



North Carolina Medicaid Bulletin

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

Visit DMA on the Web at: www.dhhs.state.nc.us/dma

Attention: All Providers

Prior Approval Process for Outpatient Therapy Services

Implementation of the prior approval process for outpatient therapy services scheduled to begin on June 1, 2002, has been delayed until a future date. Providers will be notified through the general Medicaid bulletin of the new implementation date and training schedules.

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

Bold, italicized material is excerpted from the American Medical Association Current Procedural Terminology (CPT) Codes. Descriptions and other data only are copyrighted 2001 American Medical Association. All rights reserved.

Attention: All Providers

Holiday Observance

The Division of Medical Assistance (DMA) and EDS will be closed on Monday, May 27, 2002 in observance of Memorial Day.

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

Attention: Physicians and Hospitals

Emergency Medical Screening Examinations

The Emergency Medical Treatment and Labor Act (EMTALA) requires a medical screening examination to be performed when a Medicaid recipient presents to the emergency department.

Emergency services do not need to be provided in a location specifically identified as an emergency room or an emergency department. Hospitals may deem it appropriate to conduct or complete the medical screening examination in another area within the hospital. Hospitals may use areas to deliver emergency services that are also used for other inpatient or outpatient services. For example, it may be the hospital's policy to direct all pregnant women to the labor and delivery area of the hospital to receive an emergency medical screening. This is considered an acceptable practice as long as:

- all patients with the same medical condition are moved to this location
- ability to pay is not an issue
- there is a bona fide medical reason to move the patient
- qualified medical personnel accompany the patient

The physician performing the emergency medical screening examination must bill the emergency Evaluation and Management (E/M) procedure code that describes the level of service provided. Only one emergency E/M visit code is allowed per episode.

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

Attention: All Providers

Preventive Medicine Annual Health Assessments

The N.C. Medicaid program allows one preventive medicine health assessment per year for recipients 21 years of age and older. (In the Carolina ACCESS Primary Care Provider participation application, this assessment is referred to as adult preventive medicine services. This service is one of the Carolina ACCESS participation requirements for primary care providers who enroll recipients over the age of 21.)

For adults, a complete annual health assessment consists of the following required components:

- comprehensive unclothed physical examination
- comprehensive health history
- anticipatory guidance/risk factor reduction interventions
- ordering of appropriate laboratory/diagnostic procedures

Diagnosis V700 should be billed as the primary diagnosis when billing the annual adult health assessment. Providers should select a Current Procedural Terminology (CPT) Preventive Medicine Evaluation and Management (E/M) code that describes the services provided. The annual health assessment is included in the legislated 24-visit per year limit. Injectable medications and ancillary studies for laboratory and radiology **are the only** CPT codes that are separately billable when an annual health assessment is billed.

When a recipient is scheduled for an annual health assessment and an illness is detected during the screening, the provider may continue with the screening **or** bill a sick visit. The annual health assessment and sick visit cannot be billed on the same date of service.

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

Attention: Durable Medical Equipment Providers

Reimbursement Rate Correction for Code E1390

Effective with date of service January 1, 2002, the maximum monthly rental reimbursement rate for code E1390, "oxygen concentrator, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate," is \$209.50.

The rate for code E1390 was stated incorrectly in the December 2001 general Medicaid bulletin article entitled *Change in HCPCS Codes for Oxygen Concentrators* and the April 2002 general Medicaid bulletin entitled *HCPCS Code Changes*.

