Number 4 *April 2001*

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: www.dhhs.state.nc.us/dma

Attention: All Providers

Holiday Observance

The Division of Medical Assistance (DMA) and EDS will be closed on Friday, April 13, 2001, in observance of Good Friday.

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

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

Attention: All Providers

A New Look for the Medicaid Bulletin

Recent efforts to reduce costs associated with the administration of the Medicaid program have resulted in a new look for the general Medicaid bulletin. Beginning May 2001, the bulletin will be printed with black ink on white paper.

General Medicaid bulletins, as well as special bulletins, are also available through Internet access on the Division of Medical Assistance's website at www.dhhs.state.nc.us/dma. Providers are encouraged to consider accessing the bulletin online as an alternative to receiving the bulletin through the mail.

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

Attention: ICF-MR Group Home and CAP-MR/DD Providers

Amendment to Medicaid Policy/Revision of the MR2 Form

North Carolina statutes require that area programs implement a single portal of entry and exit process for all persons with developmental disabilities in need of day/night or 24-hour services. To facilitate the monitoring of this policy as defined in G.S. 122C-3, an additional signature is now required when completing an MR2 for persons with mental retardation/developmental disabilities receiving services and supports paid for by the N.C. Medicaid program. Effective May 1, 2001, the MR2 form must be signed and dated by the area program single portal coordinator or their authorized representative for all initial placements into ICFs/MR and annually for those in CAP-MR/DD services. This is in addition to the current requirement of a signature by a physician or, in the case of a CAP-MR/DD continuing need review, a qualified developmental disabilities professional (QDDP).

For ICF-MR group home providers, payment will not be made by EDS if the MR2 is not signed by the single portal representative at the time of initial placement. All ICF/MR providers are responsible for ensuring that all persons who reside in their group homes have participated in the single portal process at their home area program.

For CAP-MR/DD providers, the initial plan of care and continued needs review will not be approved by the lead agency local approval office if the MR2 is not signed by the single portal representative.

The area program single portal coordinator should sign, authenticate, and date the MR2 form below the signature line now being completed by the physician or the QDDP.

Nora Poisella, Medical Policy Section
DMA, 919-857-4020

Attention: All Providers

Endoscopy CPT Base Codes and Their Related Procedures

The following table represents a current and updated list of base and related endoscopy codes as designated in the Resource Based Relative Value System (RBRVS). There are two new groups of codes for 2001. The effective date of service for new group **33** is January 1, 2001. The effective date of service for new group **34** is March 1, 2001. Groups **11, 12, 13, 14, 15, 16, 17, 18**, and **26** have new codes added to the related side. Group **27** has been end-dated effective with date of service April 1, 2001. This list replaces the list published in the August 2000 general Medicaid bulletin.

Scopy Base and Related Code Group

Group	Base Code	Related Codes	Comments
1	29815	29819-29823, 29825-29826	
2	29830	29834-29838	
3	29840	29843-29847	
4	29860	29861-29863	
5	29870	29871, 29874-29877, 29879-29887	
6	31505	31510-31513	
7	31525	31527-31530, 31535, 31540, 31560, 31570	
8	31526	31531, 31536, 31541, 31561, 31571	
9	31622	31625, 31628-31631, 31635, 31640-31641, 31645	
10	43200	43202, 43204-43205, 43215-43217, 43219-43220, 43226-43228	
11	43235	43231, 43232, 43239, 43241-43247, 43249-43251, 43255, 43256, 43258-43259	Effective 01/01/01 new “related” codes added from 2001 RBRVS
12	43260	43240, 43261-43265, 43267-43269, 43271-43272	Effective 01/01/01 new “related” codes added from 2001 RBRVS
13	44360	44361, 44363-44366, 44369, 44370, 44372-44373	Effective 01/01/01 new “related” codes added from 2001 RBRVS
14	44376	44377-44379	Effective 01/01/01 new “related” codes added from 2001 RBRVS
15	44388	44389-44394, 44397	Effective 01/01/01 new “related” codes added from 2001 RBRVS
16	45300	45303, 45305, 45307-45309, 45315, 45317, 45320-45321, 45327	Effective 01/01/01 new “related” codes added from 2001 RBRVS
17	45330	45331-45334, 45337-45339, 45345	Effective 01/01/01 new “related” codes added from 2001 RBRVS
18	45378	45379-45380, 45382-45385, 45387	Effective 01/01/01 new “related” codes added from 2001 RBRVS

