



# North Carolina Medicaid Bulletin

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

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

<u><i>In This Issue.....</i></u>	<u><i>Page #</i></u>	<u><i>In This Issue.....</i></u>	<u><i>Page #</i></u>
<b><u>All Providers:</u></b>		<b><u>Developmental Evaluation Centers:</u></b>	
◆ Anesthesia - Conversion from CPT Surgical Coding to CPT Anesthesia Coding .....	3	◆ Addition of V Code Diagnosis for Outpatient Specialized Therapies .....	13
◆ Business Associate Agreements .....	3	<b><u>Electronic Billers:</u></b>	
◆ CPT Code Update for 2002 .....	3	◆ Directions to the NCECS Seminars .....	23
◆ Directions to the Managed Care Seminars .....	23	◆ NCECS Software Seminar Schedule .....	22
◆ Electronic Funds Transfer Form .....	4	<b><u>Home Health Agencies:</u></b>	
◆ HIPAA Transaction Implementation .....	10	◆ HCPCS Code Changes for Home Health Supplies.....	26
◆ HIPAA – Questions and Answers .....	6	<b><u>Hospital Providers:</u></b>	
◆ Managed Care Seminar Schedule .....	21	◆ New Patient Status Codes.....	28
◆ Progesterone, per 50 mg (HCPCS Code J2675) – Coverage Reinstated.....	12	<b><u>Independent Practitioners:</u></b>	
◆ Proposed Medical Coverage Policies.....	4	◆ Addition of V Code Diagnosis for Outpatient Specialized Therapies .....	13
◆ Severe Acute Respiratory Syndrome Assessment .....	2	◆ Respiratory Therapists.....	28
◆ Termination of Coverage for Parenting Education ....	10	<b><u>Local Education Agencies:</u></b>	
<b><u>Ambulance Providers:</u></b>		◆ Outpatient Specialized Therapies .....	28
◆ New Ambulance Billing Guidelines .....	11	<b><u>Local Health Departments:</u></b>	
<b><u>Ambulatory Surgical Centers:</u></b>		◆ Addition of V Code Diagnosis for Outpatient Specialized Therapies .....	13
◆ ADA Procedure Codes Must be Billed with the “D” Prefix .....	12	◆ ADA Code Updates for the Year 2003 and the New Dental Claim Form .....	15
<b><u>Area Mental Health Centers:</u></b>		<b><u>Mecklenburg County Providers:</u></b>	
◆ Addition of V Code Diagnosis for Outpatient Specialized Therapies.....	13	◆ Injectable Drug Clarification.....	27
<b><u>At-Risk Case Management:</u></b>		<b><u>Physician Services:</u></b>	
◆ HIPAA Code Conversion for Case Management Services for Adults and Children at Risk of Abuse, Neglect or Exploitation .....	12	◆ Addition of V Code Diagnosis for Outpatient Specialized Therapies .....	13
<b><u>Community Alternatives Program Case Managers:</u></b>		<b><u>Private Duty Nursing Providers:</u></b>	
◆ HCPCS Code Changes for Home Health Supplies.....	26	◆ HCPCS Code Changes for Home Health Supplies.....	26
<b><u>Dental Providers:</u></b>			
◆ ADA Code Updates for the Year 2003 and the New Dental Claim Form .....	15		
◆ Dental Rate Change .....	13		

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

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## Attention: All Providers

# Severe Acute Respiratory Syndrome Assessment

The following memo was issued by Jeffrey Engel, M.D., State Epidemiologist on April 24, 2003 to all North Carolina health care providers.

As the worldwide SARS epidemic unfolds, it has become clear that SARS has entered into the differential diagnosis of all patients presenting with an acute febrile illness associated with respiratory tract symptoms. This memorandum is to help clinicians rule out SARS quickly in their early assessment of patients. The intention is to streamline activities associated with the evaluation of acutely ill patients and to protect the public health.

The definition for a suspected case of SARS is:

- A measured temperature > 100.4°F (38°C) AND
- Respiratory symptoms of cough and/or shortness of breath PLUS
- Onset of symptoms within the past 10 days of travel to a region where community transmission of SARS has occurred\* OR close contact to a suspected SARS case.