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

Attention: Physicians

Neonatal Intensive Care Services

Effective with date of service, June 1, 2002, the neonatal intensive care billing guidelines will change to conform with Current Procedural Terminology (CPT) guidelines. The neonatal intensive care CPT codes are:

- 99295 *Initial neonatal intensive care, per day, for the evaluation and management of a critically ill neonate or infant*
- 99296 *Subsequent neonatal intensive care, per day, for the evaluation and management of a critically ill and unstable neonate or infant*
- 99297 *Subsequent neonatal intensive care, per day, for the evaluation and management of a critically ill though stable neonate or infant*
- 99298 *Subsequent neonatal intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (less than 1500 grams)*

The neonatal intensive care CPT codes are used to report services provided per day by a physician directing the care of a critically ill newborn or managing the continuing intensive care of a very low birth weight infant. The following services are included in the global neonatal intensive care codes and should not be billed separately:

- 31500 *Intubation, endotracheal, emergency procedure*
- 36000 *Introduction of needle or intracatheter, vein*
- 36140 *Introduction of needle or intracatheter, extremity artery*
- 36420 *Venipuncture, cutdown; under age 1 year*
- 36430 *Transfusion, blood or blood components*
- 36440 *Push transfusion, blood, 2 years or under*
- 36488 *Placement of central venous catheter; percutaneous, age 2 years or under*
- 36490 *Placement of central venous catheter; cutdown, age 2 years or under*
- 36510 *Catheterization of umbilical vein for diagnosis or therapy, newborn*
- 36600 *Arterial puncture, withdrawal of blood for diagnosis*
- 36620 *Arterial catheterization or cannulation for sampling, monitoring or transfusion; percutaneous*
- 43752 *Naso- or oro-gastric tube placement, necessitating physician's skill*
- 51000 *Aspiration of bladder by needle*
- 53670 *Catheterization, urethra; simple*
- 62270 *Spinal puncture, lumbar, diagnostic*
- 94656 *Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; first day*
- 94657 *Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; subsequent days*
- 94660 *Continuous positive airway pressure ventilation (CPAP), initiation and management*
- 94760 *Noninvasive ear or pulse oximetry for oxygen saturation; single determination*
- 94761 *Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations*
- 94762 *Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring*

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Attention: All Providers

Termination of Inactive Medicaid Provider Numbers

Beginning May 2002, the Division of Medical Assistance (DMA) began terminating certain Medicaid provider numbers that do not reflect any billing activity within the previous 12 months. This action is necessary to reduce the risk of fraud and unscrupulous claims billing.

The affected providers will be notified by mail of DMA's intent to terminate their inactive Medicaid provider number and will have two weeks to respond if they wish to request that their number not be terminated. These notices will be sent to the mailing address listed in the provider's file. If the notice is returned to DMA by the U.S. Postal Service as undeliverable, the provider number will be terminated. Refer to the October 2001 general Medicaid bulletin for instructions on reporting an address change.

Once terminated, providers will be subject to the full re-enrollment process and could experience a period of ineligibility as a Medicaid provider.

This termination activity will continue on a quarterly basis with provider notices being mailed April 1, July 1, October 1, and January 1 of each year and the termination dates being effective May 1, August 1, November 1, and February 1.

Demetrae Creech, Provider Services
DMA, 919-857-4017

Attention: Mental Health Services Providers

Prior Approval and Medicare

The following article is reprinted from the March 2002 general Medicaid bulletin to correct the contact phone number. The correct contact phone number is 919-857-4020.

Prior approval is not required for Medicare covered mental health services rendered to Medicare/Medicaid dually eligible recipients when Medicare is their primary payer. Because Medicare does not require providers to request prior approval for services, it is not necessary for Medicaid providers to request authorization from ValueOptions for inpatient or outpatient services to these clients.

When Medicare is not the primary payer for services rendered by Area Mental Health Programs or their employees who are not eligible to bill Medicare, authorization must be obtained from ValueOptions in accordance with Medicaid requirements.

Carol Robertson, Behavioral Health Services
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Attention: All Providers

Unlisted CPT Codes

The N.C. Medicaid program has observed an increased frequency of claims submitted with unlisted Current Procedural Terminology (CPT) codes. As explained in the "Introduction" section of the CPT manual, providers are required to bill the CPT code that most accurately describes the service performed. If no such procedure code exists, providers are requested to bill the service using an appropriate unlisted CPT code.

