Medical Equipment Providers

**H**CPCS Codes Changes for 2005 Pediatric Enteral Nutrition Products

Effective with the date of Service **January 31, 2005**, the HCPCS codes **B4151** and **B4156** were end dated and deleted from the fee schedule. The following table provides the crosswalk for the deleted codes:

Deleted Code	Existing Code
B4151	B4150 or B4152
B4156	B4153, B4154 or B4155

Old Code	New Code	Description	Maximum Reimbursement Rate
B4151	<b>B4157</b>	Enteral formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins, & minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	\$1.15#
B4151	<b>B4158</b>	Enteral formula, for pediatric nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins & minerals, may include fiber, administered through an enteral feeding tube, 100 cal = 1 unit	\$0.63#
B4151	<b>B4159</b>	Enteral formula, for pediatrics, nutritionally complete soy based with intact nutrients, includes proteins, fats, carbohydrates, vitamins & minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 cal = 1 unit	\$0.63#
B4151	<b>B4160</b>	Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins & minerals, may include fiber, administered through an enteral feeding tube, 100 cal = 1 unit	\$0.53#
B4151	<b>B4162</b>	Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins & minerals, may include fiber, administered through an enteral feeding tube, 100 cal = 1 unit	\$1.15#
B4156	<b>B4161</b>	Enteral formula, for pediatrics, hydrolyzed/amino acids & peptide chain proteins, includes fats, carbohydrates, vitamins & minerals, may include fiber, administered through an enteral feeding tube, 100 cal = 1 unit	\$1.80#

**Note:** The pound sign (#) indicates the rates are temporary rates until Medicare’s established rates are published. HCPCS codes that are bold indicate Medicare covered service. These codes do not require prior approval. A Certificate of Medical Necessity and Prior Approval form must be completed for all items regardless of the requirement for prior approval.

The coverage criteria for these items have not changed. Refer to Clinical Coverage Policy #5 for the coverage criteria for these items on the DMA’s website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm>.

Providers are reminded that the rates listed are the maximum reimbursement rates. Rates have not changed for codes with only description changes. Providers must bill their usual and customary rate for all DME.

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

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## Attention: Physicians

### Code Change for Gastric Bypass Surgery

Effective with date of service January 1, 2005, the unlisted procedure code 43659 should not be used to bill for the laparoscopic version of gastric bypass/Roux-en-Y surgery (CPT code 43846). Providers should bill this procedure using the 2005 CPT code 43644, Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less).

Clinical coverage policy 1A-15 has been updated to reflect this code change. A copy of the policy is available on DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm>.

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

## Attention: Community Alternatives Program Providers

### Transitioning between Community Alternatives Program

When a CAP recipient is moving from one CAP program to another CAP program (for example from CAP/C to CAP/MR DD), the effective date for the new program must be the first day of the first full month of services with the new program. The timing of the termination from one CAP program and enrollment in another CAP program must be carefully coordinated with the recipient, both CAP program case managers, DMA staff in the Home Care Initiatives Unit (HCI unit), provider agencies and the local DSS Medicaid worker. The transition must also be approved through EDS.

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

## Attention: Durable Medical Equipment Providers

### HCPSC Code Description Changes for 2005 for Durable Medical Equipment and Enteral Nutrition Products

Effective with date of service **February 1, 2005**, the following code descriptions were revised on the DME fee schedule:

<b>Code</b>	<b>Revised Description</b>
<b>B4150</b>	Enteral formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories= 1 unit
<b>B4152</b>	Enteral formula, nutritionally complete, calorically dense (equal to or greater than 1.5 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories=1 unit
<b>B4153</b>	Enteral formula, nutritionally complete, hydrolyzed proteins (amino acids and peptide chain), includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories=1 unit
<b>B4154</b>	Enteral formula, nutritionally complete, for special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins and/or minerals, may include fiber, administered through an enteral feeding tube, 100 calories=1 unit
<b>B4155</b>	Enteral formula nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g. glucose polymers), proteins/amino (e.g. glutamine, arginine), fat (e.g. medium chain triglycerides) or combination, administered through an enteral feeding tube, 100 calories= 1unit
<b>E0141</b>	Walker, rigid, wheeled, adjustable or fixed height
<b>E0143</b>	Walker, folding, wheeled, adjustable or fixed height
<b>E0450*</b>	Volume control ventilator, without pressure support mode, may include, pressure control mode, used with invasive interface (e.g. tracheostomy tube)
<b>E0951</b>	Heel loop/holder, any type, with or without ankle strap, each
<b>E0952</b>	Toe loop/ holder, any type, each
<b>E0967*</b>	Manual wheelchair accessory, hand rim with projections, any type, replacement only, each
<b>E0978</b>	Wheelchair accessory, positioning belts/safety belt/pelvic strap, each
<b>E1038*</b>	Transport chair, adult size, patient weight capacity less than 250 pounds
<b>E1226*</b>	Wheelchair accessory, manual fully reclining back, (recline greater than 80 degrees), each

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**Note:** HCPCS codes followed by an asterisk (\*) indicates that the item requires prior approval. Codes listed in bold type indicate the item is covered by Medicare. A Certificate of Medical Necessity and Prior Approval form must be completed for all items regardless of the requirement for prior approval as before.

