



# 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.**

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Attention: All Providers

## Early Periodic Screening and Diagnosis Treatment (EPSDT)

The Division of Medical Assistance has issued a policy statement about the ‘treatment’ component of EPSDT. It is posted to our website at [http://www.dhhs.state.nc.us/dma/epsdt\\_policy.pdf](http://www.dhhs.state.nc.us/dma/epsdt_policy.pdf). Please note that this policy does not eliminate the requirement for prior approval and/or a continuing review for designated medical services, equipment, and supplies.

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

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>:

**8J** – Children’s Developmental Service Agency

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

# Fee Schedule

The following fee schedules are available on the Division of Medical Assistance's web site at <http://www.dhhs.state.nc.us/dma/fee/fee.htm>.

- ❖ Community Alternatives Program Services
  - CAP/AIDS
  - CAP/Children
  - CAP/CHOICE
  - CAP/DA(Disabled Adults)
  - CAP/MR/DD
- ❖ DEC-CDSA FEE SCHEDULE 2005
- ❖ Dental Services
- ❖ DRG Weight Table
- ❖ Durable Medical Equipment
- ❖ Federally Qualified Health Center
- ❖ Home Health
- ❖ Home Infusion Therapy
- ❖ Hospice
- ❖ Local Health Department(CPT/HCPCS)
- ❖ Medicaid Crossover Percentage Payment Schedule
- ❖ Nursing Facility Rates
- ❖ Orthotic and Prosthetic Devices
- ❖ Physician Fee Schedule
- ❖ Rural Health Clinic

**DMA, Rate Setting**

**919-855-4200**

## Attention: All Providers

# Piedmont Cardinal Health Plan

Effective April 1, 2005, a new plan named Piedmont Cardinal Health Plan (PCHP) will be introduced in Cabarrus, Davidson, Rowan, Stanly, and Union counties. The plan will administer all Medicaid-covered behavioral health and substance abuse services and services for persons with developmental disabilities as well as the new Piedmont Innovations waiver program, which will replace the Community Alternatives Program for the Mentally Retarded/Developmentally Disabled (CAP/MR-DD). PCHP will also include intermediate care facilities for the mentally retarded (ICF-MR) and psychiatric inpatient hospitalizations.

This new plan is a prepaid managed care plan and will be administered by Piedmont Behavioral Healthcare, a public mental health, developmental disabilities, and substance abuse (MH/DD/SA) services organization.

On April 1, 2005, all Medicaid recipients in the five counties, including recipients participating in other managed care programs, must obtain MH/DD/SA services from PCHP. Recipients participating in a managed care program will not require a referral authorization from their primary care physician to obtain services from PCHP. Medicaid will not pay individual providers of MH/DD/SA services on a fee-for-service basis in the five-county area. Except for emergency services, all providers must obtain approval/authorization from PCHP to qualify for reimbursement for MH/DD/SA services.

All eligible Medicaid recipients in the five counties will be automatically enrolled in PCHP. Medicaid recipients in the five Piedmont counties will be identified as a PCHP participant by an asterisk (\*) beside their name on their Medicaid identification (MID) card. The MID card will indicate that “\* = PCHP.” Recipients will also receive information about PCHP and the new Innovations waiver program. Recipients who are participating in the Innovations waiver program will have the indicator “CM” on their cards in addition to the “PCHP” indicator.

Some Medicaid recipients may reside and receive services outside of the five-county area but receive Medicaid from one of the five Piedmont counties. In these cases, PCHP will be responsible for authorizing and paying for services. Medicaid will not pay providers fee-for-service for any MH/DD/SA services for recipients whose residency, for Medicaid purposes, is one of the five Piedmont counties.

For additional information, refer to the March 2005 Special Bulletin II, Piedmont Cardinal Health Plan available on DMA’s website at <http://www/dhhs.state.nc.us/dma/bulletin.htm>.

