Number 5 *May 2000*

North Carolina Medicaid Bulletin

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

Attention: All Providers

Holiday Observance

The Division of Medical Assistance (DMA) and EDS will be closed on Monday, May 29, 2000 in observance of Memorial Day.

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

In This Issue…… *Page #*

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

Attention: All Providers

Fee Schedules, Reimbursement Plans and Medicaid Bulletin Subscriptions

Request for Paper Schedules/Plans

There is no charge for fee schedules or reimbursement plans requested from the Division of Medical Assistance. However, all requests for publications **should be made on the form below** at the following address, **or** you can fax your request as indicated below:

Division of Medical Assistance
Financial Operations - Fee Schedules
2509 Mail Service Center
Raleigh, N. C. 27699-2509

PLEASE NOTE: PHONE REQUESTS ARE NOT ACCEPTED

You may fax your request to **(919) 715-0896/ DMA Financial Operations**.

Do not mail your requests for paper schedules to EDS.

- ☐ After Care Surgery Period
- ☐ Ambulatory Surgery Center
- ☐ Anesthesia Base Units
- ☐ CAP
- ☐ Dental
- ☐ DME
- ☐ Home Health
- ☐ Home Infusion Therapy
- ☐ Hospital Reimbursement Plan
- ☐ ICF/MR Reimbursement Plan
- ☐ Laboratory
- ☐ Nurse Midwife
- ☐ Nursing Facility Reimbursement Plan
- ☐ Optical and Visual Aids
- ☐ Physician Fees (includes x-ray)
- ☐ Prosthetics and Orthotics
- ☐ Portable x-ray

Requestor:_____ Provider Type: _____

Address:_____
_____
_____

Contact:_____

Phone:_____

Request for Diskette of Physician Fee Schedule and Anesthesia Base Units Schedule

The **PHYSICIAN FEE SCHEDULE** and the **ANESTHESIA BASE UNIT SCHEDULE** are available on diskette or via email from **DMA** at no charge. The North Carolina Division of Medical Assistance stipulates that the information provided be used only for your internal analysis. The actual billed amount on your claims must always contain your regular billed amount and not the price on the fee schedule unless the listed price represents what you normally bill another payer or patient. The billed amount is considered during rate setting efforts.

Please complete the information below with each request:

Requestor:_____

Address:_____ E-mail Address:_____

_____

Phone: _____

Type of File on 3 ½" PC Diskette (circle one):

TEXT FILE Excel Spreadsheet

Type of Schedule on Diskette (check one):

☐ Physician Fee Schedule

☐ Anesthesia Base Units

Please submit this request to**:** or fax this request to: (919) 715-0896

Division of Medical Assistance
Financial Operations
2509 Mail Service Center
Raleigh, North Carolina 27699-2509

Medicaid Bulletin Subscriptions

N. C. Medicaid bulletins are mailed to **all enrolled** providers. Non providers (e.g. billing agencies) may subscribe to the bulletin for an annual subscription fee of $12.00. To subscribe, send a letter including the subscriber's mailing address and a check for $12.00 payable to EDS to:

EDS
Attention: Provider Enrollment
P. O. Box 300009
Raleigh, N. C. 27622

DMA – Financial Operations for fee schedules and/or reimbursement plans at 919-857-4141 or
EDS – Provider Enrollment for Bulletin Subscriptions, at 1-800-688-6696 or 919-851-8888

Attention: All Providers

Accessing Hospice Participation Information on Automated Voice Response (AVR) System

Effective May 1, 2000, Hospice stickers are no longer required on Medicaid ID Cards. Hospice participation information can be determined through the AVR system by dialing 1-800-723-4337 and following the call flow as provided below.

When a provider calls the AVR system, the AVR responds with one of the following messages.

If the system is **unavailable**, the provider receives the following message:

"Thank you for calling EDS. The North Carolina Medicaid voice inquiries system is unavailable between 1:00 AM and 5:00 AM on the 1st, 2nd, 4th, and 5th Sunday of the month, and between 1:00 AM and 7:00 AM on the 3rd Sunday of the month. Please try your call again later."

If the system is **available**, the provider receives the following greeting:

"Thank you for calling the EDS Voice Response System. Please listen carefully, our menu options have been modified since (last modify date)."

"Welcome to the EDS voice inquiry. For North Carolina Medicaid inquiries, please press 1. If you are calling from a rotary telephone or for other business, please call 919-851-8888 or 1-800-688-6696."

If the provider presses 1, the call flow continues to Step 1.0. If no entry is made after the 10-second timeout, AVR assumes the provider is calling from a rotary phone and disconnects the caller.