It is also important to know what exposures are NOT considered risk factors for SARS including:

- Domestic or international airplane travel in and of itself is not a risk factor.
- Travel in a compartment near a person who is coughing.
- Being in a crowd of people.

Thus, the vast majority of people presenting with the nonspecific clinical syndrome can have SARS rapidly ruled out because of the lack of a consistent exposure history. An acute febrile syndrome with or without atypical pneumonia is a common presentation with multiple etiologies, but without the proper exposure history, SARS need not be entertained as a possible cause.

Laboratory testing for SARS remains experimental, but validated tests should be available in the coming weeks. These tests include acute and convalescent (>21 days after symptom onset) serology, and PCR and viral culture of respiratory specimens (NP/OP swab, tracheal aspirate, BAL, etc.) all performed at the CDC. These tests, however, are only indicated in suspected SARS cases and will not be done unless case definition is met and a CDC case number has been assigned.

If a patient appears to meet case definition, immediately notify your hospital infection control staff or your local health department. The health department will assist you with completion of the CDC intake form (the process required to obtain a CDC case number), disease investigation, contact tracing, and infection control measures. The State SARS Public Health Command Center is available 24 hours a day 7 days a week, and can be reached at (919) 715-0988. As a final resource, the CDC Emergency Operation Center can be reached at (770) 488-7100.

\* As of April 24, 2003, these regions are Hong Kong, China, Singapore, Hanoi, and Toronto. Check the CDC website ([www.cdc.gov](http://www.cdc.gov)) frequently for updates.

**Public Health Command Center**  
**919-715-0988**

Attention: All Providers

## Anesthesia – Conversion from CPT Surgical Coding to CPT Anesthesia Coding

In the January 2003 general Medicaid Bulletin, providers were instructed to begin using CPT anesthesia codes beginning June 1, 2003. The implementation date has been changed to October 1, 2003. After that date, anesthesia services must be billed with CPT anesthesia codes. Claims submitted for anesthesia services billed with surgical codes after October 1, 2003 will be denied.

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

Attention: All Providers

## Business Associate Agreements

The Division of Medical Assistance has reviewed the provisions of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and determined that the relationship between the N.C. Medicaid program and enrolled N.C. Medicaid providers does not require a business associate agreement in order to comply with the HIPAA privacy regulations.

According to information posted on the U.S. Department of Health and Human Services' Office for Civil Rights (OCR) website, "Generally, providers are not business associates of payers." Health plans (payers) and those providers who conduct transactions electronically are defined as covered entities. If the only relationship between the health plan (payer) and the provider is one where the provider submits claims for payment to the health plan, then the provider is not a business associate of the health plan. Each covered entity is acting on its own behalf when a provider submits a claim to a health plan, and when the health plan assesses and pays the claim.

**Therefore, business associate agreements are not required between providers and DMA or EDS.**

The OCR is responsible for the implementation and enforcement of the HIPAA privacy regulations. Compliance information and assistance is available from the OCR website at <http://www.hhs.gov/ocr/hipaa/> or by contacting your provider association.

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

Attention: All Providers

## CPT Code Update for 2002

The Division of Medical Assistance has completed its review of the 2002 CPT codes. EDS is in the process of making the necessary system changes to allow the codes to be billed. Updates on covered CPT codes will be available in May on DMA's website at <http://www.dhhs.state.nc.us/dma/prov.htm>. A complete list of covered codes will be published in a future general Medicaid bulletin.

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

## Attention: All Providers

### Proposed Medical Coverage Policies

In accordance with Session Law 2001-424, Senate Bill 1005, proposed new or amended Medicaid medical coverage policies are available for review and comment on DMA's website at <http://www.dhhs.state.nc.us/dma/mp/proposedmp.htm>. To submit a comment related to a policy, refer to the instructions on the website. Providers without Internet access can submit written comments to the address listed below.

Darlene Creech  
Medical Policy Section  
Division of Medical Assistance  
2511 Mail Service Center  
Raleigh, NC 27699-2511

The initial comment period for each proposed policy is 45 days. An additional 15-day comment period will follow if a proposed policy is revised as a result of the initial comment period.