The manual further explains that when an unlisted CPT code is used, the service or procedure should be described. The provider is required to send a special report to explain a service that is rarely provided, unusual, variable or new. Pertinent information in a special report should include an adequate definition or description of the nature, extent, and need for the procedure including the time, effort, and equipment necessary to provide the service. Unlisted CPT codes should only be billed after thorough research fails to reveal an existing code.

Effective with date of service June 1, 2002, claims submitted with unlisted CPT codes must be submitted to EDS on paper along with a special report and operative notes. Claims submitted without a special report and operative notes will deny. Medicaid does not reimburse for unlisted CPT codes that are billed for noncovered services or procedures, or for services that are experimental or investigational in nature. New 2002 CPT codes that are still under review should not be billed as unlisted codes.

The American Medical Association's (AMA) CPT Editorial Panel is responsible for reviewing and maintaining CPT to reflect changes in medical practice. Providers are encouraged to visit the AMA website at <http://www.ama-assn.org/cpt> for detailed information about requesting new CPT procedure codes.

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

Attention: All Providers

Fluoroscopy, CPT Code 76000

Through a recent transmittal (AB-01-167), the Centers for Medicare and Medicaid Services retracted instructions given in 2001 concerning billing the professional component of fluoroscopy code 76000. These directions were published in the November 2001 general Medicaid bulletin. Effective immediately, 76000 should be billed with modifier 26 for the professional component. Adjustments will be honored retroactive to services performed on or after January 1, 2001.

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

Attention: All Providers**E**xtracorporeal Shock Wave Lithotripsy**Procedure Code 50591 End-Dated**

Effective with date of service June 1, 2002, procedure code 50591 will be end-dated to comply with the implementation of national procedure codes as required by the Health Insurance Portability and Accountability Act of 1996. Current Procedural Terminology (CPT) code 50590 should be billed for extracorporeal shock wave lithotripsy (ESWL).

CPT Code 50590 Billing Guidelines

ESWL is covered for the disintegration of upper urinary tract stones (i.e., renal calyx stones, renal pelvic stones, and upper ureteral stones). Providers should submit claims for reimbursement using the CPT code 50590, *lithotripsy, extracorporeal shock wave*, with the appropriate place of service.

Additional claims may be submitted for a second treatment on the same date of service to disintegrate stone fragments remaining after the initial treatment. **One** of the following conditions must exist and must be documented in the medical record:

- calcium oxylate and calcium phosphate stones larger than 2 cm. in diameter
- stones greater than 3 cm. in diameter, or multiple stones with an aggregate diameter greater than 3 cm.
- uric acid or cystine stones 1.5 cm. or greater in diameter

Other treatment modalities such as percutaneous lithotripsy, dissolution therapy or conventional surgery may be used in conjunction with ESWL. When an additional surgical procedure is performed in conjunction with the initial ESWL on the same day or at the same session by the same provider, the primary procedure will be reimbursed at 100 percent and subsequent procedures will be reimbursed at 50 percent. Each subsequent procedure must be billed with modifier 51 appended.

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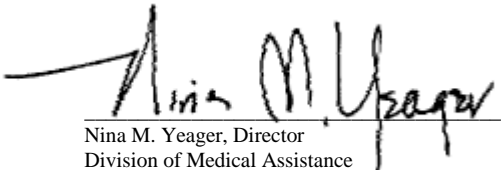
Checkwrite Schedule


May 7, 2002	June 11, 2002	July 16, 2002
May 14, 2002	June 18, 2002	July 23, 2002
May 21, 2002	June 27, 2002	July 31, 2002
May 30, 2002		

Electronic Cut-Off Schedule

May 3, 2002	June 7, 2002	July 12, 2002
May 10, 2002	June 14, 2002	July 19, 2002
May 17, 2002	June 21, 2002	July 26, 2002
May 24, 2002		

Electronic claims must be transmitted and completed by 5:00 p.m. on the cut-off date to be included in the next checkwrite. Any claims transmitted after 5:00 p.m. will be processed on the second checkwrite following the transmission date.


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