"Please choose one of the following options. To verify the status of a claim, press 1. To receive provider check write information, press 2. To verify drug coverage, press 3. To verify procedure code pricing and modifier information, press 4. To verify prior approval, press 5. To verify Recipient Eligibility and Coordination of Benefits, Managed Care and Hospice status, press 6. To verify the status of a hysterectomy statement or sterilization consent, press 7. If you are calling for pre-admission certification, please call (919) 851-8888 or 1(800) 688-6696. To repeat these options, press 9."

When the provider selects option 6 in Step 1.0, main menu, the AVR prompts the provider to enter their North Carolina Medicaid provider number for verification.

"Please enter your provider number followed by the pound sign (#)."

The system asks the caller to verify their entry. The system then validates the given provider number. If the caller has correctly entered a valid provider number, AVR speaks the following message.

"To verify Recipient Eligibility and Coordination of Benefits, press 1. To verify Hospice Eligibility, press 2. To repeat these options press 3."

When the provider selects option 2, the AVR prompts the provider to enter a valid recipient identification number (MID).

"To obtain recipient Hospice status, please enter the ten-digit recipient identification number followed by the pound sign (#).

The AVR validates the entry for 9 numeric digits followed by an alpha. The system then asks the caller to verify their entry. Once the caller verifies their entry, AVR prompts the provider to enter the date of service.

"Please enter the date of service in an eight-digit month, date, century, and year format, followed by the pound sign (#)."

The AVR will validate that the MMDDCCYY entry is a valid date and that it is not a future date. If the user enters an invalid date, the standard error message will be given. If the user enters a future date, AVR will speak the following message.

"Hospice status cannot be obtained for future dates. Please re-enter the date of service."

If the user enters a valid date, the system will verify the entry. After the user verifies the entry, the system will play the following message:

"Please wait while the requested information is retrieved."

The system will then retrieve the information from the host. If the recipient identification number is not valid the caller will hear the following message:

"The recipient, (MID), is not on file."

If the MID is valid and the recipient is on Hospice for the requested date of service, AVR will speak the following message:

"The recipient, (MID), has been reported on Medicaid Hospice for (MMDDCCYY - the specified date). Medicaid Hospice covers most care related to a terminal illness; therefore, Hospice participation may affect your ability to be paid by Medicaid. Ask the recipient or the recipient's representative to give you the name of the hospice agency. Contact the hospice agency before rendering service."

If the MID is valid and the recipient is not on Hospice for the requested date of service, AVR will speak the following message:

"The recipient, (MID), has NOT been reported on Medicaid Hospice for (MMDDCCYY - the specified date). Nevertheless, if the recipient or the recipient's representative indicates possible Hospice participation, please ask the recipient or representative for the name of the hospice agency and contact the agency before rendering services. Medicaid Hospice covers most care related to a terminal illness; therefore, Hospice participation may affect your ability to be paid by Medicaid."

Once the AVR system has completed the Hospice status transaction, the provider is given the option to check another date of service, verify Hospice status for a different recipient, or return to the main menu.

"To repeat the Hospice status for this recipient, press 1. To verify another date of service for the same recipient, press 2. To verify Hospice status for a different recipient, press 3. To return to the main menu, press 8. To repeat these options press 9. To end this call, please hang up."

For further information on the North Carolina Automated Voice Response (AVR) System, please refer to the June 1999 North Carolina Medicaid Special Bulletin. Providers who have the Medicaid Community Care Manual may refer to Appendix D in the manual for information on AVR. Appendix D is a reprint of the June 1999 special bulletin.

The call flow for Option 6 has been modified to allow inquiry on recipient Hospice status, effective for dates of service on or after May 1, 2000.

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

Attention: All Mental Health/Substance Abuse Providers

New Health Benefit

Effective July 1, 2000 a new preventive/early intervention mental health benefit will be available to approximately 400,000 state employees and teachers and 60,000 children enrolled in N. C. Health Choice. Medicaid will adopt this policy for recipients under the age of 21. This plan will allow children to get mental health checkups similar to annual physicals.

Billing guidelines:
Medicaid will pay for six unmanaged visits without a diagnosis of Mental Illness.

Diagnosis coding: Claims may be diagnosis coded in either of two ways: (1) only the first two visits can be coded with ICD-9-CM code 799.9 (a non-specific code) and the following four visits can be coded with "V" diagnosis codes; or (2) the first visit can be coded with diagnosis 799.9 and the rest of the visits can be coded with "V" diagnosis codes. In either case, a specific diagnosis code should be used as soon as a diagnosis is established. After the sixth visit, a definitive diagnosis must be submitted in order for claims to be processed.