**Darlene Creech, Medical Policy Section**  
**DMA, 919-857-4020**

## Attention: All Providers

### Electronic Funds Transfer Form

Providers are reminded to use the following fax number when submitting the Electronic Funds Transfer (EFT) Authorization Agreement for Automatic Deposit forms to the EDS Financial Unit: 919-816-4399.

EDS offers EFT as an alternative to paper checks. This service enables Medicaid payments to be automatically deposited in the provider's bank account. EFT guarantees payment in a timely manner and prevents checks from being lost or stolen.

To initiate the automatic deposit process, providers are required to complete and return an EFT form. To confirm the provider's account number and bank transit number, a voided check must be attached to the form. A separate EFT form and voided check must be submitted for each provider number. Providers must also submit a new EFT form and voided check if they change banks or bank accounts. A copy of the form is on page 4 or can be obtained on DMA's website at <http://www.dhhs.state.nc.us/dma/forms.html>.

Completed forms may be faxed to the number listed above or mailed to the address listed on the form.

**Note:** Providers will continue to receive paper checks for two checkwrite periods before automatic deposit begins or resumes to a new bank account. Providers may verify that the EFT process for automatic deposit has been completed by checking the top left corner of the last page of their Remittance and Status Report, which will indicate **EFT number** rather than **check number**.

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

### Electronic Funds Transfer (EFT) Authorization Agreement for Automatic Deposit

Electronic Data Systems (EDS) offers Electronic Funds Transfer (EFT) as an alternative to paper check issuance. This service will enable you to receive your Medicaid payments through automatic deposit at your bank while you continue to receive your Remittance and Status Report (RA) at your current mailing address. This process will guarantee payment in a timely manner and prevent your check from being lost through the mail.

To ensure timely and accurate enrollment in the EFT program, please fill out the form on this page, attach a voided check, and return it by mail or fax to:

**EDS, 4905 Waters Edge, Raleigh, NC, 27606**  
**Or**  
**Fax: 919-816-4399, Attention: Finance-EFT**

EDS will run a trial test between our bank and yours. This test will be done on the first checkwrite you are paid after we receive this form. After that, your payments will go directly to your bank account. Your RA will continue to come through the mail. On the last page of your RA, in the top left corner, it will state "EFT number", rather than "Check number", when the process has begun. Contact EDS Provider Services at 1-800-688-6696 with any questions regarding EFT.

Thank you for your cooperation in making this a smooth transition to EFT, and for helping us to make the Medicaid payment process more efficient for the Medicaid provider community.

Your Name 123 Any Street Anytown, USA 12345	0101
Pay to the Order of	Date
_____	\$ <input type="text"/>
_____ Dollars	
Bank of Anytown Anytown, USA	
For _____	VOID SIGNATURE _____
12345678 1111111 011	

**\*ONE EFT REQUEST FORM PER PROVIDER NUMBER**

We hereby certify this checking or savings account is under our direct control and access; therefore, we authorize Electronic Data Systems to initiate credit entries to our checking or savings account indicated below and the bank name below, hereafter called BANK

BANK NAME \_\_\_\_\_

BRANCH ADDRESS \_\_\_\_\_

BANK TRANSIT/ROUTING NO. \_\_\_\_\_

ACCOUNT NO. \_\_\_\_\_

CHECKING OR SAVINGS \_\_\_\_\_

**This authority is to remain in full force and effect until EDS has received written notification from us of its termination in such time and in such a manner as to afford EDS a reasonable opportunity to act on it.**

PROVIDER NAME \_\_\_\_\_

BILLING PROVIDER NUMBER \_\_\_\_\_

DATE \_\_\_\_\_ SIGNED \_\_\_\_\_

Please list a name and telephone number of someone to contact with questions EDS may have on initiating this automatic deposit.