The coverage criteria for these items have not changed. Refer to Clinical Coverage Policy #5, Durable Medical Equipment, on DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for detailed coverage information.

Providers are reminded that the rates listed are the maximum reimbursement rates. Rates have not changed for these codes. Providers must bill their usual and customary charges for all DME.

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

## Attention: End Stage Renal Disease Providers

### Rates for Dialysis Facilities

The Division of Medical Assistance implemented a Medicaid composite rate change for Hemodialysis/Peritoneal Dialysis and CAPD/CCPD based on CMS Manual System Pub. 100-02 Transmittal 27, Change Request 3554. The new end stage renal disease composite rates (1.6 percent for 2005) are effective with date of service January 1, 2005. No adjustments are allowed for prior billing.

**Sherrill Johnson, Rate Analyst**  
**DMA, 919-855-4180**

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

## HCPCS Code Updates for Medical Supplies

Effective with date of service January 31, 2005, the following HCPCS codes were end-dated to comply with national standard codes mandated by the Health Insurance Portability and Accountability Act (HIPAA). The new codes are effective with dates of service February 1, 2005.

Current HCPCS Code	New HCPCS Code	Description	Billing Unit	Maximum Reimbursement Rate
A4347	A4349	Male External Catheter With Or Without Adhesive, Disposable	Each	1.48
A4521	T4521	Adult-Sized(Disposable) Incontinence Product, Brief/Diaper, Small Size	Each	0.90
A4522	T4522	Adult-Sized(Disposable) Incontinence Product, Brief/Diaper Medium Size	Each	0.90
A4523	T4523	Adult-Sized(Disposable) Incontinence Product, Brief/Diaper Large Size	Each	0.90
A4524	T4524	Adult-Sized(Disposable) Incontinence Product, Brief/Diaper Extra Large Size	Each	0.90
A4525	T4521	Adult-Sized(Disposable) Incontinence Product, Brief/Diaper, Small Size	Each	0.90
A4526	T4522	Adult-Sized(Disposable) Incontinence Product, Brief/Diaper Medium Size	Each	0.90
A4527	T4523	Adult-Sized(Disposable) Incontinence Product, Brief/Diaper Large Size	Each	0.90
A4528	T4524	Adult-Sized(Disposable) Incontinence Product, Brief/Diaper Extra Large Size	Each	0.90
A4529	T4529	Pediatric Sized(Disposable) Incontinence Product, Brief/ Diaper, Small/Medium	Each	0.90
A4530	T4530	Pediatric Sized(Disposable) Incontinence Product, Brief/ Diaper, Large	Each	0.90
A4531	T4529	Pediatric Sized(Disposable) Incontinence Product, Brief/ Diaper, Small/Medium	Each	0.90
A4532	T4530	Pediatric Sized(Disposable) Incontinence Product, Brief/ Diaper, Large	Each	0.90
A4533	T4533	Youth Pediatric Sized(Disposable) Incontinence Product, Brief/ Diaper	Each	0.90
A4534	T4533	Youth Pediatric Sized(Disposable) Incontinence Product, Brief/ Diaper	Each	0.90
T1500	*T4539	Incontinence Product diaper/brief reusable, each	Each	22.36

**Note:** The asterisk (\*) indicates that the item is a waiver supply, which can only be billed by CAP providers. A waiver supply cannot be billed by home health and private duty nursing services.

The coverage criteria for these items have not changed. Refer to the Community Care Provider Manual on DMA’s website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for detailed coverage information.

Providers are reminded that the rates listed are the maximum reimbursement rates. Providers must bill their usual and customary charges for all services.

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

## Attention: Home Infusion Therapy and Community Alternatives Program Case Managers

### HCPCS Code Changes for 2005 for Enteral Nutrition Products

Effective with date of service January 31, 2005, HCPCS codes **B4151** and **B4156** were end-dated to comply with national standard codes mandated by the Health Insurance Portability and Accountability Act (HIPAA). The descriptions of the existing enteral codes were revised to be inclusive of the items covered by the two deleted categories. Please review the new descriptions in the chart below. The maximum reimbursement rates for the existing codes have not changed.

