North Carolina
Medicaid Special Bulletin

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## Attention: Health Departments

# CPT Code Conversion

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# HEALTH DEPARTMENT CPT CODE CONVERSION

**Effective Date:**

Effective with date of service July 1, 2000, Health Departments will be required to bill CPT codes. There will be a grace period from July 1, 2000 to September 30, 2000 when either the state created HCPC or CPT codes may be billed. The state created codes will be end dated with date of service October 1, 2000. See Appendix B for codes that will not change effective July 1, 2000.

# ATTENDING PHYSICIAN NUMBER FOR MEDICAID CLAIMS ORIGINATING IN LOCAL HEALTH DEPARTMENTS

Effectively immediately, Health Departments should discontinue any effort to obtain Attending Physician Numbers for the physicians who serve as medical directors and consultants for their agency. Health Departments **WILL NOT NEED AN ATTENDING PHYSICIAN NUMBER TO BILL CLAIMS.** This should make the transition to CPT billing easier.

Effective with date of service July 1, 2000, Medicaid developed a uniform Attending Physician Number for all Health Departments. This number is automatically inserted into the Attending Physician Number block (PIN# section in block 33 on the HCFA-1500) on each claim.

Health Departments still need to insert their facility Medicaid number in the GRP# section in block 33 to indicate who is to receive the payment for services.

# PREVENTIVE SERVICES

## Health Check Components and Billing Guidelines:

The Health Check Program is a preventive care program for Medicaid eligible children ages birth through 20. **A Health Check Screening is the only well child preventive visit reimbursable by Medicaid**. Recipients are encouraged to receive their comprehensive health checkups and immunizations on a regular, periodic schedule. A complete Health Check screening consists of the following age appropriate components required to be performed at each visit unless otherwise noted below:

- **Comprehensive unclothed physical examination**
- **Comprehensive health history**
- **Nutritional assessment**
- **Anticipatory guidance/health education**
- **Measurements, blood pressure, and vital signs**

  Blood pressure is recommended to become a part of the exam between ages 3 and 4.

- **Developmental screening, including mental, emotional, and behavioral**

  Age appropriate evaluations should be performed at each screening. In addition, three written developmental assessments should be performed: the first by 12 months, the second by 24 months and the third by 60 months.

- **Immunizations**

  Federal regulation states that immunizations are to be provided at the time of screening if they are needed.

- **Vision and hearing screenings**

  Visual assessment should be administered a minimum of two times in the first year of life, at 3 years of age, once between 4 and 5 years of age, and then every three years thereafter.

  Hearing assessment should be administered a minimum of two times in the first year of life, annually until age 3, once between 4 and 5 years of age, and then every three years thereafter.

- **Laboratory procedures**

  Includes hemoglobin/ hematocrit, urinalysis, sickle cell, tuberculin skin test, and lead screening.

  Hemoglobin or Hematocrit: Hemoglobin and/or hematocrit should be measured once during infancy (between 1 and 9 months) for all children and once during adolescence for menstruating teenagers. An annual hemoglobin/hematocrit screening for adolescent females (ages 11 to 21 years) should be performed if any of the following risk factors are present: moderate to heavy menses, chronic weight loss, nutritional deficit, or athletic activity. For hemoglobin/hematocrit guidelines for children in the Women, Infants, and Children's (WIC) Program, call your local WIC program.

  Urinalysis: Urinalysis should be performed once at 5 years of age. Also, a dipstick leukocyte esterase test to screen for infections should be performed at least once between 11 and 21 years of age (preferably at age 14) or more often as clinically indicated.

  Sickle Cell Testing: Sickle Cell test is recommended to be performed by 12 months. North Carolina hospitals are required to screen all newborns before discharge. If a child has been properly tested then the test need not be repeated. Results must be documented in the child's medical record.

- **Laboratory procedures continued:**

  Tuberculin Testing: Children at increased risk of exposure to tuberculosis should be tested and only PPD, (Purified Protein Derivative) by Mantoux method should be used. Routine tuberculin skin testing of children with no risk factors residing in low prevalence areas is not indicated.

  Children with the following risk factors should be tested:

  1. Close contacts to a case of TB disease
  2. Children with clinical or radiographic symptoms suggestive of TB
  3. Children immigrating within the past 5 years from high-prevalence countries (e.g., Asia, Africa, Latin America, or the Pacific islands)
  4. Children who are HIV infected (test annually)
  5. Children with continuous exposure to high-risk adults (e.g., HIV infected persons; homeless; injected drug users; migrant farm workers) (test every 2-3 years)
  6. Children living in locally identified high prevalence areas as determined by local health department TB control programs (baseline)

- **Laboratory procedures continued:**

Lead Screening: Federal regulation states that all participating Medicaid children are required to have a blood lead test at 12 and 24 months of age. Children between 36-72 months of age must be tested if they have not been previously tested. Providers can always perform a lead screen if clinically indicated.

Medical follow up begins with a blood lead level greater than or equal to 10 ug.dL. Capillary blood level samples are adequate for the initial screening test. Venous blood samples should be collected for confirmation of all elevated blood lead results.

| **Blood Lead Concentration** | **Recommended Response** |
|---|---|
| <10 ug/dL | Rescreen again at 24 months of age |
| 10-19 ug/dL | Confirmation (venous) testing should be conducted within three months. If confirmed, repeat testing should be conducted every two to three months until the level is shown to be <10 ug/dL on three consecutive tests (venous or fingerstick). The family should receive education and nutrition counseling, and a detailed environmental history should be taken to identify any obvious sources of exposure. If the blood lead level is confirmed at ≥10 ug/dL, environmental investigation will be offered. |
| 20-44 ug/dL | Confirmation (venous) testing should be conducted within one week. If confirmed, the child should be referred for medical evaluation and should continue to be retested every two months until the blood lead level is shown to be <10 ug/dL on three consecutive tests (venous or fingerstick). Environmental investigations are required and remediation for identified lead hazards shall occur for all children less than six years old with confirmed blood lead levels ≥20 ug/dL. |
| >45 ug/dL | The child should receive a venous lead test for confirmation as soon as possible. If confirmed, the child must receive urgent medical and environmental follow-up. Chelation therapy should be administered to children with blood lead levels in this range. Symptomatic lead poisoning or a venous lead level >70 ug/dL is a medical emergency requiring inpatient chelation therapy. |

**State Laboratory of Public Health for Blood Lead Screening**
Laboratory Services of the Department of Health and Human Services will analyze blood lead specimens for all children less than 6 years of age at no charge. Providers requiring results of specimens from children outside this age group will need to contact the State Laboratory of Public Health at (919) 733-3937.

**Note:** When the above labs are processed in the provider's office, Medicaid will not reimburse separately for these procedures. Payment for these procedures is included in the reimbursement for a Health Check screening.

All Health Check components are required to be included and documented in the medical record. Each screening component is vital for measuring a child's physical, mental, and developmental growth.

**Periodicity Schedule**

- Within the first month
- 2 months
- 4 months
- 6 months
- 12 months
- 15 months*
- 18 months
- 2 years
- 3 years
- 4 years
- 5 years
- 6 years & older

(One screening every three years for children 6 years and older)

*This screening may be performed at 9 months of age instead

**Periodic, Regular Screenings - Procedure Code W8010**
The schedule above outlines the recommended frequency of Health Check screenings dependent upon the age of the child. The intent of this schedule is to assure that a minimum number of screenings occur at critical points in a child's life.

**Note:** If a child is scheduled for a Health Check Screening and an illness is detected, the provider may continue with the screening or bill a sick visit and reschedule the screening for a later date.

**Interperiodic Screenings - Procedure Code W8016**
In addition to the periodicity schedule, interperiodic screening visits are allowed in the following circumstances:

- Upon referral by a health, developmental, or educational professional based on their determination of medical necessity. Some examples of referral sources include Head Start, Agricultural Extension Services, Early Intervention Programs, or Special Education Programs.

- When children require either a kindergarten or sports physical outside the regular schedule.

- When children whose physical, mental, or developmental illnesses or conditions have already been diagnosed and have indications that the illness or condition may require closer monitoring.

- When the screening provider has determined there are medical indications that make it necessary to schedule additional visits in order to determine whether a child has a physical or mental illness or a condition that may require further assessment, diagnosis, or treatment.

In each of these circumstances the screening provider must specify and document in the child's medical record the reason necessitating the visit. ***These visits also require that all Health Check screening components be performed.***

**Immunizations**

**Procedure Code W8012**

**An immunization administration fee may be billed (W8012)** if it is the only service provided that day, or if it is in addition to an office visit. The immunization administration fee cannot be billed in conjunction with a Health Check Screening

**Universal Childhood Vaccine Distribution Program (UCVDP)/Vaccines for Children Program (VFC)**
The Immunization Program of the North Carolina Division of Public Health, Women's and Children's section administers the Universal Childhood Vaccine Distribution Program (UCVDP). This program provides all required (and some recommended) vaccines to all of North Carolina's children (including VFC Medicaid eligible children) at no cost. Due to the availability of these vaccines at no charge, Medicaid no longer reimburses for UCVDP/VFC vaccines for children through 18 years of age.

For Medicaid eligibles 19 through 20 years of age, DMA will continue to reimburse for Medicaid covered vaccines, which are provided at no charge under the UCVDP. DMA will also continue reimbursing for Medicaid covered vaccines given to Medicaid eligible children birth through age 20 which are not provided by the UCVDP.

**The following is a list of UCVDP/VFC vaccines:**

| Codes | Vaccines | Diagnosis Codes |
|---|---|---|
| 90645 | Hib-4 dose | V03.8 or V05.8 |
| 90647 | Hib-3 dose | V03.8 or V05.8 |
| 90657* | Influenza (6-35 months of age) - High Risk Only | V04.8 |
| 90658* | Influenza (3 years and above) - High Risk Only | V04.8 |
| 90732 | Pneumococcal - High Risk Only | V03.8 or V05.8 |
| 90700 | DtaP | V06.8 |
| 90702 | DT | V06.8 |
| 90707 | MMR | V06.4 |
| 90712 | OPV | V04.0 |
| 90713 | IPV | V04.0 |
| 90716 | Varicella | V05.4 |
| 90718 | Td | V06.5 |
| 90744 | Hepatitis B Vaccine – Pediatric/Adolescent | V05.8 |

Medicaid will reimburse for the Hepatitis B vaccine purchased for high-risk individuals 19 years and older. See list below for examples of high risk categories:

- Infants born to infected mothers.
- Children born on or after November 22, 1991.
- All children entering the sixth grade.
- Household and sexual contacts of Hepatitis B carriers. 1
- Intravenous drug users.
- Sexually active homosexual and bisexual males.
- Residents in mental retardation facilities.
- Persons with recent sexual exposure to person(s) known or suspected to be infected with Hepatitis B. 1
- Hemodialysis patients.
- Persons with needle stick exposure to potentially infected blood.
- Health occupation students limited to college and community college students enrolled in health occupation courses when their tasks involve exposure to blood and blood-contaminated body fluid. 2

*****These vaccines are available through the Universal Childhood Vaccine Distribution Program (UCVDP) for **high-risk** children only effective 10/01/95. For more information, refer to the UCVDP guidelines.

If you are not enrolled in the UCVDP or if you have questions, please call 1-800-344-0569.

For our out-of-state providers (within the 40 mile radius of North Carolina), you may obtain VFC vaccines by calling your state VFC Program:

- **Georgia** (1-404-657-5013)
- **South Carolina** (1-800-277-4687)
- **Tennessee** (1-615-532-8513)
- **Virginia** (1-800-568-1929)

**Health Check Billing Requirements**

Instructions for billing a Health Check Screening on the HCFA-1500 Claim Form are the same as when billing for other medical services except for six critical differences. The six coding **requirements** specific to the Health Check Program are as follows:

**Requirement 1: Identify and Record Diagnosis Code(s)**

Place diagnosis code(s) in the correct order in Block 21. **When a Health Check screening is performed, V20.2 is always the "primary diagnosis"** followed by other codes for new or existing diagnoses. Medical diagnoses should **always** be listed before immunization diagnoses. Immunization diagnoses are not required unless billing the Immunization Administration fee only.

**Requirement 2: Identify and Record Procedure Code**

Use the correct Health Check screening procedure code in Block 24D:

| Description | HCPCS Code | Diagnosis Code |
|---|---|---|
| Regular Periodic Screening Birth through 20 years | W8010 | V20.2 (Primary Diagnosis) |
| Interperiodic Screening Birth through 20 years | W8016 | V20.2 (Primary Diagnosis) |

**Note:** A Health Check Screening is the only well child visit reimbursable by Medicaid and must have V20.2 as the primary diagnosis code.

**Requirement 3: Identify and Code Diagnosis Modifier(s)**

The diagnosis modifier is a **two-digit** code to be listed in Block 24D with the screening procedure code to describe the outcome(s) of a visit. A diagnosis modifier is required for **each medical** diagnosis in Block 21.

**If V20.2 is the only diagnosis code, the 1N modifier must be present in block 24D.**

Each additional diagnosis (with the exception of immunization diagnoses) that is listed after the V20.2, you must omit the 1N modifier, decide the outcome of the diagnosis, and choose the appropriate diagnosis modifier listed below. Every medical diagnosis used in addition to the V20.2 must have a diagnosis modifier. These modifiers listed below indicate the outcome of each medical diagnosis used in addition to V20.2.

**The following matrix should be used to determine which modifier to use**:

| | |
|---|---|
| **Follow-up with screening provider** | **XF** |
| **Referred to another provider** | **XO** |
| **No follow-up necessary** | **ZF** |

**Note:** Diagnosis modifiers may be duplicated.

**Requirement 4: Identify and Code Screening Modifier(s)**

Identify and code the appropriate screening modifier(s) in Block 24D. These modifiers are only listed when applicable and are used **in addition to** the diagnosis modifier(s):

| Modifier: | Explanation |
|---|---|
| ZD | Referral for dental care |
| ZL | Blood lead screening test drawn |
| Z1 | Referral to the WIC Program |

**Requirement 5: Record Immunization Procedure Code(s)**

**Requirement 5A: Bill for Vaccine Administration**

| Description | HCPCS Code | Diagnosis Code |
|---|---|---|
| Immunization Administration Fee | W8012 | Use an Immunization Diagnosis Code *(if only service provided)* |

List code W8012 in Block 24D on the HCFA-1500 claim form.

In Block 24G, list one unit if one immunization was administered and two units if two or more immunizations were administered per visit.

**Immunization procedure codes must be listed for all immunizations administered or due in block 24D, followed by the appropriate modifier(s) listed and charges if applicable. Refer to modifiers listed below and on the next page.**

**Requirement 5B: Immunization Modifiers**

Identify and code the appropriate immunization modifier(s). Code modifiers next to specific immunization procedure codes in Block 24D.

| Purchased Vaccines | | Free Vaccines | |
|---|---|---|---|
| Description | Modifier | Description | Modifier |
| Purchased, Dose 1 | Y1 | Free, Dose 1 | X1 |
| Purchased, Dose 2 | Y2 | Free, Dose 2 | X2 |
| Purchased, Dose 3 | Y3 | Free, Dose 3 | X3 |
| Purchased, Dose 4 | Y4 | Free, Dose 4 | X4 |
| Purchased, Dose 5 | Y5 | Free, Dose 5 | X5 |
| Purchased, Dose 6 | Y6 | Free, Dose 6 | X6 |
| Purchased, Dose 7 | Y7 | Free, Dose 7 | X7 |

**Requirement 5B: Immunization Modifiers (continued)**

Refer to the HCFA-1500 forms on pages 14, 15, and 16 when reviewing the following guidance. Use the "X" modifier when coding free vaccines covered under the UCVDP/VFC Program and the dose number which corresponds to the number in the vaccine series (Block 24D). List zero charges when using free vaccine(s) (Block 24F) and list the appropriate number of units (Block 24G). For Medicaid eligibles 19-20 years of age, and for children receiving vaccines not covered through the Universal Childhood Vaccine Distribution Program (UCVDP), use the "Y" modifier when billing for Medicaid covered vaccines plus the dose number which corresponds to the number in the vaccine series. Bill your charges and the appropriate number of units.

**Requirement 5C: Contraindication Modifiers**

The other type of immunization modifier is the contraindication modifier. These modifiers are used to report a contraindication to a specific vaccine(s). A contraindication is a medical situation that prevents or delays an immunization. The units will always be "1".

| **Description** | **Modifier** |
|---|---|
| Temporary | ZT |
| Permanent | ZP |
| Religious | ZR |

***Example:***

A child who has a temporary contraindication to a vaccine may need an evaluation in order to receive the vaccine. For example, the child is allergic to eggs and it is unclear whether to give MMR. Indicate the CPT/HCPCS code of the contraindicated vaccine (90707), the modifier ZT, zero charges, and a unit of one on the claim for that date of service. When the child returns, report the vaccine given or a permanent contraindication.