**Clinical Policy, Behavioral Health Section  
DMA, 919-855-4290**

## 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

### 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**

## Attention: Community Alternative Program Providers

### Reimbursement Rate Increase for Community Alternative Program Services

Based on the audit of providers conducted by the Division of Medical Assistance, the following rates were approved by the DHHS Rate Review Board at their meeting on January 31, 2005. These rates are effective with dates of service **February 1, 2005**.

Procedure Code	Description	Reimbursement Rate
S5125	CAP/C Personal Care	\$3.60/15 min unit
S5125	CAP/AIDS In-Home Aide II-Personal Care	\$3.60/15 min unit
S5125	CAP/AIDS In-Home Aide III-Personal Care	\$3.60/15 min unit
S5125	CAP/DA In-Home Aide II-Personal Care	\$3.60/15 min unit
S5125	CAP/DA In-Home Aide III-Personal Care	\$3.60/15 min unit
S5125	CAP/MR-DD Personal Care	\$3.60/15 min unit
S5120	CAP/MR-DD In-Home Aide Level I	\$3.60/15 min unit
S5150	CAP/C Respite Care In-Home	\$3.60/15 min unit
S5150	CAP/AIDS Respite Care In-Home, Aide Level	\$3.60/15 min unit
S5150	CAP/DA Respite Care-In Home	\$3.60/15 min unit
S5150	CAP-MR/DD Respite Care Community Based	\$3.60/15 min unit

**DMA, Rate Setting  
919-855-4200**

## Attention: Durable Medical Equipment Providers

### HCPCS Codes L2435, L5674, and L5675

In order to comply with the Centers for Medicare and Medicaid Services (CMS) HCPCS coding changes, the following codes were end-dated effective with date of service January 1, 2005 and deleted from the Orthotic and Prosthetic Fee Schedule:

HCPCS Code	Description
L2435	Addition to knee joint, polycentric joint, each joint
L5674	Addition to lower extremity, below knee, suspension sleeve, any material, each
L5675	Addition to lower extremity, below knee, suspension sleeve, heavy duty, any material, each

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

## Attention: Health Check Providers

### Health Check Seminars

Health Check seminars for all providers except for health departments are scheduled for May 2005. The April 2005 general Medicaid bulletin will have the registration form and a list of site locations for the seminars. The Seminars will focus on health check billing requirements, as well as vision and hearing assessments and developmental screenings.

A separate teleconference sponsored by the Division of Public Health is scheduled for health department providers. The April general Medicaid bulletin will include registration information for the teleconference.

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

## Attention: Hospital Providers

### Inpatient Services with Medicare Part B Coverage Only (No Part A or Part A Benefits Are Exhausted)

When a Medicaid patient, who received inpatient hospital services has Medicare Part B coverage only, or has Medicare Part B and Medicare Part A benefits are exhausted, a claim for the Part B charges must be filed with the Medicare carrier first. **Do not indicate on the claim filed to Medicare that these charges should be crossed over to Medicaid.** If the Medicare Part B claim is crossed over from the Medicare carrier, the provider must file an adjustment request in order to recoup all paid monies or a refund must be completed. Once payment has been received from Medicare Part B, file the UB-92 claim form to Medicaid completing the appropriate required fields. In addition, complete the following fields:

- a. Form locator 4 - Indicate the proper bill type.
- b. Form locator 32-35 a-b, code A3-C3 - Indicate that the Medicare Part A benefits are exhausted. Lifetime Reserve days must also be exhausted.
- c. Form locator 50 - Indicate Medicare as a payer.
- d. Form locator 54 - Indicate the Medicare Part B payment.  
Note: **Do not include the contractual adjustment for the Medicare Part B payment.**
- e. Form locator 84 – Indicate that the patient has no Medicare Part A benefits.

#### **Do not attach a copy of the Medicare EMOB with the claim form.**

If the Medicare EMOB is attached to the claim form, the claim will process incorrectly for payment. The payment from Medicare for the Part B charges will be treated like any other third party payment since the original charges are included in the Medicaid per diem/DRG rate.

If the Medicaid-allowed amount is more than the third-party payment, Medicaid will pay the difference up to the Medicaid-allowed amount. The payment (or nonpayment) must be accepted as payment in full.