Code	Revised Description
<b>B4150</b>	Enteral formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories= 1 unit
<b>B4152</b>	Enteral formula, nutritionally complete, calorically dense (equal to or greater than 1.5 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories=1 unit
<b>B4153</b>	Enteral formula, nutritionally complete, hydrolyzed proteins (amino acids and peptide chain), includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories=1 unit
<b>B4154</b>	Enteral formula, nutritionally complete, for special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins and/or minerals, may include fiber, administered through an enteral feeding tube, 100 calories=1 unit
<b>B4155</b>	Enteral formula nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g. glucose polymers),proteins/amino (e.g. glutamine, arginine), fat (e.g. medium chain triglycerides) or combination, administered through an enteral feeding tube, 100 calories= 1unit

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The coverage criteria for these items have not changed. Refer to Clinical Coverage Policy #3 (3F-CAP/C, 3G-CAP/DA, 3H-Home Infusion Therapy) 1 on DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for detailed coverage information.

Providers are reminded that the rates listed are the maximum reimbursement rates. Providers must bill their usual and customary charges for all services.

CAP Case Managers are reminded to use the modifier **BO** to indicate that the formula is being taken by mouth.

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

## Attention: Medical Doctors and Osteopaths

### HCPCS Code A4550

Medical doctors and osteopaths can now refile claims for HCPCS supply code A4550 for dates of service February 11, 2004 through July 16, 2004 that were incorrectly denied with EOB 79 "this service is not payable to your provider type in accordance with Medicaid guidelines."

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

## Attention: Mental Health Providers

# Enrollment for Mental Health Providers

By March 1, 2005, Medicaid will accept enrollment applications from mental health providers and facilities in South Carolina, Virginia, Tennessee, and Georgia that are located within a 40 mile radius of the North Carolina border. To determine if you are located within 40 miles of the North Carolina border reference our zip code list at <http://www.dhhs.state.nc.us/dma/Forms/provenroll/zip.pdf>. Participation requirements for these providers will be available on our website at <http://www.dhhs.state.nc.us/dma> and published in the March bulletin.

**Provider Services**  
**DMA, 919-855-4050**

## Attention: All Providers

# NCLeads Update

Information related to the implementation of the new Medicaid Management Information System, *NCLeads*, scheduled for implementation in mid-2006 can be found online at <http://ncleads.dhhs.state.nc.us>. Please refer to this website for information, updates, and contact information related to the *NCLeads* system.

**Thomas Liverman, Provider Relations**  
**Office of MMIS Services**  
**919-647-8315**

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## Attention: Nursing Facility Providers

### Nursing Facility Rate Increase

Effective with date of service January 17, 2005, a rate increase has been calculated and approved for nursing facilities. This is an average increase of 1.85 percent based on due to both inflation and a change in the efficiency factor. All services provided on January 17, 2005 through March 31, 2005 will be reimbursed at this revised rate.

**Nancy Vincent, Rate Setting  
DMA, 919-855-4180**

## Attention: Prescribers and Pharmacists

### Correction for Removal of Smoking Cessation Medications and Products from the Prior Authorization Drug List

The article published in the November 2004 general Medicaid bulletin on the Removal of Smoking Cessation incorrectly defined Nicotrol NS as a nicotine patch. Nicotrol NS is actually the acronym for nasal spray. The corrected article is as follows:

## Removal of Smoking Cessation Medications and

### Products from the Prior Authorization Drug List

Effective with date of service August 25, 2004, the following smoking cessation medications and products no longer require prior authorization from Medicaid:

- Zyban (bupropion)
- Nicotrol NS (nasal spray)
- Nicotrol Cartridge Inhaler

There is no limit to the number of times a recipient can receive these medications and products.

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

Attention: Physicians and Nurse Practitioners

**P**emetrexed, 500 mg (Alimta) - Billing Guideline Changes

The effective date of coverage by the Physician’s Drug Program for Alimta has changed from June 1, 2004 to **March 1, 2004**. Detailed billing instructions were published in the June 2004 general Medicaid bulletin which may be viewed at <http://www.dhhs.state.nc.us/dma/bulletin.htm#general>. Effective with date of service January 1, 2005, the code was changed to J9305. Providers should bill with the code that was in effect for specific dates of service as shown in the table below. Providers may refile claims that denied for dates of service between March 1, 2004 and June 1, 2004.

Dates of Service	HCPCS Codes
March 1, 2004 through December 31, 2004	J9999 with invoice
January 1, 2005 and after	J9305 without invoice

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

Attention: Physicians and Nurse Practitioners

**B**evacizumab (Avastin) - Billing Guideline Changes

The effective date of coverage by the Physician’s Drug Program for Avastin has changed from June 1, 2004 to **March 1, 2004**. Detailed billing guidelines were published in the June 2004 general Medicaid bulletin which may be viewed at <http://www.dhhs.state.nc.us/dma/bulletin.htm#general>. Providers were notified in the October 2004 general Medicaid bulletin that, effective with date of service October 1, 2004, the code was changed to S0116. Effective with date of service January 1, 2005, the code was changed to J9035. Providers should bill with the code that was in effect for specific dates of service as shown in the table below. Providers may refile claims that denied for dates of service between March 1, 2004 and June 1, 2004.