If a child receives the first dose of DTaP and has a reaction that results in DTaP being "permanently contraindicated", the DTaP vaccine code, 90700, will be listed at the next visit with the modifier ZP (in Block 24D of the HCFA-1500 claim form) to indicate that the vaccine is "permanently contraindicated".

To report religious exemptions, list the CPT/HCPCS code(s), the modifier ZR, zero charges, and a unit of one for every vaccine the child would have received on that date of service.

For more information on medical or religious exemptions, call the Immunization Branch at 919-733-7752.

**Requirement 6: Next Screening Date**

Providers may enter the next screening date (NSD) or have the next screening date systematically entered according to the (predetermined) Medicaid periodicity schedule on page 5. Below is an explanation of options for the NSD in block 15 of the HCFA 1500.

- **Systematically-Entered Next Screening Date**

  Providers have the following choices for block 15 of the HCFA-1500 claim form with a Health Check screening. All of these choices will result in an automatically entered NSD.

  - ***Leave block 15 blank***
  - ***Place all zeros in block 15 (00/00/0000)***
  - ***Place all ones in block 15 (11/11/1111)***

  Children with systematically entered NSDs will be tracked per the Medicaid periodicity schedule.

- **Provider Entered Next Screening Date**

  Providers have the option of entering the NSD in block 15 if they prefer. If this date is within the periodicity schedule, the system will keep this date. In the event the NSD is out of range with the periodicity schedule, the system will override the providers NSD and the appropriate NSD (based upon the periodicity schedule) will be automatically entered during claims processing. The only reason for a NSD denial is if the date entered is not in the correct format; therefore, it could not be a real date (for example 12/54/1999 or 44/10/2000 are not actual dates and the claim would deny with EOB 621).

**Tips For Billing**

- Two screening visits on different dates of service cannot be billed on the same claim form.
- Third Party Insurance must be pursued and reported in Block 29 on the HCFA-1500 claim form when preventive services are covered. If Third Party Insurance does not cover preventive services (well child screenings) clearly document in medical record and submit a claim to Medicaid.
- A Health Check screening and an office visit with different dates of service cannot be billed on the same claim form.
- A Health Check screening and an office visit cannot be paid initially on the same date of service. One claim will pay and the other will deny. The denied claim will need to be resolved through adjustments with medical justification and the denial RA.
- W8012 (Immunization Administration Fee) cannot be billed in conjunction with a Health Check screening exam. W8012 may be billed if it is the only service provided that day, or when it is in addition to an office visit. However, all immunizations administered in conjunction with W8012 must be listed by immunization procedure code (CPT'd/HCPC's) on the HCFA-1500. If W8012 is submitted without the immunization procedure codes the claim will deny.

**Health Check Coordinators**
Specially trained Health Check Coordinators are available to assist both **parents** and **providers** in assuring that Medicaid eligible children have access to Health Check services. The kinds of activities performed include, but are not limited to, the following:

- Assisting with scheduling appointments or securing transportation
- Acting as a local information, referral, and resource person for families
- Providing advocacy services in addressing social, educational, or health needs of the client
- Initiating follow-up as requested by providers when families need special assistance or fail to bring children in for screenings
- Promoting Health Check and health prevention with other public and private organizations
- Assisting families to use health care services in a consistent and responsible manner

Physicians and other primary care providers and their office staff are encouraged to establish a close working relationship with the Health Check Coordinators. As the program evolves and the Health Check Coordinators gain experience, ongoing communication should significantly enhance client participation in Health Check and assist in making preventive care services more timely and effective.

**Health Check Coordinators are currently located in 60 North Carolina counties**

| | | | | |
|---|---|---|---|---|
| Ashe | Cleveland | Guilford | Onslow | Surry |
| Avery | Columbus | Halifax | Orange | Swain |
| Bertie | Cumberland | Haywood | Pamlico | Vance |
| Brunswick | Dare | Hertford | Pasquotank | Wake |
| Buncombe | Davie | Hoke | Pender | Warren |
| Burke | Duplin | Jackson | Perquimans | Wayne |
| Caldwell | Durham | Jones | Person | Wilkes |
| Camden | Edgecombe | Lenoir | Richmond | Wilson |
| Catawba | Franklin | Macon | Robeson | *Qualla Boundary |
| Chatham | Gates | Madison | Sampson | |
| Cherokee | Graham | Nash | Scotland | |
| Chowan | Granville | New Hanover | Stanly | |
| Clay | Greene | Northampton | Stokes | |

Health Check Coordinators are housed in local Health Departments, Community and Rural Health Centers, and other community agencies.

*Eastern Band of Cherokee Indians

**Automated Information And Notification System (AINS)**

The Health Check Automated Information and Notification System (AINS) is a computerized system for identifying and following Medicaid eligible children birth through 20 years of age with regard to their activities in the health care system. It enables Health Check staff across the state to determine which Medicaid eligible children in their respective counties are receiving periodic and interperiodic Health Check screenings, immunizations, and referrals for special health care needs. The system also sends letters to the parents of Medicaid eligible children providing information on:

- The Health Check program
- Scheduled screening appointments (from the date given by the provider in block 15 of the HCFA-1500)
- Children due for a screening (per the periodicity schedule using a system generated next screening date)
- Missed referral appointments
- Other available programs and schedules

Information to operate the AINS is obtained from two sources:

1. Medicaid (paid) claims submitted by providers who perform Health Check screenings and/or treat children
2. The Eligibility Information System within the Department of Health and Human Resources, which contains data on Medicaid eligibility

The AINS uses factors such as age, degree of interaction with the health care system, and medical diagnoses to prioritize children by risk categories. Such prioritization allows Health Check staff to schedule contacts with parents of high-risk children first. This is especially helpful in counties that have numerous Medicaid eligible children. It is also used to obtain the address, phone number and head of household of Medicaid eligible children needing to be contacted. The report is reviewed to identify children with missed diagnostic referrals and children who have not been screened or who have missed screenings. These children are then followed according to priorities and procedures detailed in the Health Check Policy.

APPROVED OMB 0938 0008

PLEASE DO NOT STAPLE IN THIS AREA

**Sample Claim for Health Dept. Providers: Billing for Immunization Administration Fee**

# HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 900000000S

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Woods, Tiger

3. PATIENT'S BIRTH DATE MM DD YY: 01 16 1996 | SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 22 Master's Lane

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Raleigh | STATE: NC

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full Time Student [ ] Part Time Student [ ]

CITY | STATE

ZIP CODE: 27606 | TELEPHONE (Include Area Code): ( 919) 222-2222

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [ ] NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX: M [ ] F [ ]

b. AUTO ACCIDENT? [ ] YES [ ] NO | PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? [ ] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO *If yes*, return to and complete item 9 a-d.

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED | DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [ ] NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V06.1
2.
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 24. A DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 03 17 2000 | 03 17 2000 | 11 | 01 | W8012 | | | 27.42 | 2 | | | | |
| 2 03 17 2000 | 03 17 2000 | 11 | 01 | 90701 | X5 | | 0.00 | 1 | | | | |
| 3 03 17 2000 | 03 17 2000 | 11 | 01 | 90712 | X4 | | 0.00 | 1 | | | | |
| 4 03 17 2000 | 03 17 2000 | 11 | 01 | 90718 | X2 | | 0.00 | 1 | | | | |
| 5 | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | |

25. FEDERAL TAX I.D. NUMBER: SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 32144

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [ ] NO

28. TOTAL CHARGE: $ 27.42

29. AMOUNT PAID: $

30. BALANCE DUE: $ 27.42

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Signature on file DATE 4/2/00

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Masters County Health Dept.
124 Hole In One Court
Masters, NC 20000

PIN# 965432 GRP# 3404000

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER



(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

**PLEASE PRINT OR TYPE**

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

APPROVED OMB-0938-0008

PLEASE DO NOT STAPLE IN THIS AREA

Sample Claim for Health Dept. Providers
Core Visit with Immunizations (List Vaccines given but do not bill Administration Fee)

# HEALTH INSURANCE CLAIM FORM

PICA

PICA

1. MEDICARE ☐ (Medicare #) | MEDICAID ☒ (Medicaid #) | CHAMPUS ☐ (Sponsor's SSN) | CHAMPVA ☐ (VA File #) | GROUP HEALTH PLAN ☐ (SSN or ID) | FECA BLK LUNG ☐ (SSN) | OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 900000000M

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, Hercules

3. PATIENT'S BIRTH DATE MM DD YY: 02 05 1999 | SEX: M ☒ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 12 Mt. Olympus Drive

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: Durham | STATE: NC

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ | Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY: | STATE:

ZIP CODE: 27707 | TELEPHONE (Include Area Code): (919 ) 231-1111

ZIP CODE: | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX: M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX: M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE:

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED | DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE

1. V20.2
2.
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO

23. PRIOR AUTHORIZATION NUMBER

| 24 A DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT HCPCS | MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 03 20 2000 | 03 20 2000 | 11 | 01 | W8010 | 1N | | 77.75 | 1 | | | | |
| 2 03 20 2000 | 03 20 2000 | 11 | 01 | 90701 | X3 | | 0.00 | 1 | | | | |
| 3 03 20 2000 | 03 20 2000 | 11 | 01 | 90707 | X1 | | 0.00 | 1 | | | | |
| 4 03 20 2000 | 03 20 2000 | 11 | 01 | 90645 | X4 | | 0.00 | 1 | | | | |
| 5 | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | |

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO. 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $ 77.75

29. AMOUNT PAID $

30. BALANCE DUE $ 77.75

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Signature on File DATE 4/5/00

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

15

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Mountain County Health Dept.
122 Smather Road
Sampson, NC 20000

PIN# 7923441 GRP# 3404000

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88

*PLEASE PRINT OR TYPE*

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

PLEASE DO NOT STAPLE IN THIS AREA

Sample Claim for Health Dept. Providers
Interperiodic Health Check Screening

APPROVED OMB-0938 0008

# HEALTH INSURANCE CLAIM FORM

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE | MEDICAID | CHAMPUS | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER
(Medicare #) [X] (Medicaid #) [ ] (Sponsor's SSN) [ ] (VA File #) [ ] (SSN or ID) [ ] (SSN) [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
900000000M

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Robin, Christopher

3. PATIENT'S BIRTH DATE MM DD YY: 04 20 1989 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)
23 Winnie The Pooh Lane

6. PATIENT RELATIONSHIP TO INSURED
Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Riddle
STATE: NC

8. PATIENT STATUS
Single [ ] Married [ ] Other [ ]
Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY
STATE

ZIP CODE: 22332
TELEPHONE (Include Area Code): ( 919 ) 222-3333

ZIP CODE
TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [ ] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? PLACE (State) [ ] YES [ ] NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO *If yes*, return to and complete item 9 a-d.

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. V20.2
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 24. A DATE(S) OF SERVICE From MM | DD | YY | To MM | DD | YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 03 | 27 | 2000 | 03 | 27 | 2000 | 11 | 01 | W8016 | 1N | | 77.75 | 1 | | | | |
| 2 | | | | | | | | | | | | | | | | |
| 3 | | | | | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | | | | | |

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.
3311

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [ ] NO

28. TOTAL CHARGE $ 77.75

29. AMOUNT PAID $

30. BALANCE DUE $ 77.75

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED Signature on file DATE 4/2/00

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

16

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Pooh County Health Dept.
123 Eeyore Lane
Riddle, NC 23456

PIN# 8922111 GRP# 3404000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

## Adult Preventive Medicine:

The Adult Preventive Medicine Services are Evaluation and Management CPT codes which provide annual health assessment office visits for eligible recipients age 21and over. The expectation of preventive medicine is the prevention of illness through early detection and treatment. The codes listed below will replace the Adult Health Screening codes W8001, Y2001, and Y2004 effective July 1, 2000.

The Initial Preventive Medicine Evaluation and Management codes include: a comprehensive history, comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate laboratory/ diagnostic procedures for a new patient.

The Periodic Preventive Medicine reevaluation and management of an individual includes a comprehensive history, comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate laboratory/diagnostic procedures for an established patient.

Ancillary studies involving laboratory, radiology, screening hearing tests and injectable medications are separately reimbursed.

This table contains the age restriction and specific guidelines for the preventive codes :

| CODE | DESCRIPTION | AGE |
|---|---|---|
| 99385 | Initial preventive medicine | 21 through 39 years |
| 99386 | Initial preventive medicine | 40 through 64 years |
| 99387 | Initial preventive medicine | 65 years and over |
| 99395 | Periodic preventive medicine, established patient | 21 through 39 years |
| 99396 | Periodic preventive medicine, established patient | 40 through 64 years |
| 99397 | Periodic preventive medicine, established patient | 65 years and over |

## Family Planning:

Family planning services include those services, procedures, and supplies which enable individuals of child bearing age, including minors who are or plan to be sexually active, to freely determine the size of their families. These services are critical in the individual's decision-making process concerning which birth control method is best suited to him or her as well as the effective use of the method selected. Counseling must include information on natural family planning methods.

| CODE | DESCRIPTION | AGE | GUIDELINES |
|---|---|---|---|
| 99384 | Initial preventive medicine, adolescent | 12 through 17 years | Only for Family Planning Services.<br><br>Family Planning should be indicated by an "F" in item 24H on the HCFA-1500 Claim form, or append modifier "FP" to the procedure code in block 24D. |
| 99385 | Initial preventive medicine | 18 through 20 years | Only for Family Planning.<br><br>Family Planning should be indicated by an "F" in item 24H on the HCFA-1500 claim form or append modifier "FP" to the procedure code in block 24D. |
| 99394 | Periodic preventive medicine, established patient | 12 through 17 years | Only for Family Planning services<br><br>Family Planning should be indicated by an "F" in item 24H on the HCFA-1500 claim form or append modifier "FP" to the procedure code in block 24D. |
| 99395 | Periodic preventive medicine, established patient | 18 through 20 years | Only for Family Planning services<br><br>Family Planning should be indicated by an "F" in item 24H on the HCFA- 1500 claim form or append modifier "FP" to the procedure code in block 24D. |

This table contains the age restriction and specific guidelines for the Family Planning codes

**Birth Control Methods**
Medicaid covers medically approved birth control methods, procedures, and pharmaceuticals to prevent conception.

**Birth Control Pills**
Birth control pills, when prescribed by a physician, may be obtained through a pharmacy. Pink card recipients may obtain prescriptions through the end of the month in which the 60th postpartum day occurs. There is no copay for birth control pills for Medicaid recipients that have a pink or blue ID card.

**Diaphragms**
Medicaid recipients can choose a diaphragm as a birth control method. A physician can fit the patient and bill using the CPT code for diaphragm fitting. Diaphragms are considered a "device" and **are not** covered by the Medicaid pharmacy program.

**Intrauterine Devices (IUDs)**
The codes for IUD insertion will be according to the specific IUD (device):

- J7300 Para Gard (T380A)
- W5142 Progestacert

When billing for IUD Insertion, CPT code 58300 is used. The IUD insertion CPT code is an asterisk (*) procedure, therefore, the CPT asterisk policy applies. The CPT code for removal of IUD is 58301, which includes an office visit.

**Billing Instructions**
The Initial Preventive Medicine Evaluation and Management codes include: a comprehensive history, comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate laboratory/ diagnostic procedures, for a new patient.

The Periodic Preventive Medicine Evaluation and Management codes includes: a comprehensive history, comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate laboratory/diagnostic procedures, for an established patient.

Ancillary studies involving laboratory, radiology, and injectable medications are separately reimbursed.

The use of modifier **FP** in block 24D, or an **F** in block 24H on your HCFA-1500 form indicates Family Planning and exempts the provider from having to obtain Carolina ACCESS authorization.

**Depoprovera**
Depoprovera contraceptive injection, J1055, is a covered service. Providers are advised to use the diagnosis code for contraceptive management. The appropriate office visit code may be billed separately unless the service is only the administration of the injectable drug.

**Norplant Reimbursement Policy**
The following state created codes will be end-dated with date of service October 1, 2000:

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

The following CPT and HCPC 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".
HCPC 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.

**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.

# OB/GYN

## Baby Love Program:

The codes for Maternity Care Coordinator (MCC) services, childbirth and parenting classes and home visits will not be affected by CPT conversion. These codes will remain the same.

**Presumptive Eligibility**
In some health departments, state approved medical providers may screen the pregnant woman's income for eligibility for Medicaid for Pregnant Women (M-PW) coverage. If the screening indicates the pregnant woman will probably be eligible for full coverage under this program, the pregnant woman is issued a pink MID card. The health department can accept this card for ambulatory services including pharmacy, labs, diagnostic tests and routine prenatal care. Presumptive eligibility does not cover ambulatory services provided in the postpartum period. The pregnant woman has until the last working day of the month following the month she is determined to be presumptively eligible to apply for Medicaid.

**Emergency Medicaid Coverage for Undocumented Residents with Medical Emergencies**
Undocumented residents requiring Medicaid eligibility for coverage for medical emergencies must meet categorical and financial eligibility requirements, including state residency. Categorical requirements for Medicaid include:

- Aged
- Blind
- Disabled
- Pregnant
- Caretaker of a child under age 19

In addition, the medical services rendered must meet the federal definition of "emergency services".