Scopy Base and Related Code Group, continued

Group	Base Code	Related Codes	Comments
19	46600	46604, 46606, 46608, 46610-46612, 46614-46615	
20	47552	47553-47556	
23	50951	50953, 50955, 50957, 50959, 50961	
24	50970	50974, 50976	
25	52000	52250, 52260, 52265, 52270, 52275-52277, 52281-52283, 52285, 52290, 52300, 52305, 52310, 52315, 52317-52318	
26	52005	52320, 52325, 52327, 52330, 52332, 52334, 52341-52344	Effective 01/01/01 new "related" codes added from 2001 RBRVS
27	52335	52336-52339	End-dated 04/01/00 due to 2001 CPT update
28	56300	56301-56309, 56311, 56343-56344, 56314	End-dated due to 2000 CPT update
29	56350	56351-56356	End-dated due to 2000 CPT update
30	57452	57454, 57460	
31	49320	38570, 49321, 49322, 49323, 58550, 58551, 58660, 58661, 58662, 58670, 58671	Effective 01/01/00 new family of codes for 2000 based on RBRVS
32	58555	58558, 58559, 58560, 58561, 58562, 58563	Effective 01/01/00 new family of codes for 2000 based on RBRVS
33	52351	52345, 52346, 52352, 52353, 52354, 52355	Effective 01/01/01 new family of codes for 2001 based on RBRVS
34	31575	31576, 31577, 31578, 31579	Effective 03/01/01 new family of codes for 2001 based on RBRVS

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

Attention: All Providers

Clarification of Policy on "Stat" Charges

The Division of Medical Assistance does not recognize "stat" charges. Stat charges represent an additional fee for diagnostic tests performed on a priority basis. Diagnostic tests include both laboratory and radiology services. Costs related to performing a diagnostic test on a stat basis represent the priorities of the departmental workload and not an actual direct patient care service. Therefore, stat charges should not be billed.

Because the claim form does not provide separate details for ancillary charges, stat charges will be disallowed upon verification of hospital records and billing procedures through postpayment and audit review.

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

Attention: Hospice Providers

Hospice Election Statement Signatures

Prior to providing services, a Hospice agency must have the patient or patient's representative sign a Hospice agreement that includes a Medicaid Hospice election statement as outlined on pages 8-6 and 8-7, section 8.5 of the *N.C. Medicaid Community Care Manual*. An election statement to receive Hospice care is considered to continue through the initial election period as well as through subsequent election periods as long as the individual remains in the care of the Hospice and does not revoke the election. Additional signatures are not required at the beginning of each benefit period as long as these conditions are met and there is no break in services. The statement should also be signed for patients with pending Medicaid as well as those who indicate that they will be applying for Medicaid benefits to cover any eligibility that might be approved retroactively.

Hospice providers are reminded that Medicaid payment for Hospice is dependent upon the prompt reporting of Hospice participation. EDS must be notified when a Medicaid recipient initially elects the Hospice Medicaid benefit, begins a new benefit period, transfers to another Hospice, revokes the benefit or is discharged. This includes Medicare/Medicaid Hospice patients in nursing facilities for whom Medicaid is paying room and board. Providers should also promptly report pending Medicaid cases that have elected the Medicaid Hospice benefit.

Adelle Kingsberry, Medical Policy Section
DMA, 919-857-4021

Attention: Hospice Providers

Update To Physician Certification Requirement Guidelines

Physician certification of terminal illness is required for all Hospice recipients prior to assessing for the appropriateness of the service. Current Medicaid guidelines as listed on page 8-8, section 8.5 of the *N.C. Medicaid Community Care Manual* indicate that the physician certification must "State that the patient has a medical prognosis of six months or less to live." As a result of the Benefits Improvement and Protection Act (BIPA) of 2000, there is further clarification that certification of the terminal illness of an individual who elects Hospice "shall be based on the physician's or medical director's clinical judgment regarding the **normal course of the individual's illness**."