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

## Attention: Hospital Providers

### Inpatient Crossovers and DRG Payments

Inpatient crossovers (**excluding Skilled Nursing Facility crossovers**) are paid using the DRG assigned by Medicare. The Medicaid DRG allowable is calculated and the Medicare total payment is deducted from it. The amount is compared to the Medicare coinsurance and deductible amount. Payment is made for the lesser of the two amounts.

If a facility's Medicare DRG payment is higher than its Medicaid payment, the crossover payment will be zero. The facility cannot bill the patient for the coinsurance/deductible. The payment (or nonpayment) must be accepted as payment in full. The deductible and coinsurance amount can be included on the Medicare cost report as bad debts.



Effective with date of service January 1, 1995, Medicaid no longer paid for non-covered days when Medicare benefits began or exhausted during an acute hospital stay. The hospital's reimbursement is paid using the DRG assigned by Medicare. Since the hospital's reimbursement is based on a DRG payment from Medicare and not the number of covered days, Medicaid liability is limited to the coinsurance/deductible as calculated above. Medicaid will not reimburse for non-covered DRG days. The non-covered days of eligibility cannot be billed to the patient because DRG payment is calculated as if the recipient were covered for the entire stay.

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

## Attention: Hospitals

### Clarification of Preadmission Review for Psychiatric and Substance Abuse Treatment

In addition to the review ValueOptions already performs for acute psychiatric inpatient hospital admissions for children under 21 years of age in a free standing psychiatric hospital and adults/children in a psychiatric unit of a general hospital, ValueOptions will review all recipients that have a primary mental health or substance abuse diagnosis, regardless of bed location. ValueOptions will not review ER visits or recipients in ICU beds. If the recipient is admitted to ICU and later transferred to the psychiatric unit please contact ValueOptions at the time of the transfer for prior approval.

If a claim denies for EOB 213 and the recipient was in a medical bed, please submit a copy of the history and physical along with the discharge summary to the Division of Medical Assistance, Clinical Policy and Programs, Behavioral Health Section, 2501 Mail Service Center Raleigh, NC 27699-2501 or providers may elect to send this information electronically via ProviderLink.

A review will be conducted if the admission was determined to be a psychiatric admission and prior approval should have been obtained from ValueOptions; a non-certification letter with a provider appeal form describing the appeals process will be enclosed and mailed to the facility.

If the admission was determined to be a medical admission, an override of the denial will be sent to EDS for claims payment. Beginning the middle of March, this information will be submitted to EDS through ProviderLink.

For questions regarding ProviderLink, please contact 919-465-1855 or visit their website at [www.providerlink.com](http://www.providerlink.com).

**Behavioral Health Services  
DMA, 919-855-4290**

Attention: Independent Practitioners, Local Education Agencies, and Physicians

**R**evision to Rates for Speech Services

Effective with dates of service February 1, 2005, the rates for the following speech therapy CPT codes have changed:

Procedure Code	Description	Non-Facility Fee Maximum Reimbursement Rate	Facility Fee Maximum Reimbursement Rate
92506	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status	\$117.91	\$44.97
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individuals	\$75.00	\$26.84
92508	Group, two or more individuals	\$31.40	\$13.59
92610	Evaluation of oral and pharyngeal swallowing function	\$116.07	

**Note:** Providers must bill their usual and customary charges.

**Laurie Sever, Financial Management  
DMA, 919-855-4200**

## Attention: All Mental Health Providers

### Correct Procedure for Ordering Services and How to Determine Billable Days of Care

A service order is necessary for all levels of child psychiatric residential care. All services must be medically necessary to be billable to Medicaid as supported by documentation in the medical record. A service order for residential care must be specific to the particular level of care needed and must be ordered on or before the date of service. Per Medicaid regulations, medical necessity must be established through assessment (or subsequent reassessment) of a client and treatment plan development including the current service(s) identified to carry out the goals stated in the plan. Then service order(s) are written based on these identified medically necessary services outlined in that treatment plan.