Emergency services are defined as follows:
Services rendered after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy; or
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Bilateral tubal ligations and Norplant Insertion do not meet the definition of "emergency services" and are not reimbursed for undocumented residents.

## Obstetric (OB) Global Codes:

**Policies and Billing Guidelines for OB Services**
North Carolina Medicaid covers OB services performed by certified providers.

The services provided in uncomplicated maternity and delivery cases include antepartum care, delivery, postpartum care, and associated lab tests. When a provider renders all services associated with the maternity care and delivery, the preferred billing method is with an OB global code. The provider may bill for individual services if it is known the pregnancy will be high risk and will require care above the normal amount for a routine pregnancy, or if the provider does not see the patient for a minimum of three consecutive months before delivery.

The following list of codes is included in the OB global codes. These codes cannot be billed separately in addition to a global code.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 80055 | 81000 | 81001 | 81002 | 81003 | 83020 | 83021 | 83026 | 83030 |
| 83033 | 83036 | 83045 | 83050 | 83051 | 83055 | 83060 | 83065 | 83068 |
| 83069 | 99201 | 99202 | 99203 | 99204 | 99205 | 99211 | 99212 | 99213 |
| 99214 | 99215 | 99241 | 99242 | 99243 | 99244 | 99245 | 99251 | 99252 |
| 99253 | 99254 | 99255 | 99261 | 99262 | 99263 | | | |

**Antepartum Care**
Antepartum care includes the initial and subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, laboratory tests, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery. Medicaid covered procedure codes that include antepartum care are 59400, 59425, 59426 and 59510.

The following guidelines apply to all antepartum procedure codes.

1. The date the provider first saw the patient for antepartum care must be entered in block 15 of the HCFA-1500 claim form.
2. An antepartum care code can only be used once during the pregnancy.
3. The delivery date is used as the date of service for the antepartum global codes and the total OB global codes.
4. OB global codes include antepartum care. The provider billing an OB global code must have rendered a minimum of three months of antepartum care to the recipient.
5. A pregnancy related diagnosis must be entered as the primary diagnosis to bypass the 24-visit limit. Refer to the ICD-9 CM diagnosis book in section “Pregnancy, Childbirth, Puerperium” to select the appropriate diagnosis (diagnosis codes 640-676.9).

**Postpartum Coverage:**
Medicaid covered procedure codes that include postpartum care are 59400, 59410, 59430, 59510 and 59515. The postpartum period includes 60 days of follow-up care after the date of delivery or termination of a pregnancy. Postpartum care is not reimbursed separately when an OB global code is billed. Medicaid reimburses providers for family planning procedures, including sterilization, when provided during this period.

Medicaid coverage for pregnant women with a pink Medicaid ID card extends through the end of the month in which the 60th postpartum day occurs. This is true for women who deliver a healthy baby, as well as women who experience a miscarriage, fetal death, molar pregnancy, neonatal death or therapeutic abortion.

Medicaid uses the terms antepartum, date of delivery and postpartum instead of the surgical terms pre-operative, intra-operative and post-operative. The spans of dates during and after the pregnancy are very different than the spans of dates typically associated with minor and major surgical pre and post operative periods. Postpartum codes have 60 days follow-up assigned. When a provider renders services on the date of delivery or during the postpartum period that are totally unrelated to the actual pregnancy or delivery, the provider can bill an Evaluation and Management (E&M) procedure code appended with modifier 24 or 25 as applicable. These modifiers are only applicable to E&M codes. Refer to the April 1999 Special Medicaid Bulletin for information on when to append a modifier to an E&M code.

The following modifiers should be reviewed prior to billing obstetrical procedure codes:

| | | | |
|---|---|---|---|
| 51 | 53 | 54 | 55 |
| 58 | 59 | 73 | 74 |
| 78 | 79 | SG | Q6 |
| 62 | 80 | 82 | YA |
| QS | | | |

**Note**: See Appendix D for a description of the modifiers listed above.

**Other OB Services:**

**Ultrasounds-** are covered when medically necessary. The diagnosis code will indicate the high risk conditions warranting an ultrasound. Providers should bill using CPT codes specifying pregnant uterus. Improper diagnostic coding will result in denials.

**Fetal nonstress tests**-are covered when medically necessary. The diagnosis code will indicate the high risk conditions warranting a nonstress test.

**Multiple births**-delivery charges should not exceed the normal billed amount for a single delivery. When there are extenuating circumstances and your claim has been denied, reconsideration of payment will be given through adjustments. Request a medical review by sending a completed Medicaid Adjustment form, copy of the claim, copy of the Remittance Advice, and medical records.

**Stand-by code**-the physician stand-by CPT code 99360 is reimburseable only for physician stand-by services at high risk deliveries. This code may be billed for stand-by service relating only to the mother. The service must be requested by a physician and a diagnosis substantiating the high risk must be documented on the claim.

**MPW eligibility-** women are eligible to receive Baby Love related services until the end of the month in which the 60th postpartum day occurs.

**Global OB Codes and Guidelines:**

| Codes | Description | Guidelines |
|---|---|---|
| 59400 | Global code for routine OB care, including antepartum care, vaginal delivery and postpartum care | • The provider billing for OB care must have rendered at least 3 months of antepartum care to the recipient<br>• The date the provider first saw the recipient for antepartum care must appear in block 15 of the HCFA-1500 form<br>• The date of service on the claim for the OB care must be the date of delivery<br>• This code cannot be billed in addition to other OB global codes |
| 59409 | Vaginal delivery only with or without episiotomy and or forceps | • This code may be billed when less than 3 months of antepartum care was rendered<br>• Office visits and other antepartum services may be billed in conjunction with this code<br>• Postpartum care services are not included in this code. |
| 59410 | Vaginal delivery and postpartum care only | • This code may be billed when less than 3 months of antepartum care was rendered<br>• Office visits and other antepartum services may be billed in conjunction with this code |
| 59425 | Antepartum care only, 4-6 visits | • The provider billing for OB care must have rendered at least 3 months of antepartum care to the recipient<br>• The date the provider first saw the recipient for antepartum care must appear in block 15 of the HCFA-1500 form<br>• The date of service on the claim must be the date of delivery<br>• This code **cannot** be billed in addition to other OB global codes<br>• This code can only be billed once during the pregnancy<br>• Delivery and postpartum care are to be billed separately |

**Summary of Billing Options (continued)**

| Codes | Description | Guidelines |
|---|---|---|
| 59426 | Antepartum care only, 7 or more visits | • The provider billing for OB care must have rendered at least 3 months of antepartum care to the recipient<br>• The date the provider first saw the recipient for antepartum care must appear in block 15 of the HCFA-1500 form<br>• The date of service on the claim must be the date of delivery<br>• This code **cannot** be billed in addition to other OB global codes<br>• This code can only be billed once during the pregnancy<br>• Delivery and postpartum care are to be billed separately |
| 59514 | Cesarean delivery only | • This code may be billed when less than 3 months of antepartum care was rendered<br>• Office visits and other antepartum services may be billed in conjunction with this code<br>• Postpartum care services are not included in this code |
| 59515 | Cesarean delivery and postpartum care only | • This code may be billed when less than 3 months of antepartum care was rendered<br>• Office visits and other antepartum services may be billed in conjunction with this code |

**Sterilizations:**

The NC Medicaid Program is bound by stringent Federal guidelines in regard to coverage of sterilization procedures. Federal funding is available for an individual to be sterilized only if the following guidelines contained in 42 CFR 441.253 are met:

**1.** The recipient must be at least 21 years old at the time the sterilization consent is obtained.

**2.** The recipient must not be mentally incompetent.

**3.** The recipient must voluntarily give informed consent in accordance with all the requirements prescribed in 441.257 and 441.258. The recipient must be:

- Given an opportunity to ask and receive answers to questions concerning the procedure and provided a copy of the consent form
- Advised that sterilization consent may be withdrawn at any time before the sterilization procedure without affecting the right to future care or treatment and without loss of or withdrawal of any federally funded program benefits to which the recipient might otherwise be entitled.
- Counseled in alternative methods of family planning and birth control
- Advised that the sterilization procedure is considered to be irreversible
- Provided a thorough explanation of the specific sterilization procedure to be performed
- Provided a full description of the possible discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used
- Provided a full description of the benefits or advantages that may be expected as a result of the sterilization
- Advised that the sterilization will not be performed for at least 30 days, but not more than 180 days between the date of informed consent and the date of the sterilization except under the following circumstances:
  - Premature delivery - Informed consent must be given at least 30 days before the expected date of delivery and at least 72 hours must have passed since the informed consent was given
  - Emergency abdominal surgery - At least 72 hours must have passed since the informed consent was given
  - Provided suitable arrangements to insure that information is effectively communicated if the recipient is blind, deaf, or otherwise handicapped
  - Provided an interpreter if the recipient does not understand the language used on the consent form or the language used by the person obtaining consent.
  - Permitted to have a witness of his or her choice present when the consent is obtained

The sterilization consent form is a federally mandated document. The form must be on file with the fiscal agent and all federal regulations pertaining to the completion of the form must be satisfied prior to payment of a sterilization claim. The consent form must be Health and Human Services and State approved.

The sterilization consent form is a three-copy form. The pink copy should be given to the recipient for their records, the physician should retain the yellow copy, and the white copy should be submitted to EDS.

If the recipient name on the claim and the name on the sterilization consent form is different, a signed name change statement that verifies the recipient whose name appears on the claim and consent are the same person, must be included (**refer to the example below**).

**Reminders**

North Carolina Medicaid will not pay for sterilization reversals.

If a judicial court orders a sterilization for a recipient who is a ward of the county and is mentally incompetent, the county is responsible for reimbursement for the sterilization.

**Name Change Statement (Example)**

Elvis County Health Department
1 Graceland Drive
Hound Dog, NC 22222

Medicaid ID Number: 912345678S

To Whom It May Concern:

Mary Smith has changed her name to Mary Jones.
Dr. Elvis (Signature of representative at providers office is required)

**Procedure and Diagnosis Codes for Elective Sterilization**
The following codes are the only codes to be considered specifically for the purpose of elective sterilization:

- ICD-9 diagnosis for sterilization - V252
- CPT procedure code - 55250 (Vasectomy)
- CPT procedure code - W5075 (Sterilization)

**Sterilization Abbreviations**

The following abbreviations are acceptable on the sterilization consent form as a description of the type of sterilization procedure:
BTF = Biliateral tubal fulguration

BTS = Bilateral tubal sterilization

BTC = Bilateral tubal cauterization

BTL = Bilateral tubal ligation

HCFA clarification has also been given to use “tubal banding”, although it is not widely used.

## Guide for Completion of Sterilization Consent Form

Following is the list of fields included in the Federal consent form requirements for sterilization. All areas are required to be completed except area 9 (race). **Fields in bold print <u>can not</u> be altered.** This guide will assist in correct completion of consent forms and should help to decrease the number of denials related to errors in completing the form.

1. Person or facility who provided information concerning sterilization
2. Type of sterilization procedure to be performed
3. Recipient date of birth (must be at least 21 years of age when the consent form is signed)
4. Name of recipient as it appears on the Medicaid ID card
5. The full name of the physician scheduled to do the surgery (abbreviations, initials, or "doctor on call" are unacceptable). May use "Physician on call of Jones OB GYN clinic"
6. Type of sterilization procedure to be performed
7. **Recipient's signature (must be dated), cannot be altered, traced over or corrected**
8. **Date the consent form was signed (the date of the recipient's signature must be at least 30 days prior to the date of the sterilization). The 30 day count begins the day following the recipient's signature date**
9. Race and ethnicity (not required)
10. Language in which the form was read to the recipient, if an interpreter was used
11. **Signature of the interpreter**
12. **Signature date of the interpreter (same as # 8 and # 16)**
13. Name of recipient
14. Name of sterilization procedure
15. **Signature of person witnessing consent (must be dated see # 16)**
16. **Date (this date must be the same as the recipient signature date) Note: the doctor can also be the witness**
17. The full name and address of the facility, include street name and number, city, state, and zip code where the consent form was obtained and witnessed
18. Name of recipient
19. Actual date of sterilization
20. Type of sterilization procedure performed
21. The box is to be checked if the delivery was premature (write the recipient's expected delivery date in the space provided)
22. The box is to be checked if emergency abdominal surgery was performed
23. Physician signature (Must be legible or name must be printed below the signature. A signature stamp may be used).
24. Date must be on or after the date of service

**Consent Form Completion Tips**

- **Changed, altered, or traced over** recipient or witness signatures and/or dates are not acceptable on the consent form. Carefully review the consent form for any of these problems. If any problems are noted, the consent form should be voided and a **completely new consent form** initiated at that time. A new consent form cannot be initiated after the sterilization.
- **Inclusion of the EDC** on the sterilization consent form often prevents unnecessary delays in processing the claim, and must be present in case of premature delivery or emergency abdominal surgery. The physician's signature must be dated *on or after* the date of service (procedure date). The signature may be a signature stamp. **Handwritten signatures must be legible or the name must be printed below the written signature.**
- In the case of **premature delivery**, the informed consent form must have been signed at least 30 days before the estimated date of delivery. If 30 days have not passed, there must be **at least 72 hours** between the signing of the consent form and the surgery. In these instances, place check in box #21 and write the **date** the recipient is expected to deliver after the statement "individuals expected date of delivery".
- In the case of **emergency abdominal surgery**, there must be **at least 72 hours** between the signing of the informed consent form and the surgery.

**Interpreter Signature on Sterilization Consent Form**

When telephone interpreter services are needed to complete the sterilization consent form for non-English speaking Medicaid recipients, the interpreter's signature, date of the interpreter's service and the language used are required on the sterilization consent form. In lieu of getting the interpreter's signature on the sterilization consent form at the time the service is provided, the interpreter who explains the procedure by telephone may fax or mail the attestation of their interpreter services. Criteria for the faxed or mailed attestation are as follows:

- The wording of the attestation should be taken directly from the sterilization consent form.
- The interpreter must write his or her signature and the date the interpreter services were rendered on the attestation form.
- The date of the recipient, interpreter and witness signatures must all be the same.
- The attestation form must include the recipient's name as it appears on the Medicaid ID card as well as the Medicaid ID number.
- A copy of the attestation must be attached to the consent form when the provider submits the statement to EDS, the fiscal agent.
- The provider must maintain the original attestation document with the consent form in the patient's medical record.

# CONSENT FORM MID # _____

**NOTICE:** YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

## CONSENT TO STERILIZATION

I have asked for and received information about sterilization from (1) (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE.** I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a (2). The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded program.

I am at least 21 years of age and was born on (3) (Month Day Year)

I, (4), hereby consent

of my own free will to be sterilized by (5) (doctor)

by a method called (6). My consent expires 180 days from the date of my signature below.

**I also consent to the release of this form and other medical records about the operation to:**

Representatives of the Department of Health, Education, and Welfare or

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

(7) (Signature) Date: (8) (Month Day Year)

**You are requested to supply the following information, but it is not required:**

(9) *Race and ethnicity designation (please check)*

- ☐ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

## INTERPRETER'S STATEMENT

(If an interpreter is provided to assist the individual to be sterilized)

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in (10) language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(11) (Interpreter) (12) (Date)

## STATEMENT OF PERSON OBTAINING CONSENT

Before (13) (name of individual) signed the consent form, I explained to him/her the nature of the sterilization operation (14), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

(15) (Signature of person obtaining consent) (16) (Date)

(17) (Facility)

(Address)

## PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon (18) (Name of individual to be sterilized) on (19) (Date of sterilization)

(19 cont'd) (operation), I explained to him/her the nature of the sterilization operation (20) (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at an any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

**(Instructions for use of alternative final paragraphs:** Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

(21) ☐ Premature delivery

(22) ☐ Individual's expected date of delivery:
☐ Emergency abdominal surgery:

(describe circumstances):

(23) (Physician) (24) (Date)

372-116 **White:** PATIENT **Yellow:** PHYSICIAN **Pink:** STATE AGENCY

**Submitting Sterilization Consents Separately**
Sterilization consents may be submitted separately from the claim. The elimination of claim attachments allows electronic submission of claims.

When submitting sterilization consents separately from the claim, follow the instructions below:

- **Write the recipient's Medicaid ID** in the upper right corner of the consent form. EDS must have the MID to enter the form into the system.

- **Verify** that all the information on the form is correct

- **Mail the consent** to : EDS
  PO Box 300012
  Raleigh, NC 27622

  - **Send only** sterilization consents submitted separately from the claim to PO Box 300012.

Upon receipt, EDS will review the consent to ensure adherance to federally mandated guidelines. Reviewed results will be entered into the EDS system.