CONTACT \_\_\_\_\_ TELEPHONE NUMBER \_\_\_\_\_

**⚡ A VOIDED CHECK MUST BE ATTACHED FOR EACH BANK ACCOUNT IN ORDER FOR US TO PROCESS YOUR EFT.**

## Attention: All Providers

# H

## Health Insurance Portability and Accountability Act – Questions and Answers

The Division of Medical Assistance (DMA) is committed to implementing all of the regulations introduced as a result of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This commitment is reflected in the following bulleted mission statement:

- DMA's mission is to comply with HIPAA legislation regarding the use of standard transactions and the replacement of local code sets with national code sets, and
- DMA has deemed that no Medicaid covered services will be eliminated as a result of this legislation, and
- DMA further commits to implementing changes resulting from HIPAA without disruption to the daily operation of the Medicaid program, and
- DMA is likewise committed to implementing the provisions of the Privacy Rule.

DMA also strives to communicate HIPAA information, as it pertains to N.C. Medicaid, to the provider community. In addition to bulletin articles, such as this article on frequently asked questions, information regarding N.C. Medicaid's HIPAA effort may be found on DMA's website at <http://www.dhhs.state.nc.us/dma/hipaa.htm>.

### General Questions

#### 1. Who is responsible for training providers about HIPAA?

Each provider must assess his/her business practice and implement necessary changes to comply with the regulations introduced as a result of HIPAA. Each provider is responsible for ensuring that his/her staff, vendors, clearinghouse, and other associates are HIPAA compliant.

Training offered by the N.C. Medicaid program will be limited to the new web-based versions of the North Carolina Electronic Claims Submission (NCECS) tool. This training will be available to the providers currently using NCECS software to bill Medicaid electronically and to providers who choose to begin using the new software to bill electronically. (See page 23 for seminar information.)

All other change to the Medicaid program that are implemented as a result of HIPAA regulations will be communicated as necessary to provider through the general Medicaid bulletin and special bulletins.

#### 2. How will providers be notified of changes in the NC Medicaid program?

Specific changes implemented by N.C. Medicaid to comply with HIPAA regulations will be published in future Medicaid bulletins on DMA's website at <http://www.dhhs.state.nc.us/dma/bulletin.htm>.

General information about HIPAA, including the federal regulations, implementation deadlines, and transaction standards can be accessed online at <http://www.hhs.gov> and <http://www.cms.gov>.

#### 3. Is there one final rule regarding transactions and codes set for health plans and providers?

Yes. The initial rule, known as the HIPAA Transaction and Code Set Final Rule, was published August 17, 2000 in the Federal Register and applies to all covered entities. The rule (CFR 160 and 162) can be accessed at [http://www.access.gpo.gov/su\\_docs](http://www.access.gpo.gov/su_docs).

Addenda to the Final Rule, adopting changes to the HIPAA Electronic Transactions and Code Set Standards, was published in the Federal Register on February 20, 2003. These addenda modified a number of the electronic transactions and code sets adopted as national standards under HIPAA. The addenda can be found at <http://www.cms.hhs.gov/hipaa>. The modifications are published as Addenda to the ASC X12N Implementation Guides and are available through Washington Publishing Company at [www.wpc-edi.com](http://www.wpc-edi.com).

**4. What is the compliance deadline for the standard transactions and code sets regulation?**

According to regulation, the deadline to implement the HIPAA electronic transaction and code set standards is October 16, 2002, unless an extension was filed with the Centers for Medicare and Medicaid Services (CMS). The N.C. Department of Health and Human Services HIPAA Office filed for an extension on behalf of the N.C. Medicaid program.

**5. When will the N.C. Medicaid program be HIPAA compliant for electronic transactions and code sets?**

N.C. Medicaid plans to receive and respond to all HIPAA transactions by August 1, 2003.

Currently, N.C. Medicaid has implemented the ASC X12N 270/271 004010X092, Eligibility Benefit Inquiry/Response; ASC X12N 278 004010X094, Request for Services; and ASC X12N 834 004010X095, Benefit Enrollment and Maintenance transactions. Criteria set forth in the HIPAA Addenda regarding these transactions will be implemented by October 16, 2003.

Please pay close attention to future Medicaid bulletins and to DMA's HIPAA webpage at <http://www.dhhs.state.nc.us/dma/prov.htm> for additional information regarding implementation.