Prior approval:
Prior approval is not required for area mental health centers, however physicians and Ph.D. or Masters-level psychologists employed by physicians and who are not employed by area mental health centers must follow prior approval guidelines. Beyond the six unmanaged visits Medicaid will cover without a diagnosis of mental illness, Medicaid will cover up to 20 additional visits without prior approval. Prior approval must be requested for children under age 21 after the twenty-sixth visit. This permits a total of twenty-six unmanaged visits in a calendar year for the under 21 years of age population. This preventive mental health benefit will make it possible for children to receive services at the earliest signs of trouble.

Contact Carolyn Wiser, RN at 919-857-4025

Attention: Physicians and Health Departments

Medication Administration Codes

Effective with date of service July 1, 2000, the Medication Administration Code Q0124 will be replaced by medication specific CPT codes 90471-90788. There will be a grace period from July 1, 2000 to September 30, 2000 when the old **or** the new administration codes may be billed.

Health Check Providers must bill the Immunization Update Code W8012 for immunization administration for childhood immunizations. The CPT Therapeutic, Prophylactic, Diagnostic administration codes, 90782-90784, must be used for all other injections. W8012 can be billed with or without a separate office visit.

The newly covered CPT codes are:

CODE	ADMINISTRATION FOR
90471 "Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections and/or intranasal or oral administration); one vaccine (single or combination vaccine/toxoid)	CPT Codes 90476 through 90749 (Vaccines and toxoids) For adults only. For childhood immunization use W8012. When a significant separately identifiable Evaluation and Management service is performed, the appropriate E/M service code can be reported in addition to the vaccine and toxoid administration codes.
90472 " each additional vaccine (single or combination vaccine/toxoid	List separately in addition to code for primary procedure (90471) for CPT codes 90476 through 90749 For adults only. For childhood immunization use W8012.
90782 "Therapeutic, prophylactic or diagnostic injection (specify material injected): subcutaneous or intramuscular	For administration of subcutaneous or intramuscular injections. This includes the Immune Globulins. The drug should be billed on a separate detail line. The administration code is not billable in addition to an office visit. Code is available for adults and children.
90783 "Therapeutic, prophylactic or diagnostic injection (specify material injected); intra-arterial	For administration of intra-arterial injections. The drug should be billed on a separate detail line. The administration code is not billable in addition to an office visit. Code is available for adults and children.
90784 "Therapeutic, prophylactic or diagnostic injection (specify material injected); intravenous	For administration of intravenous injections. The drug should be billed on a separate detail line. The administration code is not billable in addition to an office visit. Code is available for adults and children.
90788 "Intramuscular injection of antibiotic (specify)	For administration of an intramuscular injection of an antibiotic. The drug should be billed on a separate detail line. The administration code is not billable in addition to an office visit. Code is available for adults and children.

Administration codes are billable when the following conditions are met:

- The injection is the sole purpose for the visit to the physician's office.
- The injectable drug administration is not given in conjunction with chemotherapy administration.
- Codes 90782-90788 are not billed in conjunction with an office visit.

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

Attention: All Providers

Resubmission vs. Filing Adjustment

If one of the following EOBs is received and the validity is questionable, do not appeal by submitting an adjustment request. Please contact EDS provider services at 1-800-688-6696 or 919/851-8888. Adjustments submitted for these EOB denials will be denied with EOB 998 "Claim does not require adjustment processing, resubmit claim with corrections as a new day claim" or EOB 9600 "Adjustment denied – claim has been resubmitted. The EOB this claim previously denied for does not require adjusting. In the future, correct/resubmit claim in lieu of sending an adjustment request." (Last Revision 02/25/00)