- File claims electronically, or

- Mail paper claims submitted with or without a consent to:

| **(Physicians)** | **(Hospitals)** |
|---|---|
| EDS | EDS |
| PO Box 30968 | PO Box 300010 |
| Raleigh, NC 27622 | Raleigh, NC 27622 |

- When denial EOB's for sterilization claims request additional information, (i.e., records to verify a procedure code or verification of a date of service), the verification attachments must be submitted with a claim along with a copy of the valid consent.

- **Do not** send sterilization consents and hysterectomy statements together. They should be sent separately.

**Hysterectomy Billing**

Consider the following before submitting the hysterectomy claim:

1. The hysterectomy diagnosis must support the necessity for the hysterectomy. Hysterectomy claims for recipients with a diagnosis of cervical dysplasia, pelvic pain, or pelvic inflammatory disease should be submitted with the following medical records: history and physical, operative notes, pathology report, discharge summary and reports for treatments performed prior to the hysterectomy (such as laparoscopic procedures, D & Cs, conizations, or cervical biopsies).

2. All physicians (primary, assistant, anesthesia, etc.) must bill the same hysterectomy procedure code for the same recipient, same date of service.

   All providers must use the correct procedure code for the type of hysterectomy performed. Correct coding eliminates recoupments.

   Acceptable CPT procedure codes for the HCFA-1500 claim form are:

| | | | | |
|---|---|---|---|---|
| 51925 | 58200 | 58262 | 58275 | 58951 |
| 58150 | 58210 | 58263 | 58280 | 59135 |
| 58152 | 58240 | 58267 | 58285 | 59525 |
| 58180 | 58260 | 58270 | 58550 | |

   Acceptable ICD-9-CM procedure codes for the UB 92 claim form are:

| | | |
|---|---|---|
| 68.3 | 68.5 | 68.7 |
| 68.4 | 68.6 | 68.8 |

   When an electronically submitted claim is received and no hysterectomy statement is on file, EDS will "hold" the claim for two weeks to allow time for the statement to be received and processed.

   According to federal regulations, improperly worded, incomplete, altered, or traced statements cannot be processed.

   Medicaid covers and reimburses for outpatient hysterectomies.

   Coverage of the observation room for outpatient surgical procedures is restricted to situations where a patient exhibits an uncommon or unusual reaction, or other postoperative complication which requires monitoring or treatment beyond the usual services provided in the immediate post operative period. Routine recovery room services are not to be billed as observation services.

3. Completing a Hysterectomy Statement

- Complete one of the three federally approved hysterectomy statements to include: the recipient's address, recipient's signature and date, witness' signature, date of surgery, and surgeon's signature, if applicable.
- If the recipient is mentally impaired, the recipient's name must be on the statement and two witnesses must sign the statement (one witness should be the legal guardian's signature).
- If the recipient signs with an X, the statement must be witnessed by two people and two witness signatures must appear on the statement.
- If the recipient is a minor, the recipient's name should be on the statement and two witnesses must sign the statement (one witness must be the parent/guardian's signature). Submit with records to include: history and physical exam, operative notes, pathology report, discharge summary and reports for treatments performed prior to the hysterectomy.
- If the recipient name on the claim and the consent form is different, a signed name change statement that verifies the recipient whose name appears on the claim and consent are the same person must be included (see page 27 for name change statement example)

**Examples of Acceptable Hysterectomy Statements (these examples should be recreated on office letterhead –exact wording must be used)**


***If the patient signs the hysterectomy statement prior to surgery:***

I HAVE BEEN INFORMED ORALLY AND IN WRITING THAT A HYSTERECTOMY WILL RENDER ME PERMANENTLY INCAPABLE OF BEARING CHILDREN:

Patient's Signature _____

Patient's Address _____

_____

Date Signed _____ Witness' Signature _____


***If the provider fails to obtain the patient's statement prior to surgery, however has informed her that she would be incapable of bearing children (this is an exception, not a rule, and will be reviewed as such):***

PRIOR TO MY SURGERY ON _____(Date of Surgery)_____, I WAS INFORMED ORALLY AND IN WRITING THAT A HYSTERECTOMY WOULD RENDER ME PERMANENTLY INCAPABLE OF BEARING CHILDREN.

Patient's Signature _____

Patient's Address _____

_____

Date Signed _____ Witness' Signature _____


***If the patient is sterile due to age, a congenital disorder, a previous sterilization or if the hysterectomy was performed on an emergency basis because of life-threatening circumstances (life-threatening should indicate that the patient is unable to respond to the information pertaining to the acknowledgment agreement. Federal regulations do not recognize metasasis of any kind as life-threatening or an emergency):***

Patient's Name _____

Patient's Address _____

_____

The above named patient was sterile prior to the hysterectomy due to:

_____

**or**

A hysterectomy was performed on the above named patient on an emergency basis and was unable to respond because of the following life-threatening circumstances: _____

_____

Physician Signature _____ Date _____

**Submitting Sterilization Consents and Hysterectomy Statements Separately**
Sterilization consents and hysterectomy statements may be submitted separately from the claim. The elimination of claim attachments allows electronic submission of claims.

When submitting sterilization consents and hysterectomy statements separately from the claim, follow the instructions below:

- **Write the recipient's Medicaid ID** in the upper right corner of the consent form. EDS must have the MID to enter the form into the system.

- **Verify** that all the information on the form is correct

- **Mail the consent/statement** to : EDS
  PO Box 300012
  Raleigh, NC 27622

- **Send Only** sterilization consents and hysterectomy statements submitted separately from the claim to PO Box 300012.

Upon receipt, EDS will review the consent/statement to ensure adherance to federally mandated guidelines. Reviewed results will be entered into the EDS system.

- File claims electronically, or

- Mail paper claims submitted with or without a consent/statement to:

  **(Physicians and Health Departments)**
  EDS
  PO Box 30968
  Raleigh, NC 27622

- When denial EOB's for sterilization and hysterectomy claims request additional information, (i.e., records to verify a procedure code or verification of a date of service), the verification attachments must be submitted with a claim.

## Abortion Guidelines:

**Coverage of nontherapeutic abortions**
A nontherapeutic abortion is any termination of pregnancy where there has been no manual or surgical interruption of pregnancy.

Missed or incomplete spontaneous abortions are examples of nontherapeutic abortions. Use the following CPT code that best describes the type of abortion rather than the type of treatment:

**HCFA-1500 procedure codes**

- 59812 - Incomplete abortion
- 59820 - Missed abortion, first trimester
- 59821 - Missed abortion, second trimester

**UB 92 procedure codes**

- 69.02 - D & C following delivery
- 69.52 - Aspiration curettage following abortion or delivery

One of the following diagnosis codes identifying the services rendered must be on the claim form when billing for nontherapeutic abortion procedure codes:

- 631 - Abnormal products of conception such as a blighted ovum (do not use for hydatidiform mole)
- 632 - Missed abortion, gestational age of 22 wks or less
- 634-634.92 - Spontaneous abortion (this diagnosis cannot be used when a procedure performed or an agent administered has caused the spontaneous abortion)
- 637-637.92 - retained products of conception following a nontherapeutic abortion

**Coverage of therapeutic abortions**
Therapeutic abortion coverage is limited to termination of pregnancy in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by physician, place the woman in danger of death unless an abortion is performed. Therapeutic abortion is also covered to terminate pregnancy as the result of rape, and pregnancy as the result of incest.

Medicaid considers a therapeutic abortion as any termination of pregnancy where fetal heart tones are present at the time of the abortive procedure. The termination of pregnancy may be induced medically (prostaglandin suppositories, etc.) or surgically (dilation and curettage, etc.). This includes the delivery of a non-viable (incapable of living outside the uterus) but live fetus, if labor was augmented by pitocin drip, laminaria suppository, etc.

Medicaid will cover legal therapeutic abortions under the following circumstances:

1. **In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by physician, place the woman in danger of death unless an abortion is performed** (revised wording required by law)

   - Medicaid must receive the physician's abortion statement that has the wording "that the abortion be necessary in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by physician, place the woman in danger of death unless an abortion is performed" (The statement must include the recipient's complete name and address)
   - The medical diagnosis and medical records must support the statement and must be submitted with the claim
   - If the abortion was necessary to save the life of the mother, regardless of whether the pregnancy was a result of rape or incest, the diagnosis and medical records must support the medical situation
   - The diagnosis code **635-635.92** "legally induced abortion" must be on claim
   - A minor must have parental consent for an abortion, pursuant to current state law (see minor consent guidelines on page 41)

2. **Incest**

   - Medicaid must receive the physician's abortion statement that the recipient was a victim of incest. The statement must contain the patient's complete name and address
   - The diagnosis code **V618** "other specified family circumstances" must be on the claim. The medical record documentation must support this diagnosis and the abortion statement. It is not required to submit medical records with the claim, but records must be available for review if necessary
   - A minor must have parental consent for an abortion, pursuant to current state law (see minor consent guidelines on page 41)

3. **Rape**

   - Medicaid must receive the physician's abortion statement that the recipient was a victim of rape. The statement must contain the patient's complete name and address
   - The diagnosis code **V715** "rape" must be on the claim. The medical record documentation must support this diagnosis and the abortion statement. It is not required to submit medical records with the claim, but records must be available for review if necessary
   - A minor must have parental consent for an abortion, pursuant to current state law (see minor consent guidelines on page 41)

**Coverage of Septic Abortions**
Septic abortions can be considered as either a nontherapeutic abortion or a therapeutic abortion depending on the diagnosis used.

The following procedure code should be used when billing for a nontherapeutic septic abortion:

- 59830 - treatment of septic abortion in conjunction with a nontherapeutic abortion diagnosis

The following procedure code should be used when billing for a therapeutic septic abortion:

- W8206 or W8207 with a therapeutic abortion diagnosis
- Documentation (abortion statement and medical records) must be attached to determine if Federal guidelines are met

**Nonobstetrical D & C codes (May be billed electronically)**

**HCFA-1500 Nonobstetrical D & C procedure code**

| | |
|---|---|
| 58120 | Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical) |
| 59160 | Curettage, post partum (separate procedure) |

**UB 92 Nonobstetrical procedure codes**

| | |
|---|---|
| 69.0 | Dilation and curettage of uterus |
| 69.09 | Diagnostic D & C |
| 69.5 | Aspiration curettage of the uterus |
| 69.59 | Other aspiration curettage of the uterus |
| 69.6 | Menstrual extraction or regulation |

**Abortion Billing Chart**

| Therapeutic | | | | |
|---|---|---|---|---|
| **Claim Type** | **Procedure** | **Approved Procedure Code** | **Diagnosis** | **Abortion Statement Required** |
| Physician | 59830, 59840, 59841, 59851, 59852, 59856, 59857 | W8206 (surgical) | 635-635.92<br>638-638.92 | Yes, with records<br>Yes, with records |
| (HCFA-1500) | 59850, 59855 | W8207 (medical) | V618<br>V715 | Yes<br>Yes |
| Hospital<br>(UB 92) | 69.0, 69.5, 69.6, 74.9, 75.0, 96.49 | N/A | 635-635.92<br>638-638.9<br>V618<br>V715 | Yes, with records<br>Yes, with records<br>Yes<br>Yes |

| Nontherapeutic | | | |
|---|---|---|---|
| **Claim Type** | **Procedure** | **Diagnosis** | **Abortion Statement Required** |
| Physician<br>(HCFA-1500) | 59870<br>59812, 59820, 59821, 59830 | 630<br>631, 632, 634-634.92, 637-637.92 | No<br>No |
| Hospital<br>(UB 92) | 69.02, 69.52 | Any OB diagnosis except 635-635.92 & 638-638.9 | Possible (medical record review will determine if statement is required) |

**Additional Coding Information**

- Procedure code 57800-dilation of the cervical canal must have records if billed with an abortion diagnosis
- Procedure code 57820-D&C of the cervical stump must have records if billed with an abortion diagnosis
- Diagnosis code 6564-fetal demise should be used when the fetus is over 22 weeks gestation. Use delivery procedure code
- Diagnosis code 632-missed abortion should be used for fetal death if the fetus is 22 weeks gestation or less. Use missed abortion procedure code 59820
- Induced abortion procedure codes - 59830, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, should be billed as W8206 or W8207. Use diagnosis 635-635.92, V715, or V618
- Procedure code 59160 is for postpartum D&C and will not be allowed if billed with a diagnosis code of 630, 631, 632, 634-634.92, 635-635.92, 637-637.92, 638-638.9, V715, or V618
- Procedure code 58120 is a non-obstetrical procedure and will not be allowed if billed with diagnosis codes 630, 631, 632, 634-634.92, 635-635.92, 637-637.92, 638-638.9, V715, or V618
- Diagnosis codes 636-636.92 for illegal therapeutic abortion are not covered by the Medicaid program

Procedure codes 69.0, 69.09, 69.5, and 69.59 are non-obstetrical procedure codes and will not be allowed if billed with diagnosis codes 631, 632, 634-634.92, 635-635.92, 637-637.92, or 638-638.9

**Federal guidelines regarding minors and abortions**
General Statute (G.S.) 90 – 21.7 requires parental or judicial consent for an unemancipated minor's abortion. "Unemancipated minor" or "minor" means any person under the age of 18 who has not been married or has not been emancipated pursuant to Article 56 of Chapter 7A of the General Statutes. Before an abortion is performed upon an unemancipated minor, the consent form must be signed by the minor **and**

1. A parent with custody of the minor; **or**
2. The legal guardian or legal custodian of the minor; **or**
3. A parent with whom the minor is living; **or**
4. A grandparent with whom the minor has been living for at least six months immediately preceding the date of the minor's written consent.

The pregnant minor may petition the district court judge assigned to the juvenile proceedings in the district court where the minor resides or where she is physically present, on her own behalf or by guardian ad litem for a waiver of the parental consent requirement if:

1. None of the persons from whom consent must be obtained is available to the physician performing the abortion or the referring physician within a reasonable time or manner; **or**
2. All of the persons from whom consent must be obtained refuse to consent to the performance of an abortion; **or**
3. The minor elects not to seek consent of the person from whom consent is required (under G.S.90-21.9).

The requirements of parental consent shall not apply when a medical emergency exists that so complicates the pregnancy as to require an immediate abortion.

**NOTE: See Appendix E for General Statute (G.S.) 14-45.1, "When Abortion Not Unlawful"**

**The Abortion Statement**
All therapeutic abortions must be submitted with an abortion statement. See the attached copy of the State approved abortion statement:

1. Recipient's name
2. Recipient address
3. Recipient's MID number
4. The gestational age of the fetus at the time of the abortion
5. Check this block if the therapeutic abortion is necessary to save the life of the mother
6. Check this block if the pregnancy is a result of rape
7. Check this block if the pregnancy is a result of incest
8. Physician's name
9. Physician's signature
10. The physician's signature date

**Note:** If #5 is checked, medical records consisting of history and physical, op report, discharge summary, ultrasound report (if applicable), consults and path report must accompany the claim.

**Abortion Statement (this example should be recreated on the providers office letterhead-exact wording must be used).**

1. Recipient's Name: _____

2. Address: _____

_____

3. Medicaid Identification Number: _____

4. Gestational Age: _____

On the basis of my professional judgment, I have performed an abortion on the above named recipient for the following reason:

5. _____ The abortion was necessary due to a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion was performed.

6. _____ Based on all the information available to me, I concluded that this pregnancy was the result of an act of rape.

7. _____ Based on all the information available to me, I concluded that this pregnancy was the result of an act of incest.

My signature on this statement is an attestation that the requirements were met and documentation is on file.

8. _____
Physician's Name

9. _____
Physician's Signature

10. _____
Date

# LABORATORY

## Panel Codes:

Refer to your current CPT code book for instructions on billing lab panel codes. These codes should only be billed by the entity performing the procedure(s).

## Pap Smear Codes:

The pap smear codes should not be used for collection of specimen. The collection of the smear is incident to the office visit and no separate fee is allowed. Providers who do not perform the lab test should not bill the pap smear code(s). Only the entity actually performing the lab test should bill the pap smear code(s). Incorrect billing of pap smear codes by the provider who did not perform the lab test will cause the lab providers claim to be denied.

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.

## Miscellaneous Guidelines:

**Venipuncture/Specimen Collection**
Medicaid reimburses for venipuncture specimen collection fee, code G0001, only to the provider who extracted the specimen. The provider billing for this collection fee must be sending the lab work outside his office to be performed. One collection fee is allowed for each recipient, regardless of the number of specimen(s) drawn.

**Handling Fee**
Medicaid does not reimburse for handling and/or conveyance of specimen.

**Laboratory Examination Diagnosis**
Medicaid does not reimburse for the generic diagnosis code V726, laboratory examination. Claims will be denied with an EOB stating: "An ICD-9 CM diagnosis code supporting the medical necessity of this service must be submitted on the claim. Re-file with the appropriate diagnosis code. Providers must submit appropriate diagnosis codes to outside labs in order for the outside lab to avoid diagnosis related denials.

**HIV Testing**
The procedure code for HIV-1 Viral Load, Quantification is 87536.

## Clinical Laboratory Improvement Amendments (CLIA):

**Definition**
Congress passed the Clinical Laboratory Improvement Amendments (CLIA) in 1988 establishing minimum quality standards for all laboratory testing to ensure high quality patient testing regardless of laboratory location.