**6. Will HIPAA make claim submissions to other state Medicaid programs easier?**

The purpose of the administrative simplification provision of HIPAA is to standardize the electronic data interchange in the health care industry overall. Because there are over 400 different electronic claim formats within the health care industry, HIPAA standards will create a more uniform mechanism for electronic data interchange. However, some health care plans, including Medicaid and Medicare, may still require situational data elements that other health plans do not require. Each health care plan will still direct their medical policy and billing requirements.

**7. Will billing requirements change?**

Medical policies will not change due to HIPAA requirements but how providers bill for a certain service may change. HIPAA regulations will allow health care plans and payers significant flexibility in how they administer programs. As stated in DMA's HIPAA Mission Statement: "DMA has deemed that no Medicaid covered services will be eliminated as a result of this legislation." HIPAA does, however, mandate the elimination of local codes, which N.C. Medicaid uses for some services. Providers will be notified of changes to billing guidelines through Medicaid bulletins.

**8. Will providers be required to submit claims electronically or can we continue to submit paper claims?**

Paper claims will continue to be accepted by N.C. Medicaid. However, providers are encouraged to use electronic claims submission and electronic remittance advice (ERA) receipt for expedient claims processing. HIPAA does not require providers to submit claims electronically to Medicaid. However, providers may be required to file Medicare claims electronically. Please contact your Medicare agent for more information.



**9. Will the CMS-1500 (HCFA-1500) claim form become obsolete? What about other claim forms currently accepted by N.C. Medicaid?**

Because HIPAA regulations only apply to electronic transactions, the paper versions of the CMS-1500, ADA-1999 version 2000, and the UB-92 claim forms can still be submitted to N.C. Medicaid for payment. However, N.C. Medicaid encourages providers to submit claims electronically.

**10. Does HIPAA affect providers who file 100 percent of their claims on paper?**

No. The electronic transaction standards regulation does not apply to providers who file all of their claims on paper. The regulation only applies to the electronic data interchange.

However, billing codes may change as a result of the requirement to implement national standard codes such as ICD-9-CM, CPT-4, CDT, NDC, and HCPCS. Code conversions are published in the general Medicaid bulletins.

**11. Will providers be required to submit prior approval (PA) requests electronically or can we continue to submit paper PA request forms?**

Although this transaction supports an electronic mechanism for requesting PA, N.C. Medicaid will still require paper supporting documentation for PA requests. The electronic prior authorization transaction lacks the medical necessity information necessary for N.C. Medicaid to render a medical decision for the request. Therefore, providers must continue to provide the appropriate PA form in order to provide the medical information necessary to render a decision. N.C. Medicaid will accept the electronic prior authorization transactions and provide a response advising the provider of the appropriate documentation necessary for a decision.

**12. Will the Automated Voice Response (AVR) system still be available after October 16, 2003?**

Yes. Providers will be notified through Medicaid bulletins of the AVR access changes and changes in the information that is available through AVR.

**13. What is taxonomy?**

The provider taxonomy is a code set that codifies provider type and provider area of specialization for all medical related providers. The National Uniform Claim Committee maintains the taxonomy code set. A provider may have more than one taxonomy code, depending on the provider's area of specialization. The taxonomy code is an **optional** data element on the 837 institutional claim, 837 professional claim, and 837 dental claim transactions. The taxonomy is not a unique number per provider. A full provider taxonomy code set can be found at <http://www.wpc-edi.com>.

**14. What is WEDI?**

WEDI is the acronym for Workgroup for Electronic Data Interchange. WEDI works with the implementation of electronic data interchange in the health care industry. For more information, visit their website at <http://wedi.org/>.

## **Coding**

**1. Will local codes be eliminated?**

To comply with the implementation of HIPAA transaction and code set standards, N.C. Medicaid will convert all local codes to standard national codes. Providers are notified of code conversions through Medicaid bulletins.