0002	0069	0128	0181	0236	0326	0574	0669	0825
0003	0074	0129	0182	0237	0327	0575	0670	0860
0004	0075	0131	0183	0240	0356	0576	0671	0863
0005	0076	0132	0185	0241	0363	0577	0672	0864
0007	0077	0133	0186	0242	0364	0578	0673	0865
0009	0078	0134	0187	0244	0394	0579	0674	0866
0011	0079	0135	0188	0245	0398	0580	0675	0867
0013	0080	0138	0189	0246	0424	0581	0676	0868
0014	0082	0139	0191	0247	0425	0584	0677	0869
0017	0084	0141	0194	0249	0426	0585	0679	0875
0019	0085	0143	0195	0250	0427	0586	0680	0888
0023	0089	0144	0196	0251	0428	0587	0681	0889
0024	0090	0145	0197	0253	0430	0588	0682	0898
0025	0093	0149	0198	0255	0435	0589	0683	0900
0026	0094	0151	0199	0256	0438	0590	0685	0905
0027	0095	0153	0200	0257	0439	0593	0688	0908
0029	0100	0154	0201	0258	0452	0604	0689	0909
0033	0101	0155	0202	0270	0462	0607	0690	0910
0034	0102	0156	0203	0279	0465	0609	0691	0911
0035	0103	0157	0204	0282	0505	0610	0698	0912
0036	0104	0158	0205	0283	0511	0611	0732	0913
0038	0105	0159	0206	0284	0513	0612	0734	0916
0039	0106	0160	0207	0286	0516	0616	0735	0917
0040	0108	0162	0208	0289	0523	0620	0749	0918
0042	0110	0163	0210	0290	0525	0621	0755	0919
0041	0111	0164	0211	0291	0529	0622	0760	0920
0046	0112	0165	0213	0292	0536	0626	0777	0922
0047	0113	0166	0215	0293	0537	0635	0797	0925
0049	0114	0167	0217	0294	0548	0636	0804	0926
0050	0115	0170	0219	0295	0553	0641	0805	0927
0051	0118	0171	0220	0296	0556	0642	0814	0929
0058	0120	0172	0221	0297	0557	0661	0817	0931
0062	0121	0174	0222	0298	0558	0662	0819	0932
0063	0122	0175	0223	0299	0559	0663	0820	0933
0065	0123	0176	0226	0316	0560	0665	0822	0934
0067	0126	0177	0227	0319	0569	0666	0823	0936
0068	0127	0179	0235	0325	0572	0668	0824	0940

0941	1050	1442	5001	7904	7948	7992	9211	9256
0942	1057	1443	5002	7905	7949	7993	9212	9257
0943	1058	1502	5201	7906	7950	7994	9213	9258
0944	1059	1506	5206	7907	7951	7996	9214	9259
0945	1060	1513	5216	7908	7952	7997	9215	9260
0946	1061	1866	5221	7909	7953	7998	9216	9261
0947	1062	1868	5222	7910	7954	7999	9217	9263
0948	1063	1873	5223	7911	7955	8174	9218	9264
0949	1064	1944	5224	7912	7956	8175	9219	9265
0950	1078	1949	5225	7913	7957	8326	9220	9266
0952	1079	1956	5226	7914	7958	8327	9221	9267
0953	1084	1999	5227	7915	7959	8400	9222	9268
0960	1086	2024	5228	7916	7960	8401	9223	9269
0967	1087	2027	5229	7917	7961	8901	9224	9272
0968	1091	2235	5230	7918	7962	8902	9225	9273
0969	1092	2236	6703	7919	7963	8903	9226	9274
0970	1152	2237	6704	7920	7964	8904	9227	9275
0972	1154	2238	6705	7921	7965	8905	9228	9291
0974	1156	2335	6707	7922	7966	8906	9229	9295
0986	1170	2911	6708	7923	7967	8907	9230	9600
0987	1175	2912	7700	7924	7968	8908	9231	9611
0988	1177	2913	7701	7925	7969	8909	9232	9614
0989	1178	2914	7702	7926	7970	9036	9233	9615
0990	1181	2915	7703	7927	7971	9054	9234	9625
0991	1183	2916	7704	7928	7972	9101	9235	9630
0992	1184	2917	7705	7929	7973	9102	9236	9631
0995	1186	2918	7706	7930	7974	9103	9237	9633
0997	1197	2919	7707	7931	7975	9104	9238	9642
0998	1198	2920	7708	7932	7976	9105	9239	9684
1001	1204	2921	7709	7933	7977	9106	9240	9801
1003	1232	2922	7712	7934	7978	9174	9241	9804
1008	1233	2923	7717	7935	7979	9175	9242	9806
1022	1275	2924	7733	7936	7980	9180	9243	9807
1023	1278	2925	7734	7937	7981	9200	9244	9919
1035	1307	2926	7735	7938	7982	9201	9245	9947
1036	1324	2927	7736	7939	7983	9202	9246	9993
1037	1350	2928	7737	7940	7984	9203	9247	
1038	1351	2929	7738	7941	7985	9204	9248	
1043	1355	2930	7740	7942	7986	9205	9249	
1045	1380	2931	7741	7943	7987	9206	9250	
1046	1381	2944	7788	7944	7988	9207	9251	
1047	1382	3001	7794	7945	7989	9208	9252	
1048	1400	3002	7900	7946	7990	9209	9253	
1049	1404	3003	7901	7947	7991	9210	9254	

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

Attention: All Physicians

Correction To Injectable Drug List

Effective with date of service April 1, 2000, the following correction is made to the fee for Daunorubicin Citrate Liposome 10 mg, J9151. The fee listed in the April Medicaid Bulletin was for the previous dosage of 50 mg which was the dosage for the state code W5163.