**Types**
There are three categories of testing based on complexity of the testing method: Waived tests; moderate complexity, including the subcategory of Provider Performed Microscopy (PPM); and high complexity. Based on the complexity of the testing performed, CLIA specifies regulations for quality control, quality assurance, patient test management, personnel, inspections and proficiency testing to assure accurate and reliable testing.

**Requirements**
Laboratories must obtain certification, pay applicable fees and comply with regulations regarding proficiency testing, personnel, inspections, patient test management, quality control and quality assurance. The Health Care Financing Administration (HCFA) has undertaken an initiative to monitor CLIA compliance for physician office laboratories (POLs) as well as independent laboratories. Physicians are reminded to bill for only those tests in which certification has been granted.

To verify that your CLIA certification number is on file, contact EDS Provider Services at 1-800-688-6696 or 919-851-8888.

# MODIFIERS

## Definition:

Modifiers are two-digit identifiers billed with the procedure code to convey specific information regarding the procedure or service to which it is appended. Using modifiers when processing claims enables Medicaid to adopt many of Medicare's policies, and allow providers to bill more uniformly between carriers.

Instead of using type of treatment codes, providers are required to bill utilizing modifiers, up to three per detail, to denote specific information regarding the services rendered. A modifier allows a provider to indicate that a service rendered to a patient has been altered by some special circumstance(s) while the code description remains the same. If no special circumstances exist and further description of the service rendered is not needed, the code should be billed without a modifier. Using appropriate modifiers will be required, but not all circumstances will need a qualifying modifier.

## List of Covered Modifiers:

Refer to Appendix D for the list of modifiers recognized by NC Medicaid. Any modifiers not on this list must not be billed to Medicaid. Services billed with modifiers not recognized by Medicaid will deny.

## How to Bill on the HCFA-1500 Form:

Modifiers must be inserted in block 24D to the right of the procedure code. Up to 3 modifiers can be used per detail line. Be aware that not every procedure code or situation requires a modifier, and not all modifiers are approved for all provider types.

## Global Surgery Policy:

**Introduction**
The global surgical package is an all-inclusive package associated with a procedure. The global surgery package for a major procedure includes a preoperative period (one day prior to the date of surgery), intraoperative care (the day of the surgery), and a postoperative period (a predetermined amount of time following the procedure based on the complexity of the procedure). The postoperative period begins the day after the surgery.

The global surgery package for a minor procedure includes the day of surgery and a pre-determined postoperative period beginning the day after surgery.

Surgical procedures are classified as major procedures or minor procedures.

**Major Procedures**
The major global surgical policy reimburses the physician performing the surgery one fee for the following services related to the surgery:

- Preoperative visits
- Intraoperative services
- Complications following surgery
- Postoperative visits
- Postsurgical pain management by the surgeon
- Supplies and miscellaneous services

When one or more physicians perform portions of these services, a modifier must be used to identify the circumstance in order to receive reimbursement during the global period.

Major procedures are assigned a 60 or 90 day follow up care period. For most major procedures the global surgery period includes one day preoperative, one day intraoperative, and 90 days postoperative, to equal a total of 92 days.

***Global Surgery Policy continued:***

**Minor Procedures**
Minor surgical procedures are assigned either a zero day follow up care period or a ten-day follow up care period. If the procedure is assigned ten follow up care days, the total global surgery period includes one day intraoperative and ten days postoperative, to equal a total of 11 days. There is no preoperative care day assigned to minor procedures.

**Surgical and Postoperative Care**
When a physician performs the surgical procedure and another physician, or entity, provides the postoperative services, modifier 54 is appended to the surgical code by the physician performing the surgery. The surgeon transfers the postoperative management (follow-up) to another physician or entity. The provider rendering the follow-up management appends modifier 55 to the surgical code and the applicable to/from dates are noted in field 16 of the HCFA-1500 claim form.

The provider rendering the postoperative care will receive a percentage of the global fee for the surgery since this provider is rendering a portion of the total services included in the global rate for the surgery. Individual evaluation and management visits are not billed for the usual management of the postoperative care. The amount received includes all services normally necessary for the routine follow-up associated with the surgery regardless of the number of visits made during the post-operative period.

If services unrelated to the routine care required during the postoperative period are rendered, refer to modifiers 24, 58, 78 and 79.

| **Surgical and Postoperative Billing Scenarios** | | |
|---|---|---|
| **Services Rendered** | **By** | **How to Bill** |
| Surgery, preoperative care and all postoperative care | Physician #1 | Bill the surgical procedure code, **no** modifier 54 or 55<br><br>Date of service must be the date of surgery |
| Surgery and preoperative only | Physician #1 | Bill the surgical procedure code **with** modifier 54<br><br>Date of service must be the date of surgery |

| | | |
|---|---|---|
| Postoperative care only | Physician #2<br><br>(or more) | Bill the same surgical procedure, same date of service, and same place of service as the surgeon, **with** modifier 55<br><br>Date of service on the detail must be the date of surgery<br><br>The dates that physician # 2 was responsible for postoperative care must be noted in field 16 of the HCFA 1500 form |
| Surgery, preoperative care and initial postoperative care | Physician #1 | First detail: Bill the surgical procedure code **with** modifier 54<br><br>Second detail: Bill the same procedure code, same date of service, and same place of service as the first detail, **with** modifier 55<br><br>The dates that the surgeon was responsible for postoperative care must be noted in field 16 of the HCFA 1500 form |
| Remaining Postoperative care | Physician #2<br>(or more) | Bill the same surgical procedure code as physician # 1, **with** modifier 55<br><br>Date of service must be the date of surgery<br><br>The dates that the physician was responsible for postoperative care must be noted in field 16 of the HCFA 1500 form |

**Coding Guidelines**
Refer to the April, 1999 Medicaid Bulletin for a list of major and minor surgical procedures.

## Other Modifier Issues:

**Modifier 25 - Significant, Separately Identifiable Evaluation and Management (E/M) Service by the Same Physician on the Same Day of the Procedure or Other Service**

Evaluation and management (E/M) services on the same day as surgery are considered included in the service of surgery and are not routinely allowed separate reimbursement. A physician may need to indicate that the patient's condition required a separate procedure on the day a minor procedure was performed. Modifier 25 appended to an E/M procedure code denotes that the service was a significant, separately identifiable service performed by the same physician on the same day as the minor procedure, and should be reimbursed separately. Modifier 25 can only be used on established patient E/M codes. Refer to the April 1999 General Medicaid Bulletin for a list of minor surgical procedure codes.

The initial evaluation for new patients is paid separately even on the day of surgery; therefore a new patient E/M code does not require the modifier 25 when a minor surgical procedure is performed in addition to the separately identifiable E/M service.

**Modifier 24 - Unrelated E/M Service by the Same Physician During a Postoperative Period**

Modifier 24 indicates that certain Evaluation and Management (E/M) services performed during the postoperative period of a major or minor surgery by the **same** provider who performed the procedure or by the provider responsible for the postoperative care of the patient are unrelated to the original procedure performed. This must be supported by a diagnosis that is unrelated to the original procedure. The postoperative period begins the day following surgery.

Separate reimbursement will be allowed without appending modifier 24 if an **unrelated** E/M service is rendered during the postoperative period by a different provider with a **different specialty** than the provider that performed the original procedure. Separate reimbursement will also be allowed without appending modifier 24 if a service **related** to the original surgery but not part of the postoperative services is rendered by a different provider with a **different specialty** than the provider that performed the original procedure.

**Modifier 50 - Bilateral Procedure**

Modifier 50 appended to the procedure code denotes that a procedure was performed bilaterally during a single operative session. This bilateral modifier is used only when the exact same service/code is reported for each site. Modifier 50 is only to be appended to procedure codes when anatomically bilateral procedures could be performed and there is no wording in the code description to denote the procedure is for one or both sides. Appending modifier 50 signifies that the procedure was performed bilaterally during the same operative session.

**Modifier 76 - Repeat Procedure by the Same Physician on the Same Day**

Modifier 76 is appended to report that a diagnostic procedure or service was repeated by the same provider on the same date of service. Modifier 76 is used to indicate that a repeat diagnostic procedure was medically necessary and is not a duplicate billing of the original procedure done on the same date of service.

**Modifier 77 - Repeat Procedure by Another Physician on the Same Day**

Modifier 77 is appended to report that a diagnostic procedure or service had to be repeated by a different provider on the same date of service. Modifier 77 indicates that a repeat procedure performed by a different provider was medically necessary and is not a duplicate billing of the original procedure done on the same date of service.

**Modifier 51 - Multiple Procedures**
Modifier 51 indicates several procedures were performed on the same day or at the same operative session, by the same provider. Modifier 51 identifies surgical procedures performed in combination, whether through the same or another incision or involving the same or different anatomy. Multiple related surgical procedures or a combination of medical and surgical procedures performed at the same session must be designated with modifier 51. Medicaid will not determine the major procedure for the provider. It is the provider's responsibility to correctly identify the primary and secondary procedures in order to be reimbursed appropriately. The primary procedure billed on the first detail of the claim without modifier 51 will be reimbursed at 100% of the allowed amount, and subsequent procedures billed with modifier 51 will be reimbursed at 50% of the allowed amount.

Refer to General Medicaid Bulletin July 1999 for a complete list of procedure codes that are acceptable with modifier 51.

**Modifiers RT and LT - Right Side, Left Side**
Modifiers RT and LT are used to identify procedures performed on the right or left side of the body. By appending RT or LT to a CPT "bilateral" code, reimbursement will reflect that a "unilateral" procedure was performed. If a provider bills a code with a description that states "bilateral" but only one side is performed, modifier RT or LT must be appended to denote on which side the procedure was performed.

Modifiers RT or LT must be appended to these codes if the procedure is performed only on one side. Medicaid reimbursement will be based on the procedure being performed as unilateral only.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 27392 | 27395 | 33976 | 33978 | 35549 | 40701 | 40702 | 40843 | 42507 | 42508 |
| 42509 | 42510 | 51575 | 51585 | 51595 | 54130 | 54135 | 55041 | 55815 | 55865 |
| 56312 | 56313 | 56632 | 57109 | 57112 | 58950 | 58951 | 58952 | 70330 | 71060 |
| 71110 | 71111 | 73050 | 73520 | 73565 | 73700 | 73701 | 73702 | 73720 | 73725 |
| 75662 | 75671 | 75680 | 75716 | 75724 | 75733 | 75743 | 75803 | 75807 | 75822 |
| 75833 | 75842 | 76094 | 76102 | 76516 | 76519 | 93875 | 93880 | 93922 | 93923 |
| 93924 | 93925 | 93930 | 93965 | 93970 | | | | | |

Listed below are codes also designated by a "2" in the RBRVS but described by CPT as "unilateral and bilateral". Appending either modifier RT or LT to these codes provides additional information regarding the procedure but does not affect reimbursement.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 51820 | 52290 | 52300 | 52301 | 54430 | 55200 | 55250 | 55300 | 55450 | 58600 |
| 58605 | 58700 | 58720 | 58800 | 58805 | 58900 | 58920 | 58925 | 61000 | 61001 |
| 61253 | 63045 | 63046 | 63047 | 63048 | 69210 | 76645 | 92081 | 92082 | 92083 |
| 92265 | | | | | | | | | |

**Modifiers TC and 26 - Technical and Professional Components**

Certain procedures are comprised of a combination of a professional component and a technical component. Types of physician services that have both a technical and professional component include diagnostic and therapeutic radiology services, certain diagnostic tests that involve a physician's interpretation, and physician pathology services. When the complete procedure for these services is billed, both components are included.

- Professional component of a service is the physician's interpretation and report of the results of certain non-surgical procedures such as radiology, diagnostic, and pathology services. The provider using modifier 26 for the professional component must prepare a written report that includes findings, relevant clinical issues, and, if appropriate, comparative data. This documentation must be retained in the patient's medical records for a period of not less than five years. When the provider renders only the professional component of the procedure, he must bill with Modifier 26 appended to the procedure code. Only the professional component will be reimbursed.
- Technical component includes the performance of the procedure and ownership of the equipment and supplies. When the provider renders only the technical component of the procedure, he must bill with modifier TC appended to the procedure code. Only the technical component will be reimbursed.
- Certain diagnostic tests have codes defining a complete procedure. Other tests have codes that define a professional and an associated technical component of the test. **Do not** bill modifier TC with a procedure code that describes the technical component of the procedure in the code definition. For example, code 93041, *Rhythm ECG, one to three leads, tracing only without interpretation and report,* cannot be billed with modifier TC. **Do not** bill modifier 26 with a procedure code that describes the professional component of the procedure in the code definition. For example, code 93010, *Electrocardiogram, routine ECG with at least 12 leads, interpretation and report only,* cannot be billed with modifier 26.
    - There are two options for billing both the technical and professional components of a procedure. Reimbursement is the same for either billing option.

**OPTION #1**

Bill the procedure code on one detail **without** modifier TC or 26. This denotes a "complete procedure."

**OPTION # 2**

Bill the procedure code on two separate details, one detail with modifier 26 and the second detail with modifier TC. For example: Detail 1: 76604-**26**, Detail 2: 76604-**TC**. Payment will not exceed the allowed amount for the complete procedure described in option #1.

**Note**: If your internal billing system requires or defaults to a Type Of Service (TOS), which is block 24C on the HCFA-1500, you must use the TOS that relates to the correct modifier. For example, TOS "04" relates to modifier 26, TOS "T" relates to modifier TC. When billing for the complete procedure TOS "31" should be used with no modifier.

# PHARMACY

The local health departments may choose to enroll in the North Carolina Medicaid Pharmacy Program to dispense drugs effective July 1, 2000. These health department pharmacies will be required to adhere to all rules and regulations of the Medicaid Pharmacy Program as well as those imposed upon them by the North Carolina Board of Pharmacy. The pharmacies will also be required to supply and maintain an up to date record of the pharmacist manager (including phone number) who will supervise the pharmacy operation at each health department.

You may obtain an application and a participation agreement from the Provider Enrollment Unit at the Division of Medical Assistance. If you have further questions please call Benny Ridout, DMA Pharmacy Director, at (919) 857-4034.

# DENTAL

## Health Department Dental Clinics:

Effective July 1, 2000, Health Department Dental Clinics can begin billing dental services using ADA and CPT codes listed in the North Carolina Dental Services Manual. These services will be billed on the 1999 ADA claim form.

For purposes of determining proper use of codes for payment, the Division of Medical Assistance (DMA) has adopted the procedure codes and their respective descriptions as defined in the most recent edition of the American Dental Association Current Dental Terminology (CDT-3) manual and the Current Procedural Terminology (CPT) manual. Only the procedures listed in the North Carolina Dental Services Manual are covered under the North Carolina Medicaid Dental Program. The Dental Services Medicaid Manual also lists service restrictions for North Carolina Medicaid for each covered procedure code.

Dental Seminars will be held throughout the state in May, 2000 where a new dental services manual will be distributed. During the seminar, EDS will present the information included in that manual. That presentation will include basic Medicaid information, procedure code coverage, procedure code service restrictions, prior approval process, completion of the ADA claim form, and resolution of the most common denials.

Currently, Health Departments bill using DHS Dental Clinic Visit procedure code Y2005. Effective September 30, 2000 the code will be end dated. At that time, Health Department Dental Clinics must bill ADA and CPT codes listed in the dental services manual.

| | |
|---|---|
| Procedure Code | Y2005 |
| Description | DHS Dental Clinic Visit |
| **End Date** | **September 30, 2000** |

An implementation period of July 1, 2000 through September 30, 2000 will allow Y2005 to continue to be billed or ADA and CPT codes can be billed on the ADA claim form. This will allow for testing and a smooth transition. EDS will audit claims to ensure that procedure code Y2005 and the dental ADA/CPT codes are not allowed on the same date of service.