**Remittance Advice****1. What is the difference between the electronic remittance advice (ERA) and the paper remittance advice (RA)?**

The ERA consists of two transactions: the 835 claim payment/advice transaction and the 277 pending (unsolicited) claim status transaction. These two transactions provide information on paid claims, adjusted claims, refunds, and pending claims payments. The ERA transactions and the 277 unsolicited claims status are intended to be used as an aid to account balancing and direct posting to patient accounts. The unsolicited claim status transaction is not a HIPAA-mandated transaction. Providers are not mandated to implement this transaction. However, if a provider elects to receive an 835 transaction, the 277 transaction will be created automatically for that provider when there are pending claims on file. Providers may elect to ignore the unsolicited 277.

The paper RA also provides information on claims payment but includes a greater level of detail on claim denials. All providers will continue to receive the paper version of the RA, even if they choose to receive the ERA transactions.

**2. Will the EOB codes on the ERA be the same as the EOB codes on the paper RA?**

N.C. Medicaid will implement the use of the standard Claims Adjustment Reason Code set, Remittance Remark Code set, Claim Status Category Code set, and Claim Status Code set for the ERA transactions as mandated by HIPAA. The EOBs currently used for paper RAs will not change. The AVR system will continue to provide explanations for paper EOB codes.

**Claims Software Vendors and Clearinghouses****1. What is the process for providers who work with a clearinghouse?**

The health care clearinghouse must comply with the standards outlined in the August 17, 2000 rule. There are additional requirements found in 45 CFR 162.923 (c) (1-2) and 45 CFR 162.930 that are specific to clearinghouses. Requirements for covered entities are outlined in 45 CFR 162.923. Because a clearinghouse is contracted by a provider to act as their agent, it is the provider's responsibility to verify that the clearinghouse is HIPAA compliant.

**2. Will providers be held liable if their clearinghouse or billing agent is not compliant with the HIPAA transaction and code set standards regulation by October 16, 2003?**

For questions regarding legal liability, please contact the Centers for Medicare and Medicaid Services (CMS). Their website is <http://www.cms.gov>.

**3. Is N.C. Medicaid working with software companies and clearinghouses to ensure that they are HIPAA compliant? How will vendors and clearinghouses be notified of what changes are necessary?**

It is the provider's responsibility to ensure that their software or clearinghouse is HIPAA compliant.

The X12N transaction HIPAA implementation guides are available on the Washington Publishing Company's website at <http://www.wpc-edi.com>. Consult the NCPDP website at <http://www.ncpdp.org> for the NCPDP transaction standards for retail pharmacy services.

**4. What is a trading partner agreement and how does it affect me?**

As defined in § 160.103 of the Transaction and Code Sets final rule, a trading partner agreement is defined as an agreement related to the exchange of information in electronic transactions, whether the agreement is distinct or part of a larger agreement, between each party to the agreement. (For example, a trading partner agreement may specify, among other things, the duties and responsibilities of each party to the agreement in conducting a standard transaction.)

Providers who conduct electronic transactions with N.C. Medicaid will either need to enter into a trading partner agreement directly with N.C. Medicaid or through their clearinghouse depending on how they submit electronic transactions. The trading partner agreement for N.C. Medicaid contains information regarding testing, what type of transactions will be exchanged, and protocol information for the exchange of those transactions.

**5. When will testing with providers begin?**

The projected time to begin testing directly with N.C. Medicaid is June 2003. In lieu of testing directly with N.C. Medicaid, providers may test with a third party certification service. Once certification information is on file with N.C. Medicaid, providers will have the capability to submit and receive HIPAA compliant transactions.

For more information regarding third party certification, please refer to the WEDI/SNIP Testing and Certification white paper at <http://snip.wedi.org>.

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

Attention: All Providers

## Health Insurance Portability and Accountability Act Transaction Implementation

In October 2002, the N.C. Medicaid program implemented the following Health Insurance Portability and Accountability Act (HIPAA) electronic transactions:

- ASC X12N 270/271, Eligibility Benefit Inquiry/Response Transaction
- ASC X12N 278, Request for Services Transaction

If you are interested in submitting either of these transactions, please contact the EDS Electronic Commerce Services Department at 1-800-688-6696, option 1.

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

Attention: All Providers

## Termination of Coverage for Parenting Education

Effective with date of service June 30, 2003, Parenting Education (W8205) will be discontinued. The N.C. Medicaid program will no longer cover this service.