It can only be medically necessary for a child to be in one distinct level of 24-hour residential care at a time as a client can only occupy one bed at the time midnight census is taken at any facility. Medicaid billing is based on this midnight census and payment for only one level of residential care on a particular date of service is allowed. The first date the client is occupying a bed on or before midnight and therefore counted in the midnight census is the admission date and the first billable date of service. The day the client is discharged from the facility and therefore no longer occupying a bed at midnight constitutes the discharge date. The discharge day is not considered a day of patient care and is not billable to Medicaid. A required step down plan may list other levels of residential care as possible follow up to the current services needed. However, this does not make the planned step down services medically necessary until such time as this medical necessity is established and written into an updated treatment plan as an active and current intervention. Remember that admission and discharge criteria must be met to “admit” and later “discharge” a client to or from a residential facility. Therefore, if a client is discharged from one level of 24-hour residential care and admitted to another, the medical necessity has ceased to exist for the discharging facility’s level of care. If a client must be readmitted at a later date to the original level of residential care, a new service order must be written to re-establish medical necessity according to the required progression of assessment, planning and then ordering of services. Therefore, do not, under any circumstances, order more than one level of residential service at a time. If a service order is written and that residential service remains medically necessary continuously, as evidenced by updated treatment plans, a new order for that particular service does not need to be written as long as the recipient is still an active area program client. Treatment plans must still be updated every 12 months and any time the client’s condition warrants a change or addition to the plan.

A refund of Medicaid payments for these residential services will continue to be requested for any date(s) of service identified without a valid service order.

#### **Please reference:**

1. Level of Care Resource Manual, August 1999
2. Quality Assurance and Management Communiqué, July 2001
3. NC Div. of MH/DD/SAS Medicaid Communiqué, July 1, 1999
4. Memorandum to residential treatment providers from Jim Jarrard, DMH, Aug. 1, 2003
5. Residential Treatment Definitions, 9/14/00
6. Medicaid Service Guidelines, July 1999
7. Clinical Guidelines Series for Area Programs APSP 50, 9 7/1/99

**Carol Robertson, RN, Section Chief**  
**DMA Behavioral Health**  
**919-855-4260**

Attention: Nurse Practitioners

**M**ental Health Reimbursement Rate Update

Effective February 1, 2005, mental health CPT codes for nurse practitioners are reimbursed as follows:

CPT CODE	NON-FACILITY RATE	FACILITY RATE
90805	\$56.67	\$54.40
90807	\$82.61	\$80.63
90811	\$62.21	\$59.09
90813	\$87.96	\$85.13
90815	\$124.93	\$122.10
90816	\$51.86	\$51.86
90818	\$78.35	\$78.35
90821	\$116.57	\$116.57
90823	\$55.79	\$55.79
90826	\$82.88	\$82.88
90828	\$121.35	\$121.35
H0001	\$22.00	\$22.00
H0004	\$22.00	\$22.00
H0004 HQ	\$8.11	\$8.11
H0004 HR	\$22.00	\$22.00
H0004 HS	\$22.00	\$22.00
H0005	\$8.11	\$8.11
H0031	\$22.00	\$22.00

Providers must bill their usual and customary charges.

Providers may receive a current fee schedule by completing and submitting a copy of the [Fee Schedule Request form](#), which can be found DMA’s website <http://www.dhhs.state.nc.us/dma/forms.html>.

Providers can also find the Mental Health Rate Schedule online at <http://www.dhhs.state.nc.us/dma/fee/mhfee.htm>.

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

Attention: Personal Care Providers (Excluding Adult Care Homes)

**R**eimbursement Rate Increase for Personal Care Services

Effective with date of service February 1, 2005, the Medicaid maximum reimbursement rate for In-Home Personal Care Services (PCS) is \$3.60 per 15 minute unit. The rate was increased as a result of the Division of Medical Assistance’s audit of PCS providers and was approved by the DHHS Rate Review Board at their meeting on January 31, 2005.