**Note:** See a sample of the ADA claim form on the following 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

# *APPENDIX – A*

## HEALTH DEPARTMENT CROSSWALK TO CPT CODES

(This list is not all-inclusive)

| STATE CODE | CPT CODE |
|---|---|
| Y2011 Maternal Health Visit | 99201 – 99205 E&M – New Patient office visit<br>99211 – 99215 E&M – Established Patient office visit<br>59425 Antepartum care only; 4 – 6 visits<br>59426 Antepartum care only; 7 or more visits<br>59400 Global OB<br>59410 Vaginal delivery including postpartum care<br>59430 Postpartum care only<br>59510 Global with C-Section<br>59515 Cesarean delivery including postpartum care |
| Y2033 Non stress test | 59025 |
| Y2032 Intrapartum care | 59409 Vaginal delivery<br>59514 Cesarean delivery only |
| Y2135 Ultrasound | 76805 – 76828 |
| J2790 Rho(D) Immune Globulin | 90384 or 90385 |
| Y2023 Child Health Treatment | 99201 – 99205<br>99211 – 99215 |
| Y2026 Cardiology Care | 99201 – 99205<br>99211 – 99215 |
| Y2016 Orthopedic Care | 99201 – 99205<br>99211 – 99215 |
| Y2031 Physical therapy | 97001 Physical Therapy evaluation<br>97002 Physical Therapy re-evaluation<br>97010 – 97750 Physical therapy codes |
| Y2025 Neurology Care | 99201 – 99205<br>99211 – 99215 |
| Y2014 Speech and Hearing Assessment | 92506, 92525, 92551<br>92598 is non covered |
| Y2030 Speech Therapy | 92507, 92508, 92510, 92526 |
| Y2134 Neuromuscular Care | 99201 – 99205<br>99211 – 99215 |
| Y2035 Myelodysplasia Care | 99201 – 99205<br>99211 – 99215 |
| Y2001 Family Planning, Initial | 99384 Initial Preventive Medicine, 12 – 17 years old<br>99385 Initial Preventive Medicine, 18 – 39 years old<br>99386 Initial Preventive Medicine, 40 – 64 years old |
| Y2002 Family Planning Limited visit | 99211 – 99215 |
| Y2003 Family Planning Extended visit | 99211 – 99215 |
| Y2004 Family Planning | 99394 Periodic Preventive Medicine, 12 – 17 years old<br>99395 Periodic Preventive Medicine, 18 – 39 years old<br>99396 Periodic Preventive Medicine, 40 – 64 years old |

| STATE CODE | CPT CODE |
|---|---|
| W5131 Norplant Insertion | 11975 Insertion, implantable contraceptive capsules |
| W5132 Norplant removal | 11976 Removal, implantable contraceptive capsules |
| W5133 Norplant, removal and insertion | 11977 Removal with reinsertion, implantable contraceptive capsules |
| W5134 IUD Insertion | 58300 Insertion of IUD<br>58301 Removal of IUD |
| W5141 Depo-Provera Contraceptive injection | J1055 |
| Y2225 Rabies Immune Globulin | 90375 Rabies Immune Globulin (Rlg)<br>90376 Rabies Immune Globulin (Rlg-HT) |
| 90726 Rabies vaccine | 90675 Rabies vaccine, for IM use<br>90676 Rabies vaccine, for intradermal use |
| Y2039 Comprehensive Adult Health Assessment | 99385 – 99387 Initial Preventive Medicine. -<br>99395 – 99397 Periodic Preventive Medicine |
| Y2038 Chronic Disease Monitoring | 99201 - 99205<br>99211 – 99215 |
| Y2027 Adult Treatment | 99201 – 99205<br>99211 – 99215 |
| Q0124 Adult administration fee for injections | 90471, 90472, 90782, 90783, 90784, 90788 depending on the drug, and route of administration |

**DEVELOPMENTAL EVALUATION CENTERS CROSSWALK**

| | |
|---|---|
| Y2100 Physical Diagnosis and Assessment | 99241 – 99245 New or Established Patient Office Consultations<br>99201 – 99205 E & M Office visit codes<br>99211 – 99215 E & M Established pt. visits<br>99271 – 99275 Confirmatory Consultations<br>92551 Screening test, pure tone, air only<br>92567 Tympanometry<br>92568 Acoustic reflex testing<br>92587 Evoked otoacoustic emissions |
| Y2101 Physical Treatment and Patient Instruction | 99211 – 99215 |
| Y2102 Psychological Diagnosis and Assessment | 96100 Psychologicxal testing<br>96110 Developmental testing, limited<br>96111 Developmental testing, extended<br>96115 Neurobehavioral status exam<br>96117 Neuropsychological testing |
| Y2103 Psychological Treatment and Patient Instruction | 90804 Individual Psychotherapy, 30 min.<br>90806 Individual Psychotherapy, 45-50 min.<br>90808 Individual Psychotherapy, 75-80 min.<br>90810 Individual Psychotherapy, 20-30 min.<br>90812 Individual Psychotherapy, interactive<br>90814 Individual Psychotherapy, interactive<br>90846 Family Psychotherapy<br>90847 Family Psychotherapy |

| STATE CODE | | CPT CODE |
|---|---|---|
| Y2105 | Socio-emotional Dysfunction Treatment and Patient Instruction | 90804, 90806, 90808, 90812, 90814, 90846, 90847 |
| Y2106 | Speech, Language and Hearing Diagnosis and Assessment | 92506, 92525, 92551, 92567, 92568 Speech/Language<br>92551, 92552, 92553, 92555, 92556, 92557, 92567, 92568, 92569, 92579, 92582, 92583, 92585, 92587, 92588, 92589, 92590, 92591, 92592, 92593, 92594, 92595 Audiology |
| Y2107 | Speech, Language and Hearing Treatment and Patient Instruction | 92507, 92508, 92510, 92526 Speech/Language<br>92507, 92508, 92510 Audiology |
| Y2108 | Neuromotor Diagnosis and Treatment | 97001, 97002, 97003, 97750 Physical Therapy Diagnosis and Assessment<br>97003, 97004, 97703, 97750 Occupational Therapy Diagnosis and Assessment |
| Y2109 | Neuromotor Treatment and Patient Instruction | 97010, 97032, 97110, 97112, 97113, 97116, 97124, 97140, 97520, 97530, 97770 PT Treatment and Patient Instruction<br>97010, 97032, 97110, 97112, 97113, 97140, 97520, 97530, 97770 OT Treatment and Patient Instruction |
| Y2110 | Dysfunctions of Learning Diagnosis and Assessment | 96110 or 96111 Developmental testing |
| Y2111 | Dysfunctions of Learning Treatment and Patient Instruction | 97770 Development of cognitive skills |
| Y2136 | Intermediate Assessment | 96110 or 96111 Developmental testing |

# *APPENDIX – B*

## UNCHANGED HEALTH DEPARTMENT CODES

The following Health Department codes will remain unchanged:

| | |
|---|---|
| W8010 | Child Health Screening, Periodic |
| W8012 | Immunization Update |
| W8016 | Child Health Screening, Interperiodic |
| W8019 | Environmental Lead Investigation |
| W8201 | Maternal Care Coordination (Initial) |
| W8202 | Maternal Care Coordination (Subsequent) |
| W8203 | Childbirth Education Classes |
| W8204 | Maternal Care Skilled Nurse Home Visit |
| W8205 | Parenting Education Classes |
| Y2012 | TB Control Treatment |
| Y2013 | STD Control Treatment |
| Y2034 | Refugee Health Assessment |
| Y2041 | Medical Nutrition Therapy |
| Y2044 | Maternity Care Coordination Home Visit |
| Y2045 | Childbirth Refresher Course |
| Y2046 | Postpartum Assessment Home Visit |
| Y2047 | Newborn Assessment – Home Visit |
| Y2048 | Newborn EPSDT Screen Home Visit |
| Y2049 | Intensive Psychosocial Counseling |
| Y2104 | Socio-emotional Dysfunction Diagnosis and Assessment |
| Y2155 | Child Service Coordination |
| Y2200 | DME, Prosthetics, orthotics,supplies |
| Y2351 | Medical Nutrition Therapy |
| Y2525 | MOW Visit, Brief |
| Y2526 | MOW Visit, Standard |
| Y2527 | MOW Visit, Extended |

# *APPENDIX – C*

## INJECTABLE DRUG LIST

Following is a list of FDA approved injectable drugs currently covered by the North Carolina Medicaid Program when provided in a physician's office or health department for the FDA indications. **Fees and newly covered drugs are effective with date of service on or after October 1, 1999**. Immunizations are included on a separate list (see page 7).

Physicians will continue to bill on the HCFA-1500 claim form using the appropriate drug code, and indicating the number of units administered as specified in the listing.

**These injectable drugs are listed alphabetically, their trade name is shown in parentheses.**

(*) - Designates newly covered drugs.

(^) - Designates a change in code.

(#) - Designates drugs not previously published with effective dates for coverage prior to 10/1/99.

(**) - Designates an invoice is required to accompany the HCFA-1500 claim form. Payment is based on the invoice price.

| | ***Procedure Code*** | ***Description*** | ***Fees*** |
|---|---|---|---|
| # | J0130 | Abciximab 10 mg | 487.37 |
| | J1120 | Acetazolamide Sodium, up to 500 mg (Diamox) | 28.15 |
| | J0150 | Adenosine I.V. (Adenocard I.V.) 6 mg. | 28.67 |
| ^ | J0151 | Adenosine (Adenoscan) 90 mg | 201.93 |
| | J0170 | Adrenalin, Epinephrine, up to 1 ml ampule | .90 |
| | Q0156 | Albumin Infusion 5%/500ml | 135.37 |
| | Q0157 | Albumin Infusion 25%/50ml | 78.29 |
| | J0205 | Alglucerase, per 10 units (Ceredase) | 35.64 |
| | J0256 | Alpha 1 Proteinase Inhibitor Human A (Prolastin) 10 mg. | 1.98 |
| | J9015 | Aldesleukin (Proleukin, Interleuken II 22 million IU (SDV) | 503.14 |
| | J2996 | Alteplase Recombinant, per 10 mg (Activase) | 248.48 |
| # | J0207 | Amifostine 500 mg. | 332.79 |
| # | W5181 | Amikacin Sulfate 500 mg | 15.79 |
| | J0280 | Aminophyllin, up to 250 mg | 1.10 |
| | J1320 | Amitriptyline HCL, up to 20 mg (Elavil, Enovil) | .05 |
| | J0300 | Amobarbital, up to 125 mg (Amytal) | 2.09 |
| ^ | J0285 | Amphotericin B 50 mg | 84.23 |
| * | J0286 | Amphotericin B Any Lipid Formulation 50 mg | 128.78 |
| # | W5189 | Amphotericin B Lipid Complex (Abelcet) 100 mg | 174.60 |
| | J0295 | Ampicillin Sodium/Sulbactam Sodium, per 1.5 gm | 6.69 |
| | J0290 | Ampicillin, up to 500 mg (Omnipen, Polycillin-N, Totacillin-N) | 1.01 |
| | J0350 | Anistreplase, per 30 units (Eminase) | 2,391.69 |
| * | J7197 | Antithrombin II (human) per I.U. | .75 |
| * | J0395 | Arbutamine HCL 1 mg | 173.28 |
| | J9020 | Asparaginase, 10,000 units (Elspar) | 51.94 |
| | J0460 | Atropine Sulfate, up to 0.3 mg | .54 |
| | J2910 | Aurothioglucose, up to 50 mg (Solganal) | 12.92 |

| | *Procedure Code* | *Description* | *Fees* |
|---|---|---|---|
| | W5156 | Azithromycin, oral suspension 1 unit = 1 gm packet (Zithromax), only oral drug on list | 18.32 |
| | J0475 | Baclofen, Kit 1*20 ml. Amp. 10 mg/20ml., 500 meg/ml. | 204.86 |
| | W5170 | Baclofen, Kit 2*5 ml. Amp. 10 mg./5 ml., 2000 meg./ml. | 427.78 |
| | W5169 | Baclofen, Kit 4*5 ml. Amp. 10 mg./5ml., 2000 meg./ml. | 752.68 |
| * | J0476 | Baclofen (for intrathecal Trial) 50 mcg | 70.39 |
| | J0510 | Benzquinamide HCL, up to 50 mg (Emete-CON) | 5.20 |
| | J0702 | Betamethasone Acetate and Betamethasone Sodium Phosphate, per 3 mg | 4.47 |
| | J0704 | Betamethasone Sodium Phosphate, per 4 mg | 3.05 |
| | J0520 | Bethanechol Chloride up to 5 mg (Urecholine) | 4.90 |
| | J0190 | Biperiden, Akineton 5 mg | ** |
| | J9040 | Bleomycin Sulfate, 15 units (Blenoxane)/2 ml | 274.90 |
| | J0945 | Brompheniramine Maleate , 10mg | .73 |
| | J0635 | Calcitriol, 1 mcg amp.(Calcijex) | 12.17 |
| | J0610 | Calcium Gluconate, up to 10 ml (Kaleinate) | 1.26 |
| | J0620 | Calcium Glycerophosphate and Calcium Lactate, per 10 ml (Calphosan) | 2.44 |
| | W5166 | Camptosar 5 CC | 521.58 |
| | J9045 | Carboplatin, 50 mg (Paraplatin) | 93.95 |
| | J9050 | Carmustine, 100 mg (Bicnu) | 89.84 |
| | J0690 | Cefazolin Sodium, up to 500 mg (Ancef, Kefzol, Zolicef) | 1.51 |
| # | W5185 | Cefepime HCL (Maxipime HCL) 500 mg | 6.94 |
| | J0695 | Cefonicid Sodium, 1 gram (Monocid) | 23.55 |
| | J0698 | Cefotaxime Sodium, per gm (Claforan) | 11.26 |
| | J0694 | Cefoxitin Sodium, 1 gm (Mefoxin) | 9.46 |
| | J0713 | Ceftazidime per 500 mg | 6.93 |
| | J0715 | Ceftizoxime Sodium, per 500 mg (Cefizax) | 5.84 |
| | J0696 | Ceftriaxone Sodium, per 250 mg (Rocephin) | 10.50 |
| | J0697 | Cefuroxime Sodium, per 750 mg (Kefurox, Zinacef) | 6.10 |
| | J1890 | Cephalothin Sodium, up to 1 gm (Keflin) | 9.74 |
| | J0710 | Cephapirin Sodium, up to 1 gm (Cefadyl) | 1.48 |
| | J0720 | Chloramphenicol Sodium Succinate, up to 1 gm | 5.87 |
| | J1990 | Chlordiazepoxide HCL, up to 100 mg (Librium) | 20.65 |
| | J2400 | Chlorprocaine HCL 30 ml | 8.57 |
| | J0390 | Chloroquine HCL, up to 250 mg | 15.39 |
| | J1205 | Chlorothiazide Sodium 500 mg. | 8.85 |
| | J0730 | Chlorpheniramine Maleate, per 10 mg | .36 |
| | J3230 | Chlorpromazine HCL, 50 mg (Thorazine, Ormazines) | 1.80 |
| | J3080 | Chlorprothixene, up to 50 mg (Taractan) | 9.25 |
| | J0725 | Chorionic Gonadotropin, per 1,000 usp units | 1.54 |
| | J0740 | Cidofovir 375 mg. | 687.70 |
| | J0743 | Cilastatin Sodium; Imipenem, per 250 mg | 13.39 |
| | W5176 | Cimetadine HCL (Tagamet) 300 mg | 2.99 |
| | W5183 | Ciprofloxacin (Cipro) 200 mg. | 12.96 |
| | J9062 | Cisplatin, 50 mg (Plantinol, Platinol AQ) | 195.08 |
| | J9060 | Cisplatin, 10 mg (Platinol, Plantinol AQ) | 39.01 |
| | J9065 | Cladribine, per 1 mg (Leustatin) | 48.85 |
| # | J0735 | Clonidine Hydrochloride 1 mg | 46.02 |