The clarification emphasizes that medical prognostication of life expectancy is not always exact. Therefore, physician certifications should not be unduly scrutinized or "second guessed," thereby unnecessarily delaying or preventing the provision of Hospice care to Medicaid recipients. This update to guidelines is effective for certifications made for Medicaid Hospice patients on or after December 21, 2000, the date of enactment of BIPA 2000.

Adelle Kingsberry, Medical Policy Section
DMA, 919-857-4021

Attention: All Providers

Modifier 51

Modifier 51 indicates that on the same day or at the same operative session the same provider performed several procedures. Multiple related surgical procedures or a combination of medical and surgical procedures performed at the same session must be designated with modifier 51. It is not appropriate to append modifier 51 to all procedure codes.

Procedure codes defined as "add-on" codes cannot be performed without the primary procedure and are not appropriate with modifier 51.

When billing multiple endoscopy procedure codes, it is not appropriate to append modifier 51.

The following procedure codes **are exempt** from modifier 51:

11001	11101	11201	11720	11721	11732	11922	11975
11977	13102	13122	13133	13153	15001	15101	15121
15201	15221	15241	15261	15343	15351	15401	15787
15850	16036	17003	17004	17304	17305	17306	17307
17310	19001	19126	19291	19295	19340	20660	20931
20936	20937	20938	20974	20975	20979	21088	21089
22103	22116	22216	22226	22328	22522	22585	22614
22632	22840	22841	22842	22843	22844	22845	22846
22847	22848	22851	26125	26861	26863	27358	27692
29819	29820	29821	29822	29823	29825	29826	29834
29835	29836	29837	29838	29843	29844	29845	29846
29847	29861	29862	29863	29871	29874	29875	29876
29877	29879	29880	29881	29882	29883	29884	29885
29886	29887	31510	31511	31512	31513	31527	31528
31529	31530	31531	31535	31536	31540	31541	31560
31561	31570	31571	31576	31577	31578	31579	31625
31628	31629	31630	31631	31635	31640	31641	31645
32000	32002	32020	32501	32850	33141	33517	33518
33519	33521	33522	33523	33530	33572	33924	33930
33940	33960	33961	33968	34808	34813	34826	35390
35400	35500	35600	35681	35682	35683	35700	36218
36248	36415	36430	36488	36489	36491	36540	36550
36620	36625	36660	37195	37206	37208	37250	37251
38102	38570	38746	38747	43202	43204	43205	43215
43216	43217	43219	43220	43226	43227	43228	43231
43232	43239	43240	43241	43242	43243	43244	43245
43245	43246	43247	43249	43250	43251	43255	43256
43258	43259	43261	43262	43263	43264	43265	43267
43268	43269	43271	43272	43635	43752	44015	44121
44132	44133	44135	44136	44139	44361	44363	44364
44365	44366	44369	44370	44372	44373	44377	44378
44379	44389	44390	44391	44392	44393	44394	44397
44500	44955	45303	45305	45307	45308	45309	45315

Exempt Procedure Codes, continued

45317	45320	45321	45327	45331	45332	45333	45334
45337	45338	45339	45345	45379	45380	45382	45383
45384	45385	45387	46604	46606	46608	46610	46611
46612	46614	46615	47001	47133	47550	47553	47554
47555	47556	48160	48400	48550	48554	49321	49322
49323	49568	49905	50300	50555	50557	50559	50561
50572	50574	50575	50576	50578	50580	50953	50955
50957	50959	50961	50974	50976	52007	52010	52204
52214	52224	52250	52260	52265	52270	52275	52276
52277	52281	52282	52283	52285	52290	52300	52301
52305	52310	52315	52317	52318	52320	52325	52327
52330	52332	52334	52336	52337	52338	52339	52341
52342	52343	52344	52345	52346	52352	52353	52354
52355	56606	57454	57460	58300	58550	58551	58558
58559	58560	58561	58562	58563	58611	58660	58661
58662	58670	58671	58672	58673	59050	59051	59412
59425	59426	59525	60512	61055	61107	61210	61609
61610	61611	61612	61795	62252	62284	62367	62368
63035	63043	63044	63048	63057	63066	63076	63078
63082	63086	63088	63091	63308	64472	64476	64480
64484	64550	64623	64627	64727	64778	64783	64787
64832	64837	64859	64872	64874	64876	64901	64902
65760	65765	65767	65771	67331	67332	67334	67340
67335	69300	69710	69990				

Except for the following procedure codes, all Radiology procedure codes **are exempt** from modifier 51:

78306	78320	78803
78802	78806	78807

All Pathology and Laboratory procedure codes **are exempt** from modifier 51.