New Code	Description	Fee
J9151	Daunorubicin Citrate Liposome 10 mg	$61.37

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

Attention: Dental Providers

New Dental Claim Form and Code Updates for the Year 2000

The American Dental Association (ADA) has updated the ADA claim form and the Current Dental Terminology Users Manual for the year 2000. The ADA recommended use of the 1999 ADA claim form beginning in January, 2000. While keeping in compliance with the ADA changes, DMA and EDS must allow time for system changes to be implemented before accepting the 1999 ADA claim form. Providers should continue to use the 1994 ADA claim form for North Carolina Medicaid. DMA and EDS are working on the necessary system changes that must occur before acceptance of the 1999 form. Our anticipated implementation date for the 1999 ADA claim form is July 1, 2000. A transition period of three months will allow the 1994 and the 1999 claim forms to be accepted from July 1, 2000 through September 30, 2000.

Note: See a sample of the 1999 ADA claim form on the following page.

Updates to the Current Dental Terminology Users Manual contain revised procedure code descriptions, procedure code deletions, and new ADA procedure code additions. DMA and EDS strive to use codes in accordance with the ADA; however, providers should continue to submit the procedure codes identified in the North Carolina Medicaid Dental Services Manual until further notification. DMA and EDS are working on the necessary system changes that must occur before the new procedure codes will be implemented. The anticipated implementation date for the new ADA procedure codes is also July 1, 2000.

Watch upcoming Medicaid Provider Bulletins for exact dates and additional information regarding implementation of the 1999 ADA claim form and 1999 ADA code updates.

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

Sample of the 1999 ADA Claim Form
(next page)

Dental Claim Form

1. ☐Dentist's pre-treatment estimate ☐Dentist's statement of actual services — Specialty (see backside)
2. ☐Medicaid Claim ☐EPSDT — Prior Authorization #
3. Carrier Name
4. Carrier Address
5. City | 6. State | 7. Zip

PATIENT

8. Patient Name (Last, First, Middle) | 9. Address | 10. City | 11. State
12. Date of Birth (MM/DD/YYYY) / / | 13. Patient ID # | 14. Sex ☐M ☐F | 15. Phone Number ( ) | 16. Zip Code
17. Relationship to Subscriber/Employee: ☐Self ☐Spouse ☐Child ☐Other_____
18. Employer/School Name_____ Address_____

SUBSCRIBER / EMPLOYEE

19. Subs./Emp. ID#/SSN# | 20. Employer Name | 21. Group #
22. Subscriber/Employee Name (Last, First, Middle)
23. Address | 24. Phone Number ( )
25. City | 26. State | 27. Zip Code
28. Date of Birth (MM/DD/YYYY) / / | 29. Marital Status ☐Married ☐Single ☐Other | 30. Sex ☐M ☐F

39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

X_____
Signed (Patient/Guardian) Date (MM/DD/YYYY)

OTHER POLICIES

31. Is Patient covered by another plan ☐No (Skip 32–37) ☐Yes: ☐Dental or ☐ Medical | 32. Policy #
33. Other Subscriber's Name
34. Date of Birth (MM/DD/YYYY) / / | 35. Sex ☐M ☐F | 36. Plan/Program Name
37. Employer/School Name_____ Address_____
38. Subscriber/Employee Status ☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student
40. Employer/School Name_____ Address_____

41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

X_____
Signed (Employee/subscriber) Date (MM/DD/YYYY)

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity | 43. Phone Number ( ) | 44. Provider ID # | 45. Dentist Soc. Sec. or T.I.N.
46. Address | 47. Dentist License # | 48. First visit date of current series: | 49. Place of treatment ☐Office ☐Hosp. ☐ECF ☐Other
50. City | 51. State | 52. Zip Code | 53. Radiographs or models enclosed? ☐Yes, How many?_____ ☐No | 54. Is treatment for orthodontics? ☐Yes ☐No If service already commenced: Date appliances placed _____ Total mos. of treatment remaining _____
55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No — If no, reason for replacement: _____ Date of prior placement: _____
56. Is treatment result of occupational illness or injury? ☐No ☐ Yes Brief description and dates_____
57. Is treatment result of: ☐auto accident? ☐other accident? ☐neither Brief description and dates_____