| | ***Procedure Code*** | ***Description*** | ***Fees*** |
|---|---|---|---|
| | J0745 | Codeine Phosphate, per 30 mg | .64 |
| | J0760 | Colchicine, 1 mg | 4.54 |
| | J0770 | Colistimethate Sodium, up to 150 mg (Coly-Mycin M) | 38.62 |
| | J0800 | Corticotropin, up to 40 units (Acthor, ACTH) | 4.33 |
| | J0810 | Cortisone Acetate, up to 50 mg | .90 |
| | J0835 | Cosyntropin, per 0.25 mg (Cortrosyn) | 13.34 |
| | J3420 | Cyanocobalamin, B 12 1000 mcg | .19 |
| | J9096 | Cyclophosphamide Lyophilized 1 gm (Cytoxan Lyophilized) | 46.41 |
| | J9093 | Cyclophosphamide Lyophilized, 100 mg (Cytoxan Lyophilized) | 5.82 |
| | J9091 | Cyclophosphamide, 1.0 gm (Cytoxan, Neosar) | 44.08 |
| | J9070 | Cyclophosphamide, 100 mg (Cytoxan, Neosar) | 5.46 |
| | J9092 | Cyclophosphamide, 2.0 gm (Cytoxan, Neosar) | 92.85 |
| | J9080 | Cyclophosphamide, 200 mg (Cytoxan, Neosar) | 10.36 |
| | J9090 | Cyclophosphamide, 500 mg (Cytoxan, Neosar) | 22.03 |
| | J9094 | Cyclophosphamide, Lyophilized, 200 mg (Cytoxan Lyophilized) | 11.05 |
| | J9095 | Cyclophosphamide, Lyophilized, 500 mg (Cytoxan Lyophilized) | 23.20 |
| | J9097 | Cyclophosphamide Lyophilized 2gm | 92.85 |
| | J9100 | Cytarabine 100 mg (Cytosar U) | 5.96 |
| | J9110 | Cytarbine 500 mg | 23.71 |
| | J9130 | Dacarbazine 100 mg | 10.44 |
| | J9140 | Dacarbazine 200 mg | 20.88 |
| | J7513 | Daclizumab (Zenapax) 25 mg | 377.43 |
| | J9120 | Dactinomycin .5 mg (Cosmegen) | 11.71 |
| | J1645 | Dalteparin (Fragmin) per 2500 I.U./.2 ml. | 10.16 |
| | J9150 | Daunorubicin HCL, 10 mg (Cerubidine) | 76.03 |
| * | J9151 | Daunorubicin Citrate Liposomal 10 mg | 61.37 |
| | J0895 | Deferoxamine, Mesylate 500 mg per 5cc (Deferal) | 10.89 |
| | W5195 | Denileukin Diftitox 18 mcg (Ontak) | 59.55 |
| | J1000 | Depoestradiol Cypionate, up to 5 mg | .90 |
| | J1095 | Dexamethasone Acetate 8 mg | 2.18 |
| | J2597 | Desmopression Acetate per 1 mcg | 4.44 |
| | J1100 | Dexamethosone Sodium, up to 4mg/ml | .45 |
| | J1190 | Dexrazoxane HCL 250 mg | 143.04 |
| * | J7110 | Dextran 75 | 93.30 |
| | J7042 | Dextrose/Normal Saline – 5%, 500 ml = 1 unit | 10.21 |
| | J7070 | Dextrose/Water – 5%, 1000 cc = 1 unit | 11.22 |
| | J7060 | Dextrose/Water – 5%, 500 ml = 1 unit | 9.25 |
| | J3360 | Diazepam, up to 5 mg (Valium, Zetran) | .71 |
| | J1730 | Diazoxide, up to 300 mg (Hyperstat IV) | 95.80 |
| | J0500 | Dicyclomine HCL up to 20 mg (Bentyl, Dilomine, Antispas) | 1.71 |
| | J9165 | Diethylstilbestrol Diphosphate, 250 mg (Stilphostrol) | 13.68 |
| | J1160 | Digoxin, up to 0.5 mg (Lanoxin) | 1.86 |
| | J1110 | Dihydroergotamine, up to 1 mg | 11.89 |
| | J0470 | Dimecaprol, up to 100 mg | 22.49 |
| | J1240 | Dimenhydrinate, 50 mg | .64 |
| | J1200 | Diphenhydramine HCL, up to 50 MG (Benadryl) | .78 |
| | J1245 | Dipyridamole, per 10 mg (Persantine IV) | 17.27 |
| | J1212 | DMSO, Dimethyl Sulfoxide, 50%, 50 ml | 32.94 |

| | ***Procedure Code*** | ***Description*** | ***Fees*** |
|---|---|---|---|
| | J1250 | Dobutamine HCL, 250 mg | 10.83 |
| # | J9170 | Docetaxel 20 mg | 256.63 |
| # | W5180 | Dolasetron Mesylate 5 ml | 140.29 |
| * | J1260 | Dolasetron Mesylate 1 mg | 1.20 |
| | W5167 | Doxil 10 mg/ml | 295.31 |
| | J9000 | Doxorubicin HCL, 10 mg (Adriamycin Rubex) | 36.13 |
| | J1810 | Droperidol and Fentanyl Citrate, up to 2 ml ampule (Innovar) | 8.96 |
| | J1790 | Droperidol, up to 5 mg (Inapsine) | 2.61 |
| | J1180 | Dyphylline, up to 500 mg | 5.02 |
| | J0600 | Edetate Calcium Disodium up to 1000 mg | 34.61 |
| | J1650 | Emoxaparin Sodium (Lovenox) 30 mg | 15.16 |
| | Q9920 | EPO, per 1000 units, Patient HCT 20 or less | 10.83 |
| | Q9921 | EPO, per 1000 units, Patient HCT 21 | 10.83 |
| | Q9922 | EPO, per 1000 units, Patient HCT 22 | 10.83 |
| | Q9923 | EPO, per 1000 units, Patient HCT 23 | 10.83 |
| | Q9924 | EPO, per 1000 units, Patient HCT 24 | 10.83 |
| | Q9925 | EPO, per 1000 units, Patient HCT 25 | 10.83 |
| | Q9926 | EPO, per 1000 units, Patient HCT 26 | 10.83 |
| | Q9927 | EPO, per 1000 units, Patient HCT 27 | 10.83 |
| | Q9928 | EPO, per 1000 units, Patient HCT 28 | 10.83 |
| | Q9929 | EPO, per 1000 units, Patient HCT 29 | 10.83 |
| | Q9930 | EPO, per 1000 units, Patient HCT 30 | 10.83 |
| | Q9931 | EPO, per 1000 units, Patient HCT 31 | 10.83 |
| | Q9932 | EPO, per 1000 units, Patient HCT 32 | 10.83 |
| | Q9933 | EPO, per 1000 units, Patient HCT 33 | 10.83 |
| | Q9934 | EPO, per 1000 units, Patient HCT 34 | 10.83 |
| | Q9935 | EPO, per 1000 units, Patient HCT 35 | 10.83 |
| | Q9936 | EPO, per 1000 units, Patient HCT 36 | 10.83 |
| | Q9937 | EPO, per 1000 units, Patient HCT 37 | 10.83 |
| | Q9938 | EPO, per 1000 units, Patient HCT 38 | 10.83 |
| | Q9939 | EPO, per 1000 units, Patient HCT 39 | 10.83 |
| | Q9940 | EPO, per 1000 units, Patient HCT 40 | 10.83 |
| # | J1325 | Epoprostenol .5 mg | 15.70 |
| | Q0136 | Epotin Alpha (for non ESRD use) P/1000 units | 10.83 |
| | J1330 | Ergonovine Maleate, up to 0.2 mg | 4.27 |
| | J1362 | Erythromycin Gluceptate, per 250 mg | 5.50 |
| | J1364 | Erythromycin Lactobionate, per 500 mg | 5.64 |
| | J1380 | Estradiol Valerate, up to 10 mg | .58 |
| | J1390 | Estradiol Valerate, up to 20 mg | 1.17 |
| | J0970 | Estradiol Valerate, up to 40 mg | 1.73 |
| | J1410 | Estrogen Conjugated, per 25 mg (Premarin Intravenuous) | 43.89 |
| | J1435 | Estrone, per 1 mg | .18 |
| | J0590 | Ethylnorepinephrine HCL, 1 ml (Bronkephrine) | 3.96 |
| | J1436 | Etidronate Disodium, per 300 mg (Didronel) | 60.46 |
| | J9181 | Etoposide, 10 mg (Vepesid) | 12.07 |
| | J9182 | Etoposide, 100 mg (Vepesid) | 120.70 |
| | J3010 | Fentanyl Citrate, up to 2 ml (Sublimaze) | 1.22 |
| | J7190 | Factor VIII (anti-hemophilic factor) (human) per IU (Hemofil M) | .62 |

| | ***Procedure Code*** | ***Description*** | ***Fees*** |
|---|---|---|---|
| * | J7191 | Factor VIII (anti-hemophilic factor) Porcine per IU | 1.51 |
| | J7192 | Factor VIII (anti-hemophilic factor) Recombinant- per IU | .77 |
| ^ | J7194 | Factor IX – (Benefix 1 IU) | .26 |
| * | Q0160 | Factor IX (Antihemophilic Factor, Purified, non-recombinant) – per I.U. | .86 |
| * | Q0161 | Factor IX (Antihemophilic Factor, recombinant) – per I.U. | .95 |
| | J1440 | Filgrastim , 300 mcg (Neupogen) | 155.50 |
| | J1441 | Filgrastim , 480 mcg (Neupogen) | 247.64 |
| | J9200 | Floxuridine, 500 mg (FUDR) | 123.08 |
| | J9185 | Fludarabine Phosphate, 50 mg (Fludara) | 200.24 |
| | J9190 | Fluorouracil, 500 mg (Adrucil) | 2.25 |
| | J2680 | Fluphenazine Decanoate, up to 25 mg (Prolixin Decanoate) | 14.44 |
| | J1455 | Foscarnet Sodium, per 1000 mg | 10.97 |
| | J1940 | Furosemide, up to 20 mg (Lasix, Furomide M.D.) | .53 |
| | J1460 | Gamma Globulin, Intramuscular, 1 cc | 2.17 |
| | J1470 | Gamma Globulin, Intramuscular, 2 cc | 4.33 |
| | J1480 | Gamma Globulin, Intramuscular, 3 cc | 6.50 |
| | J1490 | Gamma Globulin, Intramuscular, 4 cc | 8.66 |
| | J1500 | Gamma Globulin, Intramuscular, 5 cc | 10.83 |
| | J1510 | Gamma Globulin, Intramuscular, 6 cc | 13.00 |
| | J1520 | Gamma Globulin, Intramuscular, 7 cc | 15.16 |
| | J1530 | Gamma Globulin, Intramuscular, 8 cc | 17.33 |
| | J1540 | Gamma Globulin, Intramuscular, 9 cc | 19.49 |
| | J1550 | Gamma Globulin Intramuscular 10 cc | 21.66 |
| | J1560 | Gamma Globulin, Intramuscular, over 10 cc (use correct combinations of services) | ** |
| | J1570 | Ganciclovir Sodium, 500 mg (Cytovene) | 32.19 |
| * | J7310 | Ganciclovir, Long-acting Implant 4.5 mg | 4,512.50 |
| | J9201 | Gemcitabine HCl. 200 mg | 84.04 |
| | J1580 | Gentamicin (Garamycin Sulfate) 80 mg | 1.03 |
| | J1610 | Glucagon Hydrochloride, per 1 mg | 51.98 |
| | J1600 | Gold Sodium Thiomaleate, up to 50 mg | 10.65 |
| | J1620 | Gonadorelin Hydrochloride, per 100 mcg | 140.57 |
| | J9202 | Goserelin Acetate Implant, per 3.6 mg (Zoladex) | 424.16 |
| | J1626 | Granisetron Hydrochloride 100 mcg | 16.79 |
| | J1631 | Haloperidol Decanoate, per 50 mg (Haldol Decanoate – 50 or 100) | 25.99 |
| | J1630 | Haloperidol, up to 5 mg (Haldol) | 1.31 |
| | J1642 | Heparin Sodium, (Heparin Lock Flush), per 10 units | .05 |
| | J1644 | Heparin Sodium, per 1000 units | .15 |
| # | J9355 | Herceptin (Trastuzumab) 10 mg | 46.41 |
| ^ | J7315 | Hyalgan (Sodium Hyaluronate) 20 mg. (Series of 5 weekly injections) | 119.31 |
| | J3470 | Hyaluronidase, up to 150 units (Wydase) | 6.29 |
| | W5168 | Hycamtin 4 mg | 565.20 |
| | J0360 | Hydralazine HCL, up to 20 mg (Apresoline) | 8.34 |
| | J2480 | Hydrochlorides of Opium Alkaloids, up to 20 mg (Pantopon) | 3.08 |
| | J1700 | Hydrocortisone Acetate, up to 25 mg | .52 |
| | J1710 | Hydrocortisone Sodium Phosphate, up to 50 mg | 4.69 |
| | J1720 | Hydrocortisone Sodium Succinate, up to 100 mg | 2.66 |

| | ***Procedure Code*** | ***Description*** | ***Fees*** |
|---|---|---|---|
| | J1170 | Hydromorphone, up to 4 mg (Dilaudid) | 1.03 |
| | J1739 | Hydroxyprogesterone Caproate 125 mg/ml | 1.22 |
| | J1741 | Hydroxyprogesterone Caproate, 250 mg/ml | 2.44 |
| | J3410 | Hydroxyzine HCL, up to 25 mg (Vistaril, Vistaject-25, Hyzine-50) | .66 |
| ^ | J7320 | Hylan G-F 20 (Synvisc) 16 mg/ 2 ml Series of 3 weekly injections | 194.62 |
| | J1980 | Hyoscyamine Sulfate, up to 0.25 mg (Levsin) | 4.81 |
| * | J7130 | Hypertonic Saline Solution 50 or 100 meq, 20 cc vial | 3.09 |
| # | J1742 | Ibutilide Fumarate 1 mg. | 186.69 |
| | J9211 | Idarubicin Hydrochloride, 5 mg | 303.09 |
| | J9208 | Ifosfamide, 1 gm | 127.93 |
| | J1785 | Imiglucerase, per unit (Cerezyme) | 3.56 |
| | J3270 | Imipramine HCL, up to 25 mg (Tofranil) | ** |
| | J1561 | Immune Globulin, Intravenous, per 500 mg (Gammar IV) | 39.25 |
| | W5196 | Infliximab 5 mg (Remicade) | 29.25 |
| | J1820 | Insulin, up to 100 units (Pork Regular) | 3.51 |
| | J9213 | Interferon, Alfa-2A, recombinant, 3 million units (Roferon) | 31.55 |
| | J9214 | Interferon, Alfa-2B, Recombinant, 1 million units (Intron A) | 11.27 |
| | J9215 | Interferon, Alfa-N3, 250,000 IU | 7.17 |
| * | J9212 | Interferon, Alfacon-1, Recombinant, 1 mcg | 1.06 |
| | J9216 | Interferon, Gamma 1-B, 3 million units (Actimmune) | 126.35 |
| # | J9206 | Irinotecan 20 mg | 104.59 |
| | J1750 | Iron Dextran, Infed 50 mg | 17.01 |
| | J1840 | Kanamycin Sulfate, 500 mg (Kantrex, Klebcil) | 3.03 |
| | J1850 | Kanamycin Sulfate, 75 mg (Kantrex, Klebcil) | 2.74 |
| | J1885 | Ketorolac Tromethamine, per 15 mg (Toradol) | 5.46 |
| | W5172 | Ketorolac Tromethamine, per 30 mg | 9.32 |
| | W5171 | Ketorolac Tromethamine, per 60 mg | 9.89 |
| | J1910 | Kutapressin, up to 2 ml | 11.44 |
| | J0640 | Leucovorin Calcium, per 50 mg | 17.03 |
| | J9217 | Leuprolide Acetate (for depot suspension), 7.5 mg (Lupron)<br>(22.5 mg allowed for DX 185 only) | 536.67 |
| | J1950 | Leuprolide Acetate (for depot suspension), per 3.75 mg (Lupron)<br>Leuprolide Acetate (for depot suspension), per 11.25 mg(Lupron) 3 months | 431.40<br>431.40x3 |
| | J9218 | Leuprolide Acetate, per 1 mg (Lupron) | 116.77 |
| | J1955 | Levocarnitine per 1 gm | 32.49 |
| * | J1956 | Levofloxacin 250 mg | 17.86 |
| | J1960 | Levorphanol tartrate, up to 2 mg | 3.57 |
| | J2000 | Lidocaine HCL, 50 cc | 2.62 |
| | J2010 | Lincomycin HCL, up to 300 mg (Lincocin) | .90 |
| | J2060 | Lorazepam, 2 mg (Ativan) | 7.91 |
| | W5128 | Lupron Depot Pediatric 11.25 mg | 971.83 |
| | W5129 | Lupron Depot Pediatric 15 mg | 1,070.37 |
| | W5127 | Lupron Depot Pediatric 7.5 mg | 535.19 |
| | J3475 | Magnesium Sulfate, 500 mg, injection | .40 |
| | J2150 | Mannitol, 25% in 50 ml | 2.80 |