The only Medicine procedure codes that **are appropriate** with modifier 51 are in the following table:

92975	92980	92982	92986
92987	92990	92992	92993
92995	92997	93501	93505
93508	93510	93511	93514
93524	93526	93527	93528
93529	93530	93531	93532
93533	93536	96405	96406
99170			

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

Attention: Hospice Providers

Hospice Services Reimbursement Rate Increase

Effective with date of service April 1, 2001, the maximum allowable rate for the following Hospice services increased. These rates are in response to the Benefits Improvement and Protection Act (BIPA) transmitted by HCFA Region IV. These rates are in effect from April 2001 to January 2002 when Hospice rates are normally scheduled for review. Please update the Hospice rate schedule appearing in the March 2001 general Medicaid bulletin with this schedule.

		Routine Home Care	**Continuous Home Care**	**Inpatient Respite Care**	**General Inpatient Care**	**Hospice Intermediate R & B**	**Hospice Skilled R & B**
Metropolitan Statistical Area	SC	RC 651 Daily	RC 652 Hourly (1)	RC 655 Daily (2) (3) (4)	RC 656 Daily (3) (4)	RC 658 Daily (5)	RC 659 Daily (5)
Asheville	39	103.14	25.06	113.07	459.43	93.64	124.44
Charlotte	41	107.45	26.11	116.76	477.24	93.64	124.44
Fayetteville	42	100.09	24.32	110.46	446.79	93.64	124.44
Greensboro/ Winston-Salem/ High Point	43	104.34	25.35	114.10	464.39	93.64	124.44
Hickory	44	104.93	25.50	114.61	466.83	93.64	124.44
Jacksonville	45	95.06	23.10	106.15	425.97	93.64	124.44
Raleigh/Durham	46	108.32	26.32	117.51	480.87	93.64	124.44
Wilmington	47	109.59	26.63	118.60	486.13	93.64	124.44
Rural	53	98.48	23.93	109.08	440.13	93.64	124.44
Goldsboro	105	98.82	24.01	109.38	441.56	93.64	124.44
Greenville	106	107.97	26.24	117.22	479.44	93.64	124.44
Norfolk Currituck County	107	99.66	24.22	110.09	445.03	93.64	124.44
Rocky Mount	108	101.97	24.78	112.07	454.59	93.64	124.44

Note: Providers are expected to bill their usual and customary charges. Adjustments will not be accepted.

Key to Hospice Rate Table:

SC = Specialty Code
RC = Revenue Code

1. A minimum of eight hours of continuous home care must be provided.
2. There is a maximum of five consecutive days including the date of admission but not the date of discharge for inpatient respite care. Bill for the sixth and any subsequent days at the routine home care rate.
3. Payments to a hospice for inpatient care are limited in relation to all Medicaid payments to the agency for hospice care. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient respite and general inpatient days may not exceed 20 percent of the aggregate total number of days of hospice care provided during the same time period for all the hospice's Medicaid patients. Hospice care provided for patients with acquired immune deficiency syndrome (AIDS) is excluded in calculating the inpatient care limit. The hospice refunds any overpayments to Medicaid.

4. Date of Discharge: For the day of discharge from an inpatient unit, the appropriate home care rate must be billed instead of the inpatient care rate unless the recipient expires while an inpatient. When the recipient is discharged as deceased, the inpatient rate (general or respite) is billed for the discharge date.
5. When a **Medicare/Medicaid** recipient is in a nursing facility, Medicare is billed for routine or continuous home care, as appropriate, and Medicaid is billed for the appropriate long-term care rate. When a **Medicaid only** hospice recipient is in a nursing facility, the hospice may bill for the appropriate long-term care (SNF/ICF) rate in addition to the home care rate provided in revenue code 651 or 652. See section 8.15.1, page 8-12, of the *N.C. Medicaid Community Care Manual* for details.