58. Diagnosis Code Index (optional)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____

59. Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee

Admin. Use Only

60. Identify all missing teeth with "X"

Permanent																Primary										
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

Total Fee	
Payment by other plan	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

61. Remarks for unusual services

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X_____
Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed
64. City | 65. State | 66. Zip Code

J588 (Same as ADA Dental Claim Form) – J589, J590, J591

To Reorder, call 1-800-947-4746

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Attention: All Providers

Pap Smear Billing Changes

Based on recommendations to align with Medicare, the following policy changes are effective with date of service June 01, 2000 when billing Pap smears:

Physician Interpretation Procedure Code and Billing Information
CPT **88141** is the only code that physicians may use to bill the **physician interpretation** of a Pap smear. Because code 88141 has no components, it must be billed without a modifier. For dates of service June 1, 2000 and after, code 88141 appended with modifier 26 will be denied. Hospitals billing for the physician interpretation should bill 88141 on the HCFA-1500 claim form using the hospital's professional provider number.

Technical Pap Smear Component Procedure Codes and Billing Information
The technical procedure codes are listed below. The provider rendering the technical service must choose a technical procedure code from one of the following methods:

Thin Layer	Non-Bethesda	Bethesda	Not Specified
88142	88150	88164	88147
88143	88152	88165	88148
88144	88153	88166	
88145	88154	88167	

Laboratories and physicians: Bill the technical component procedure code without a modifier on the HCFA–1500 claim form.

Hospitals: Bill the technical component procedure code, without a modifier, using **Revenue Code (RC) 311** on the UB-92 claim form.

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

Attention: All Nursing Facility Providers

Discharge of a Nursing Facility Resident

When a Nursing Facility resident requires hospitalization, the Nursing Facility provider must indicate a discharged status in form locator 22 and a discharged bill type in form locator 4 on the UB-92 claim form. Nursing Facility claims billed incorrectly are subject to recoupments.

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

Attention: Physicians, Health Departments, Nurse Practitioners, Nurse Midwives, Rural Health, and FQHC Providers

Implantable Contraceptive Capsules

Effective with date of service July 1, 2000, all physicians will bill the Current Procedural Terminology (CPT) codes for the Implantable Contraceptive Capsules (previously referred to as Norplant). There will be a grace period from July 1, 2000 to September 30, 2000 when the Implantable Contraceptive Capsules may be billed using state created codes or CPT codes. The state created codes that will be end-dated with date of service October 1, 2000 are:

W5131 Insertion procedure Norplant system
W5132 Removal procedure Norplant system
W5133 Removal and re-insertion plus Norplant System kit

The following CPT/HCPCS codes will be used for physician billing on the HCFA-1500 claim form:

CPT 11975 "Insertion, implantable contraceptive capsules".
CPT 11976 "Removal, implantable contraceptive capsules".
CPT 11977 "Removal with reinsertion, implantable contraceptive capsules".
A4260 " Levonorgestrel (contraceptive) implant system**,** including implants and supplies".

The global period for the procedure codes are one (1) pre-care day and ninety (90) post-operative days.

Reminder: Please indicate "F" in item 24H on the HCFA-1500 claim form or append modifier "FP" to the procedure code to indicate Family Planning.

Hospital expenditures for the contraceptive kit and needed supplies will be included in the DRG for the procedure.

The Division of Medical Assistance sought clarification from the Attorney General's Office with respect to the capacity of minors to consent to the use of the implantable contraceptive capsules. The General Statute is as follows:

General Statute 90-21.5. Minor's consent sufficient for certain medical health services.

(a) Any minor may give effective consent to a physician licensed to practice medicine in North Carolina for medical health services for the prevention, diagnosis and treatment of (i) venereal disease and other diseases reportable under G.S. 130A-135, (ii) pregnancy, (iii) abuse of controlled substances or alcohol, and (iv) emotional disturbance. This section does not authorize the inducing of an abortion, performance of a sterilization operation, or admission to a 24 hour facility licensed under Article 2 of Chapter 122C of the General Statutes except as provided in G.S. 122C-222. This section does not prohibit the admission of a minor to a treatment facility upon his own written application in an emergency situation as authorized by G.S. 122C-222

(b) Any minor who is emancipated may consent to any medical treatment, dental and other health services for himself or for his child.

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

Attention: Home Health Providers

HCPCS Codes for Skilled Nursing Visits

Several questions were asked at the February Home Health Provider Seminars regarding the appropriate HCPCS code that should be used to describe certain skilled nursing visits. This article provides clarification for providers who were not in attendance when the questions were asked.