**DMA, Rate Setting  
919-855-4200**

Attention: Psychologists, Social Workers, and Certified Clinical Supervisors, and Addictions Specialists

**M**ental Health Reimbursement Rate Update

Effective February 1, 2005, mental health CPT codes for psychologists, social workers, and certified clinical supervisors and addictions specialists are reimbursed as follows:

CPT CODE	MAXIMUM REIMBURSEMENT
H0001	\$22.00
H0004	\$22.00
H0004 HQ	\$8.11
H0004 HR	\$22.00
H0004 HS	\$22.00
H0005	\$8.11
H0031	\$22.00

Providers must bill their usual and customary charges. Providers can request a fee schedule by using the Fee Schedule Request Form, which is located on DMA’s website at <http://www.dhhs.state.nc.us/dma/forms.html>.

Providers can also find a copy of the Mental Health Rate Schedule on DMA’s website at <http://www.dhhs.state.nc.us/dma/fee/fee.htm>.

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

Attention: Private Duty Nursing Providers

**R**ate Change for PDN Providers

In September 2004, the rate for RC590 for private duty nursing was erroneously changed from \$35.36 to \$101.41. This rate has now been corrected to \$35.36. Systematic adjustments will be made for any claims submitted with dates of service between July 1, 2004 and July 31, 2005 that were paid at the incorrect rate.

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

## Attention: Physicians, Nurse Practitioners

### Natalizumab, 300 mg (Tysabri, J3490) – Billing Guidelines

Effective with date of service **December 1, 2004**, the N.C. Medicaid program covers natalizumab (Tysabri) for use in the Physician's Drug Program. Tysabri is indicated for the treatment of patients with relapsing forms of multiple sclerosis to reduce the frequency of clinical exacerbations. The FDA's recommended dosing schedule is 300 mg by IV infusion every four weeks.

The ICD-9-CM diagnosis code required when billing for Tysabri is **340.0 (Multiple Sclerosis)**. Providers must bill J3490, the unclassified drug code, with an invoice attached to the CMS-1500 claim form. **An invoice must be submitted with each claim.** The paper invoice must indicate the recipient's name and Medicaid identification 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 CMS-1500 claim form. For Medicaid billing, one unit of coverage is the 300 mg/15 ml vial. The maximum reimbursement rate per unit is \$2,033.65. Providers must bill their usual and customary charge. Add this drug to the list of drugs in the Physician's Drug Program, published in the November 2004 general Medicaid bulletin.

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

## Attention: Prescribers and Pharmacists

### Expansion in Coverage of Zelnorm

Effective with date of service August 16, 2004, the N.C. Medicaid program expanded coverage of Zelnorm to include the treatment of chronic idiopathic constipation for males who are less than 65 years of age. Previously, Zelnorm was only covered for the short-term treatment of irritable bowel syndrome in women with the primary symptom of constipation and for the treatment of chronic idiopathic constipation in women less than 65 years of age.

**Lisa Weeks, Clinical Pharmacist**  
**DMA, 919-855-4300**

## Attention: Prescribers and Pharmacists

### New Form Available for Oxycontin Prior Authorization

Effective January 11, 2005, a new form is available for requesting Oxycontin prior authorizations. The new form is available on the Pharmacy Prior Authorization website. The miscellaneous drug request form will no longer be accepted for Oxycontin prior authorization requests. Additional information, including prior authorization criteria, is available online at <http://www.ncmedicaidpbm.com>.

**Lisa Weeks, Clinical Pharmacist**  
**DMA, 919-855-4300**

## Attention: Prescribers and Pharmacists

### Removal of Enbrel from the Prior Authorization Drug List

Effective with date of service January 12, 2005, Enbrel no longer requires prior authorization from the Medicaid outpatient pharmacy program.

**Lisa Weeks, Clinical Pharmacist**  
**DMA, 919-855-4300**

## 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.

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## Holiday Closing

The Division of Medical Assistance (DMA) and EDS will be closed Friday, March 25, 2005 in observance of Good Friday.

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## 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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Mark T. Benton, Interim Director  
Division of Medical Assistance  
Department of Health and Human Services

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Cheryll Collier  
Executive Director  
EDS

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