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

Attention: All Providers

Lead Awareness Month

United Parents Against Lead of North Carolina (UPAL/NC) is pleased to announce that Governor Mike Easley issued a proclamation declaring April 2001 as Lead Awareness Month. UPAL/NC and the Division of Medical Assistance (DMA) would like to take this opportunity to recognize the Medicaid providers who are already testing all one- and two-year-old children for lead poisoning, and to encourage those Medicaid providers who may not have begun testing to do so now.

Federal Medicaid regulations state that all children participating in Medicaid are required to have a blood lead test at 12 and 24 months of age. Children between 36 and 72 months of age must be tested if not previously tested. Providers can always perform a lead screen if it is clinically indicated.

If you would like more information about how lead poisoning affects families over a long-term period, call Kris Joyner, Director, UPAL/NC at 252-937-4112 or e-mail UPAL/NC at upalnc1@hotmail.com. If you would like more information on billing for lead screening, contact EDS.

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

Attention: All Providers

Platelet-derived Wound Healing Formula, Procuren

Providers have been billing a platelet-derived formula, Procuren, which is intended to treat non-healing wounds as part of a comprehensive wound care program. To date, there is insufficient data to establish the safety and effectiveness of Procuren. Therefore, Procuren is noncovered and must not be billed under RC386.

Postpayment review of records reflecting payment of Procuren will result in recoupment.

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

Attention: All Providers

Provider Visit Request

The Division of Medical Assistance and EDS encourage providers to attend program-specific seminars as advertised in the general Medicaid bulletin and to utilize printed training materials to supplement the information supplied at the time of enrollment.

EDS Provider Services also offers providers support through the Automated Voice Response System for eligibility and claims inquiry; telephone attendants available to assist in answering detailed questions when resolving claims issues; and travel representatives for one-on-one training.

Individual provider visits are offered to all Medicaid providers, regardless of type and specialty, and may be requested any time during the year. To request an individual visit, complete and return the form below. An EDS Provider Representative will contact you to schedule a visit and discuss the type of issues you would like addressed.

Return completed form to:

EDS Provider Services
PO Box 300009
Raleigh, North Carolina 27622

Provider Visit Request Form
(No Fee)

Provider Name _____ Provider Number _____

Address _____ Contact Person _____

City, Zip Code _____ County _____

Telephone Number (___) _____ Date _____

List any specific issues you would like addressed in the space provided below.

_____

_____

_____

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

Attention: Dental Providers

Dental Seminars

Dental seminars are scheduled for June 2001. The May general Medicaid bulletin will have the registration form and a list of site locations for the seminars. Please list any issues you would like addressed at the seminars. Return form to:

Provider Services
EDS
P.O. Box 300009
Raleigh, NC 27622

_____

_____

_____

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

Attention: All Providers

Basic Medicaid Seminars Rescheduled to June 2001

The Basic Medicaid seminars that were scheduled for April 2001, have been cancelled and rescheduled for June 2001. The May general Medicaid bulletin will have the registration form and a list of site locations for the seminars.

Providers who registered for the Basic Medicaid seminars that were scheduled for April 2001 will need to re-register for the seminars that are scheduled for June 2001.

Please list any issues you would like addressed at the seminars. Return form to:

Provider Services
EDS
P.O. Box 300009
Raleigh, NC 27622

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

Checkwrite Schedule

April 10, 2001	May 8, 2001	June 12, 2001
April 17, 2001	May 15, 2001	June 19, 2001
April 26, 2001	May 22, 2001	June 28, 2001
	May 31, 2001	

Electronic Cut-Off Schedule

April 6, 2001	May 4, 2001	June 8, 2001
April 12, 2001	May 11, 2001	June 15, 2001
April 20, 2001	May 18, 2001	June 22, 2001
	May 25, 2001	

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.

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

Christopher T. Deelsnyder, CE
Administrative Process Management
EDS

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