1. Q. For supply-only patients, what code should be used to describe the 60-day RN assessment visit to ensure the patient is receiving the appropriate medical supplies?

A. W9958 (Home Health skilled nursing visit not otherwise classified).

2. Q. Our agency provides monthly skilled nursing visits to CAP/DA clients – which we refer to as "CAP assessment visits." What code should be used?

A. Medicaid guidelines do not include a service identified as a "CAP assessment visit." Home Health services to CAP clients are based on the same criteria used for all Medicaid recipients. There are no special exemptions or allowances for CAP recipients. When billing for a skilled nursing visit, determine if the purpose of the visit is described on the MEDICARE-Medicaid Billing Guide in Section 5 of the *Medicaid Community Care Manual.* If Medicare covers the visit, bill Medicare. When Medicare does not cover the visit, determine if the monthly visit to a CAP recipient meets the description in Item A.4 on the chart. This visit is for observation and evaluation after a period with no significant changes in intervention – the patient's condition is chronic but stable yet there continues to be a documented medical necessity for intermittent nursing visits. In such situations, W9952 is the appropriate code and the limits on the chart apply. When a need for a Medicare-covered intervention is identified, MEDICARE becomes the primary payer.

3. Q. If more than one skilled nursing task/activity described on the chart is provided during the same visit, such as prefilling a medi-planner and prefilling insulin syringes, which code is used?

A. First, determine if either activity meets Medicare coverage guidelines. If so, bill the visit to Medicare. If Medicare does not cover the visit, then determine which Medicaid HCPCS code to use based on the code that describes the most important skilled nursing activity in relation to the patient's health and well-being. If the activities appear equal in importance, use your best judgement to select the code. The HCFA-485 and your clinical documentation should support your HCPCS code selection.

4. Q. When documentation supports that wound care no longer meets Medicare criteria for a dually-eligible patient, which code should be used to bill Medicaid?

A. In rare cases when Medicare does not cover wound care, use W9958 (Home Health skilled nursing visit not otherwise classified). Before billing Medicaid, pay special attention to instructions in the note in C.13 on the MEDICARE-Medicaid Billing Guide, page 5-20, Section 5, Community Care Manual.

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

Attention: Hospice Providers

Frequently Asked Questions (FAQ's) About the Hospice Participation Reporting Requirements

This article gives the answers to the most frequently asked questions regarding the new Hospice participation reporting requirements.

1. Q. Do I need to report when one of my patients dies?

A. No. The patient's date of death is put in the system through the Eligibility Information System.

2. Q. I have a patient who has elected the Hospice Medicaid benefit; however, their Medicaid is still pending. When do I call to report their election?

A. When you encounter this situation, you will need to make two telephone calls to the EDS Prior Approval unit.
1.) Make the initial call when the patient elects Hospice within the six-day time frame.
2.) Once the patient's Medicaid is approved call EDS and let them know this patient was previously reported as a pending Medicaid patient. EDS will then give you a confirmation number that dates back to your original telephone call.

3. Q. I have a Medicaid Hospice patient whose next benefit period starts next Monday. I am sure the patient will re-elect Hospice. Because I will be on vacation next week, I would like to call the election in on Friday. May I do so?

A. No. You may not call in the election of a new benefit period until the date the patient re-elects Medicaid Hospice.

4. Q. Our Hospice admitted a patient on March 1, 2000. The office manager was out of town and could not call the election in until March 14, 2000. Can we get a retroactive confirmation number?

A. No. Hospice agencies must make sure they have a procedure to report all patients within the six-day grace period.

5. Q. I have a patient with Medicare and Medicaid. The patient has elected both Medicare and Medicaid Hospice. The patient is at home and Medicaid will never be billed. Do I need to call this patient's information to EDS?

A. No. It is not necessary to call EDS unless you are planning on billing Medicaid.

6. Q. The patient who has elected Medicare and Medicaid Hospice has now decided to enter a nursing home. Our agency will need to begin billing Medicaid for the room and board. When do we need to call EDS for a confirmation number?

A. You must call EDS within six days of the patient's admission to the nursing home. The benefit start date will be the date the patient entered the nursing home and the benefit end date will coincide with the end date for the current Medicare benefit period.

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

Attention: OB/GYN Providers

OB/GYN Seminar Schedule

Seminars for OB/GYN providers are scheduled in June 2000. Business office managers, Medicaid billing supervisors, and other billing personnel should plan to attend. These seminars will review program guidelines, coding, claim form completion, and follow-up, and will also focus on the most common denials for this provider type. Electronic claims submission will also be discussed as it is encouraged to facilitate faster claims payment.