| | *Procedure Code* | *Description* | *Fees* |
|---|---|---|---|
| | J9230 | Mechlorethamine Hydrochloride (Nitrogen Mustard), 10 mg | 10.12 |
| | J1055 | Medroxyprogesterone Acetate for Contraceptive Use, 150 mg (Depo-Provera) | 43.29 |
| | J1050 | Medroxyprogesterone Acetate, 100 mg (Depo-Provera) | 9.45 |
| | J9245 | Melphalan Hydrochloride 50 mg (Alkeran) | 329.17 |
| | J2180 | Meperidine and Promethazine HCL, up to 50 mg (Mepergan Injection) | 3.72 |
| | J2175 | Meperidine Hydrochloride, per 100 mg (Demerol HCL) | .65 |
| | J3450 | Mephentermine, up to 30 mg | 1.90 |
| | J0670 | Mepivacaine (Carbocaine) 10 ml | 1.79 |
| | J9209 | Mesna, 200 mg (Mesnex) | 33.03 |
| | J0380 | Metaraminol Bitartrate 10 mg (Aramine) | 1.07 |
| | J1230 | Methadone HCL, up to 10 mg | .55 |
| | J2970 | Methicillin Sodium, up to 1 gm (Staphcillin) | 4.99 |
| | J2800 | Methocarbamol, up to 10 ml (Robaxin) | 4.05 |
| | J9250 | Methotrexate Sodium, 5 mg | .37 |
| | J9260 | Methotrexate Sodium, 50 mg | 3.81 |
| | J1970 | Methotrimeprazine, up to 20 mg | 20.47 |
| | J3390 | Methoxamine, up to 20 mg (Vasoxyl) | 22.04 |
| | J0210 | Methyldopate HCL, up to 250 mg (Aldomet) | 8.53 |
| | J2210 | Methylergonovine Maleate, up to 0.2 mg (Methergine) | 3.06 |
| | J1020 | Methylprednisolone Acetate, 20 mg (Depo Medrol) | 2.29 |
| | J1030 | Methylprednisolone Acetate, 40 mg | 4.59 |
| | J1040 | Methylprednisolone Acetate, 80 mg | 9.17 |
| | J2930 | Methylprednisolone Sodium Succinate, up to 125 mg (SoluMedrol, Anetha Pred) | 5.09 |
| | J2920 | Methylprednisolone Sodium Succinate, up to 40 mg (Solu Medrol, Anetha Pred) | 1.92 |
| | J2765 | Metoclopramide HCL, up to 10 mg (Reglan) | 1.80 |
| | J2250 | Midozolem HCL (Versed) per 1 mg | 2.34 |
| | J2260 | Milrinone Lactate, per 5 ml (Primacor) | 28.42 |
| | J9290 | Mitomycin, 20 mg (Mutamycin) | 365.15 |
| | J9291 | Mitomycin, 40 mg (Mutamycin) | 730.30 |
| | J9280 | Mitomycin, 5 mg (Mutamycin) | 118.29 |
| | J9293 | Mitoxantrone Hydrochloride, per 5 mg (Novantrone) | 199.87 |
| | J2275 | Morphine Sulfate (preservative-free sterile solution), per 10 mg | 7.99 |
| | J2270 | Morphine Sulfate, up to 10 mg | 1.05 |
| * | J2271 | Morphine Sulfate 100 mg | 7.77 |
| | J2310 | Nalaxone Hydrochloride (Narcan) per 1 mg | 3.98 |
| | J2300 | Nalbuphine Hydrochloride, 10 mg | 3.62 |
| | J2321 | Nandrolone Decanoate, up to 100 mg | 8.88 |
| | J2322 | Nandrolone Decanoate, up to 200 mg | 12.01 |
| | J2320 | Nandrolone Decanoate, up to 50 mg | 4.93 |
| | J0340 | Nandrolone Phenpropionate, up to 50 mg (Duradolin) | 7.48 |
| | J9390 | Navelbine 10 mg | 62.92 |
| | J2710 | Neostigmine Methylsulfate, up to 0.5 mg (Prostigmine) | .47 |
| | J7030 | Normal Saline Solution, 1000 cc, infusion | 8.36 |
| | J7050 | Normal Saline Solution, 250 cc, infusion | 10.60 |
| | J7040 | Normal Saline Solution, Sterile 500 ml=1 unit, infusion | 9.08 |

| | ***Procedure Code*** | ***Description*** | ***Fees*** |
|---|---|---|---|
| | J2405 | Ondansetron Hydrochloride, per 1 mg (Zofran) | 5.51 |
| ^ | J2355 | Oprelvekin (Newmega) 5 mg | 224.49 |
| | J2360 | Orphenadrine Citrate, up to 60 mg | 1.44 |
| * | J7196 | Other Hemophilia Clotting Factors (e.g., anti-inhibitors) | .88 |
| | J2700 | Oxacillin Sodium, up to 250 mg (Bactocile, Prostaphlin) | .61 |
| | J2410 | Oxymorphone HCL, up to 1 mg | 2.50 |
| | J2460 | Oxytetracycline HCL, up to 50 mg (Terramycin IM) | .85 |
| | J2590 | Oxytocin, up to 10 units (Pitocin, Syntocinon) | .53 |
| | J9265 | Paclitaxel, 30 mg (Taxol) | 164.83 |
| | J2430 | Pamidronate Disodium, per 30 mg (Aredia) | 208.58 |
| | J2440 | Papaverine HCL, up to 60 mg | 3.24 |
| | J9266 | Pegaspargase (Onscospar) Single Dose vial 5 ml/ SDV | 1,255.57 |
| | J0540 | Penicillin G Benzathine and Penicillin G Procaine, up to 1,200,000 units | 12.08 |
| | J0550 | Penicillin G Benzathine and Penicillin G Procaine, up to 2,400,000 units | 24.86 |
| | J0530 | Penicillin G Benzathine and Penicillin G procaine, up to 600,000 units | 5.91 |
| | J0570 | Penicillin G Benzathine, up to 1,200,000 units (Bicillin L-A, Permapen) | 13.36 |
| | J0580 | Penicillin G Benzathine, up to 2,400,000 units (Bicillin L-A, Permapen) | 26.71 |
| | J0560 | Penicillin G Benzathine, up to 600,000 units (Bicillin L-A, Permapen) | 6.68 |
| | J2540 | Penicillin G Potassium, up to 600,000 units | .27 |
| | J2510 | Penicillin G Procaine, Aqueous, up to 600,000 units | 2.34 |
| | J2512 | Pentagastrin, per 2 ml (Peptavlon) | 28.78 |
| | J2545 | Pentamidine (Pentam 300) | 112.96 |
| # | W5192 | Pentamidine Isethionate | 100.91 |
| | J3070 | Pentazocine HCL, up to 30 mg (Talwin) | 3.51 |
| | J2515 | Pentobarbital Sodium (Nembutal Sodium Solution) 50 mg | 1.17 |
| * | J9268 | Pentostatin, 10 mg | 1,484.61 |
| | W5194 | Piperacillin Sodium 4 gm (Pipracil) | 22.85 |
| | J3310 | Perphenazine, up to 5 mg (Trilafon) | 5.99 |
| | J2560 | Phenobarbital Sodium, up to 120 mg | 6.10 |
| | J2760 | Phentolamine Mesylate, up to 5 mg (Regitine) | 30.32 |
| | J2370 | Phenylephrine HCL, up to 1 ml (NeoSynephrine) | 2.17 |
| | J1165 | Phenytoin Sodium (Dilantin) | .73 |
| | J9270 | Plicamycin, (Mithracin) 2.5 mg | 85.68 |
| # | J9600 | Porfimer Sodium 75 mg | 2,322.52 |
| | J3480 | Potassium Chloride 2 meq. | .05 |
| | J2730 | Pralidoxime Chloride, up to 1 gm (Protopam Chloride) | 57.87 |
| | J2650 | Prednisolone Acetate, up to 1 ml | .50 |
| | J2640 | Prednisolone Sodium Phosphate, to 20 mg | .63 |
| | J1690 | Prednisolone Tebutate, up to 20 mg | 3.69 |
| | J2690 | Procainamide HCL, up to 1 gm (Pronestyl) | 5.23 |
| | J0780 | Prochlorperazine Edisylate 10 mg Compazine, Cotranzine, Compa-Z, Ultrazine-10 | 2.30 |
| | J2675 | Progesterone, per 50 mg | 1.17 |
| | J2950 | Promazine HCL, up to 25 mg (Sparine, Prozine-50) | .43 |
| | J2550 | Promethazine HCL, up to 50 mg (Phenergan, Phenazine) | 1.06 |
| | J1930 | Propiomazine HCL, up to 20 mg | 3.74 |
| | J1800 | Propranolol HCL, up to 1 mg (Inderal) | 5.64 |

| | ***Procedure Code*** | ***Description*** | ***Fees*** |
|---|---|---|---|
| | J2720 | Protamine Sulfate, per 10 mg | .67 |
| | J2725 | Protirelin, per 250 mg | 22.28 |
| | J2780 | Rantidine (Zantac) 25 mg. | 1.37 |
| * | J2994 | Reteplase 37.6 mg/ 2 SDV | 2,481.87 |
| | J7120 | Ringers Lactate Infusion, up to 1000 cc | 11.81 |
| ^ | J9310 | Rituximab (Rituxan) 100 mg./ 10ml. | 380.26 |
| * | W5198 | Sandostatin (Octreotide Acetate) 100 mcg | 211.99 |
| | J2820 | Sargramostim (GM-CSF), (Leukine, Prokine) 50 mcg | 24.34 |
| | J2860 | Secobarbital Sodium, up to 250 mg (Seconal) | 7.23 |
| | Y1856 | Sodium Bicarbonate 7.5% up to 50 ml | 16.72 |
| | J2912 | Sodium Chloride 9% per ml | .14 |
| | J3320 | Spectinomycin-Dihydrochloride, up to 2 gm (Trobicin) | 21.65 |
| | X1270 | Stadol | 7.58 |
| * | J7051 | Sterile Saline or Water up to 5cc | .94 |
| | J2995 | Streptokinase, per 250,000 IU | 109.86 |
| | J3000 | Streptomycin 1 gm | 5.35 |
| | J9320 | Streptozocin, 1 gm (Zanosar) | 95.80 |
| | J0330 | Succinycholine Chloride, up to 20 mg (Anectine, Quelicin, Surostrin) | .08 |
| | W5158 | Taxotere 20 mg | 255.92 |
| | W5159 | Taxotere 80 mg | 1,023.70 |
| | J3105 | Terbutaline Sulfate, up to 1 mg (Brethine) | 2.04 |
| | J1060 | Testosterone Estradiol Cypionate, 50 mg | .98 |
| | J1080 | Testosterone Estradiol Cypionate, 200 mg | 1.60 |
| | J1090 | Testosterone Cypionate, 50 mg | .57 |
| | J1070 | Testosterone Estradiol Cypionate, 100 mg | 1.15 |
| | J0900 | Testosterone Enanthate and Estradiol Valerate 1 cc | 1.55 |
| | J3120 | Testosterone Enanthate, 100 mg | .68 |
| | J3130 | Testosterone Enanthate, 200 mg | 1.35 |
| | J3150 | Testosterone Propionate, 100 mg | 1.03 |
| | J3140 | Testosterone Suspension, 50 mg | .49 |
| | J0120 | Tetracycline, up to 250 mg (Achromycin) | ** |
| | J3280 | Thiethylperazine Maleate, 10 mg (Norzine, Torecan) | 4.04 |
| | J9340 | Thiotepa Triethylenthiophosphoromide, 15 mg | 83.47 |
| | J2330 | Thiothixene, up to 4 mg (Navane) | 12.76 |
| | J3240 | Thyrotropin, up to 10 i.u. | 180.67 |
| # | J3240 | Thyrotropin Alfa (Thyrogen) 0.9 mg | 347.94 |
| | J3260 | Tobramycin Sulfate, up to 80 mg (Nebcin) | 5.00 |
| # | J9350 | Topatecan 4 mg. | 519.11 |
| | J3265 | Torsemide 10 mg/ml | 1.00 |
| | J2670 | Tolazoline HCL, up to 25 mg (Priscoline HCL) | 3.38 |
| | J3301 | Triamcinolone Acetonide, per 10 mg | .88 |
| | J3302 | Triamcinolone Diacetate, per 5 mg | .18 |
| | J3303 | Triamcinolone Hexacetonide, per 5 mg | 2.16 |
| | J0400 | Trimethapan Camsylate up to 500 mg | 25.55 |
| | J3250 | Trimethobenzamide HCL, up to 200 mg (Tigan) | 2.61 |
| | J3305 | Trimetrexate Glucoronate 25 mg | 59.56 |
| | J3350 | Urea, up to 40 gm | 76.19 |

| | ***Procedure Code*** | ***Description*** | ***Fees*** |
|---|---|---|---|
| | J3365 | Urokinase, 250,000 i.u. vial | 442.85 |
| | J3364 | Urokinase, 5000 iu vial | 53.77 |
| # | W5193 | Valstar (Valvubicin) 800 mg | 1,404.00 |
| | J3370 | Vancomycin HCL, up to 500 mg | 8.11 |
| | J9360 | Vinblastine Sulfate, 1 mg | 3.38 |
| | J9370 | Vincristine Sulfate, 1 mg (Oncovin, Vincasar PFS) | 28.65 |
| | J9375 | Vincristine Sulfate, 2 mg | 34.52 |
| | J9380 | Vincristine Sulfate, 5 mg (Oncovin, Vincasar PFS) | 86.30 |
| | J3430 | Vitamin K, Phytonadione 1 mg/0.5ml | 2.60 |
| # | J2500 | Zemplar (Paricalcitol) 5 mcg | 23.83 |

# *APPENDIX – D*

## COVERED MODIFIER LIST

| Modifier | Description |
|---|---|
| **24** | Unrelated E/M, same physician during postoperative period |
| **25** | Significant, separately identifiable E/M service, same physician, same day |
| **26** | Professional component |
| **50** | Bilateral procedure |
| **51** | Multiple procedures |
| **53** | Discontinued procedures |
| **54** | Surgical care only |
| **55** | Postoperative care only |
| **57** | Decision for surgery |
| **58** | Staged or related service by same physician during postoperative period |
| **59** | Distinct procedural service |
| **62** | Two surgeons |
| **66** | Surgical team |
| **73** | Discontinued outpatient hospital or ASC procedure prior to anesthesia |
| **74** | Discontinued outpatient hospital or ASC procedure after anesthesia |
| **76** | Repeat procedure by the same physician |
| **77** | Repeat procedure by another physician |
| **78** | Return to the OR for related procedure during postoperative period |
| **79** | Unrelated procedure or service, same physician during postoperative period |
| **80** | Assistant surgeon |
| **82** | Assistant surgeon (resident is unavailable) |
| **90** | Purchased service |
| **CC** | Procedure code change |
| **E1** | Upper left eyelid |
| **E2** | Lower left eyelid |
| **E3** | Upper right eyelid |
| **E4** | Lower right eyelid |
| **F1** | Left hand, second digit |
| **F2** | Left hand, third digit |
| **F3** | Left hand, fourth digit |
| **F4** | Left hand, fifth digit |
| **F5** | Right hand, thumb |
| **F6** | Right hand, second digit |
| **F7** | Right hand, third digit |
| **F8** | Right hand, fourth digit |
| **F9** | Right hand, fifth digit |
| **FA** | Left hand, thumb |
| **FP** | Family planning |
| **LC** | Left circumflex coronary artery |
| **LD** | Left anterior descending coronary artery |
| **LT** | Left side |
| **Q6** | Service provided by locum tenens physician |
| **Q7** | One class “A” finding |
| **Q8** | Two class “B” findings |
| **Q9** | One class “B” and two class “C” findings |
| **QS** | Monitored anesthesia care service |
| **QW** | CLIA waived test |
| **RC** | Right coronary artery |
| **RT** | Right side |

| Modifier | Description |
|---|---|
| **SG** | Ambulatory surgical center (ASC) facility service |
| **T1** | Left foot, second digit |
| **T2** | Left foot, third digit |
| **T3** | Left foot, fourth digit |
| **T4** | Left foot, fifth digit |
| **T5** | Right foot, great toe |
| **T6** | Right foot, second digit |
| **T7** | Right foot, third digit |
| **T8** | Right foot, fourth digit |
| **T9** | Right foot, fifth digit |
| **TA** | Left foot, great toe |
| **TC** | Technical component |
| **YR** | Routine foot care visit |
| **YT** | Radiation therapy, treatment course ended, one or two fractions |
| **YA** | General anesthesia |

**Note:** Refer to April 1999 Medicaid Special Bulletin for further details on all modifiers listed above.

# *APPENDIX – E*

## GENERAL STATUTE (G.S.) 14-45.1 "WHEN ABORTION NOT UNLAWFUL"

General Statute (G.S.) 14-45.1 establishes further conditions that govern coverage of abortions in cases of rape or incest. This information is printed below:

a) Notwithstanding any of the provisions of G.S. 14-44 and 14-45, it shall not be unlawful during the first 20 weeks of a woman's pregnancy, to advise, procure, or cause a miscarriage or abortion when the procedure is performed by a physician licensed to practice medicine in North Carolina in a hospital or clinic certified by the Department of Health and Human Services to be a suitable facility for the performance of abortions.

b) Notwithstanding any of the provisions of G.S. 14-44 and 14-45, it shall not be unlawful, after the twentieth week of a woman's pregnancy, to advise, procure, or cause a miscarriage or abortion when the procedure is performed by a physician licensed to practice medicine in North Carolina in a hospital licensed by the Department of Health and Human Services, if there is substantial risk that continuance of the pregnancy would threaten the life or gravely impair the health of the woman.

c) The Department of Health and Human Services shall prescribe and collect on an annual basis, from hospitals or clinics where abortions are performed, such representative samplings of statistical summary reports concerning the medical and demographic characteristics of the abortions provided for in this section as it shall deem to be in the public interest. Hospitals or clinics where the abortions are performed shall be responsible for providing these statistical summary reports to the Department of Health and Human Services. The reports shall be for statistical purposes only and the confidentiality of the patient relationship shall be protected.

d) The requirements of G.S. 130-43 are not applicable to abortions performed pursuant to this section.

e) Nothing in this section shall require a physician licensed to practice medicine in North Carolina or any nurse who shall state an objection to abortion on moral, ethical, or religious grounds, to perform or participate in medical procedures which result in an abortion. The refusal of such physician to perform or participate in these medical procedures shall not be a basis for damages for such refusal, or for any disciplinary or any other recriminatory action against such physician.

f) Nothing in this section shall require a hospital or other health care institution to perform an abortion or to provide abortion services.