Dates of Service	HCPCS Code
March 1, 2004 through September 30, 2004	J9999 with invoice
October 1, 2004 through December 31, 2004	S0116 without invoice
January 1, 2005 and after	J9035 without invoice

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

**Attention: Home Infusion Therapy (HIT) Providers and Community Alternatives Programs (CAP) Case Managers.**

**New Pediatric Enteral Supply Codes**

The following pediatric enteral supply codes have been added to the fee schedule effective with date of service **February 1, 2005 and after.**

New Code	Description	Maximum Reimbursement Rate
B4157	Enteral formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins, & minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	1.15#
B4158	Enteral formula, for pediatric nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins & minerals, may include fiber, administered through an enteral feeding tube, 100 cal = 1 unit	0.63#
B4159	Enteral formula, for pediatrics, nutritionally complete soy based with intact nutrients, includes proteins, fats, carbohydrates, vitamins & minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 cal = 1 unit	0.63#
B4160	Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins & minerals, may include fiber, administered through an enteral feeding tube, 100 cal = 1 unit	0.53#
B4161	Enteral formula, for pediatrics, hydrolyzed/amino acids & peptide chain proteins, includes fats, carbohydrates, vitamins & minerals, may include fiber, administered through an enteral feeding tube, 100 cal = 1 unit	1.15#
B4162	Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins & minerals, may include fiber, administered through an enteral feeding tube, 100 cal = 1 unit	1.80#

**Note:** The pound sign (#) indicates the rates are temporary rates until Medicare’s established rates are published.

Refer to Clinical Coverage Policy #3 (3F, 3G for CAP; 3H for HIT) for the coverage criteria for these items on the DMA’s website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm>.

Providers are reminded that the rates listed are the maximum reimbursement rates. Providers must bill their usual and customary rate for all enteral supplies CAP Case Managers are reminded to use the modifier BO to indicate that the formula is being taken by mouth.

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

**Attention: UB-92 BILLERS**

**R**evue Codes: RC070 and RC077

The following revenue codes were end dated retroactively for any dates of service on or after January 1, 2004:

<b>Revenue Codes</b>	
RC 070	Adolescent Psychiatric R&B
RC 071	Child Psychiatric R&B
RC 072	Substance Abuse Rehab
RC 073	Other Rehab Private
RC 074	Adolescent Psychiatric Semi Private
RC 075	Child Psychiatric Semi Private
RC 076	Substance Abuse Semi Private
RC 077	Other Rehab Semi Private

Claims filed with these revenue codes after March 1, 2005 for dates of service on or after January 1, 2004 will deny with EOB 537 (Procedure Code or Procedure/Modifier code combination is not covered for this date of service).

Refer to the following chart of the revenue code that should now be billed for these services:

<b>Previous Revenue Code</b>	<b>New Revenue Code</b>
RC 070	RC 114
RC 071	RC 114
RC 072	RC 116
RC 073	RC 118*
RC 074	RC 124
RC 075	RC 124
RC 076	RC 126
RC 077	RC 128*

**Note:** The asterisk (\*) indicates revenue codes that were effective with dates of service January 1, 2004.

Claims that were previously paid with the revenue codes 070-077 will not be recouped.

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

**Proposed Clinical Coverage Policies**

In accordance with Session Law 2003-284, proposed new or amended Medicaid clinical coverage policies are available for review and comment on DMA’s website at <http://www.dhhs.state.nc.us/dma/prov.htm>. To submit a comment related to a policy, refer to the instructions on the website. Providers without Internet access can submit written comments to the address listed below.

Gina Rutherford  
Division of Medical Assistance  
Clinical Policy Section  
2501 Mail Service Center  
Raleigh, NC 27699-2501

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

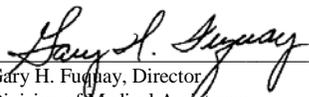
**Checkwrite Schedule**

January 6, 2005	February 8, 2005	March 15, 2005
January 11, 2005	February 15, 2005	March 22, 2005
January 19, 2005	February 24, 2005	March 31, 2005
January 27, 2005	March 8, 2005	April 12, 2005

**Electronic Cut-Off Schedule**

December 30, 2004	February 4, 2005	March 11, 2005
January 7, 2005	February 11, 2005	March 18, 2005
January 14, 2005	February 18, 2005	March 24, 2005
January 21, 2005	March 4, 2005	April 8, 2005

*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.*

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

  
\_\_\_\_\_  
Cheryl Collier  
Executive Director  
EDS



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