Due to limited seating, pre-registration is required. Providers not registered are welcome to attend if reserved space is adequate to accommodate.

Please select the most convenient site and return the completed registration form to EDS as soon as possible. Seminars begin at 10:00 a.m. and end at 1:00 p.m. Providers are encouraged to arrive by 9:45 a.m. to complete registration.

Directions are available on page 18 of this bulletin.

Tuesday, June 6, 2000
Four Points Sheraton
5032 Market Street
Wilmington, NC

Tuesday, June 20, 2000
Holiday Inn Conference Center
530 Jake Alexander Blvd., S.
Salisbury, NC

Thursday, June 15, 2000
Catawba Valley Technical College
Highway 64-70
Hickory, NC
Auditorium

Monday, June 26, 2000
WakeMed
MEI Conference Center
3000 New Bern Avenue
Raleigh, NC
Park at East Square Medical Plaza

(cut and return registration form only)

OB/GYN Provider Seminar Registration Form
(No Fee)

Provider Name _____ Provider Number_____

Address _____ Contact Person _____

City, Zip Code_____ County _____

Telephone Number _____ Fax Number: _____ Date Mailed: _____

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

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

Directions to the OB/GYN Seminars

The registration form for the OB/GYN workshops are on page 17 of this bulletin.

WILMINGTON, NORTH CAROLINA

FOUR POINTS SHERATON

I-40 East into Wilmington to Highway 17 - just off I-40. Turn left onto Market Street and the Four Points Sheraton is located approximately ½ mile on the left.

RALEIGH, NORTH CAROLINA

WAKEMED MEI CONFERENCE CENTER

Directions to the Parking Lot:
Take the I-440 Raleigh Beltline to New Bern Avenue, Exit 13A (New Bern Avenue, Downtown). Travel toward WakeMed. Turn left onto Sunnybrook Road and park at the East Square Medical Plaza which is a short walk to the conference facility. **Parking is not allowed in the parking lot in front of the Conference Center. Vehicles will be towed if not parked in the East Square Medical Plaza parking lot located at 23 Sunnybrook Road.**
Directions to the Conference Center from Parking Lot:
Cross Sunnybrook Road and follow sidewalk access up to Wake County Health Department. Walk across the Health Department parking lot and ascend steps (with blue handrail) to MEI Conference Center. Entrance doors at left.

SALISBURY, NORTH CAROLINA

HOLIDAY INN CONFERENCE CENTER

Traveling South on I-85: Take exit 75 and turn right on Jake Alexander Blvd. **Traveling North on I-85:** Take exit 75 and turn left on Jake Alexander Blvd. Travel approximately ½ mile and the Holiday Inn is located on the right.

HICKORY, NORTH CAROLINA

CATAWBA VALLEY TECHNICAL COLLEGE

Take I-40 to exit 125 and go approximately 1/2 mile to Highway 70. Travel East on Highway 70 and the college is approximately 1.5 miles on the right. Ample parking is available. Entrance to Auditorium is between the Student Services and the Maintenance Center. Follow sidewalk (toward Satellite Dish) and turn right to Auditorium Entrance.

Attention: Hospital Providers

Hospital Seminars

Hospital seminars are scheduled in July 2000. The June 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: Physicians

Injectable Drug Fee Change

Effective with date of service May 1, 2000, the maximum allowable fee has been changed for the following injectible drugs:

J1020	Methylprednisolone Acetate 20 mg	$2.29
J1030	Methylprednisolone Acetate 40 mg	4.59
J1040	Methylprednisolone Acetate 80 mg	9.17

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

Attention: Hospital Providers

ICD-9 Procedure Code 47.09

The September 1999 Medicaid Bulletin, page 11, published a list of noncovered services for providers. ICD-9-CM Procedure Code 47.09 (other appendectomy) was listed as noncovered. Effective with date of service November 1, 1999, DMA implemented coverage of Procedure Code 47.09 for abdominal appendectomy when the diagnosis code reflects appendicitis.

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

Checkwrite Schedule

May 9, 2000	June 13, 2000	July 11, 2000
May 16, 2000	June 20, 2000	July 18, 2000
May 23, 2000	June 29, 2000	July 27, 2000
May 31, 2000		

Electronic Cut-Off Schedule

May 5, 2000	June 9, 2000	July 7, 2000
May 12, 2000	June 16, 2000	July 14, 2000
May 19, 2000	June 23, 2000	July 21, 2000
May 26, 2000		

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

John W. Tsikerdanos
Executive Director
EDS

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