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

## Attention: Ambulance Providers

### New Ambulance Billing Guidelines

Effective with date of service May 31, 2003, the N.C. Medicaid program will end-date the following codes to comply with the Health Insurance Portability and Accountability Act (HIPAA): Y0050, Y0060, Y0070, Y0002, Y0003, Y0004, and Y0001. Providers must bill the replacement codes listed in the following table, effective with date of service June 1, 2003. **The N.C. Medicaid program reimburses according to the level of care provided to the recipient. Call Reports must validate the level of care provided to the recipient.**

Old Code	Description	New Code	Description
Y0050	Helicopter, per nautical mile	A0436	Rotary wing air mileage, per statute mile
Y0060	Fixed wing, lift off	A0430	Ambulance service, conventional air services, transport, one-way (fixed wing)
Y0070	Fixed wing, per nautical mile	A0435	Fixed wing air mileage, per statute mile
Y0001	Non-emergency transport, round-trip	T2003	Non-emergency transportation, encounter/trip (round-trip)
Y0002	State-to-state placement, base rate one-way, prior approval required	RC 549	Ambulance/other (state-to-state), prior approval required*
Y0003	Fixed wing, lift off, state-to-state placement, prior approval required		
Y0004	Helicopter, lift off, state-to-state placement, prior approval required		

\* Beginning June 1, 2003, providers will indicate state-to-state placement by using Revenue Code 549 in conjunction with the appropriate HCPCS code indicated in this bulletin article or the article in the December 2002 general Medicaid bulletin article (available on DMA's website at <http://www.dhhs.state.nc.us/dma/bulletin.htm>). Prior approval is required for state-to-state transport.

#### Fixed Wing Air Ambulance

**Definition:** Fixed Wing (FW) air ambulance is transportation by FAA-certified FW aircraft providing medically necessary services and supplies.

#### Rotary Wing Air Ambulance

**Definition:** Rotary Wing (RW) air ambulance is transportation by FAA-certified helicopter providing medically necessary supplies and services.

#### Round Trip

**Definition:** Round trip is non-emergency transportation by ambulance from point of pick-up to destination and return to point of pick-up on the same day by the same provider. If the ambulance remained in the vicinity of the destination, did not return to base, and did not respond to other calls for transport, a round trip should be billed.

#### Point of Pick-Up

**Definition:** Point of Pick-Up is the location of the recipient at the time he/she is placed on board the ambulance.

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

## Attention: Ambulatory Surgical Centers

### ADA Procedure Codes Must be Billed with the "D" Prefix

Effective with dates of service October 1, 2003, all dental procedure codes must be billed with the "D" prefix (such as D0120, D0150, etc) for electronic and paper claims. Dental ADA procedure codes will not be accepted with the numeric zero prefix after September 30, 2003. Services billed using the numeric zero prefix procedure codes will deny with the explanation of benefit (EOB) message 0024, which states: "Procedure code, procedure/modifier combination or revenue code is missing, invalid, or invalid for this bill type. Correct and rebill denied detail as a new claim."

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

## Attention: All Providers

### Progesterone, per 50 mg (HCPCS Code J2675) – Coverage Reinstated

The N.C. Medicaid program has reinstated the code for progesterone, J2675, for use in the Physician's Drug Program effective with dates of service January 1, 2003 and after. Previous billing guidelines apply.

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

## Attention: At-Risk Case Management

### HIPAA Code Conversion for Case Management Services for Adults and Children at Risk of Abuse, Neglect or Exploitation

To comply with the implementation of national code sets mandated by the Health Insurance Portability and Accountability Act (HIPAA), it is necessary to end-date all N.C. Medicaid state-created (local) codes and convert to national codes. Effective with date of service May 31, 2003, local code Y2321 for at-risk services to adults and local code Y2322 for at-risk services to children will be end-dated. Effective with date of service June 1, 2003, providers must submit national code T1017 for all at-risk services. T1017 will be the only billable code for services provided to either adults or children. This change applies to both paper and electronic claim formats.

Please continue to use the CMS-1500 claim form (formerly HCFA-1500). T1017 must be indicated in the same, block 24D, on the claim form as the previous "Y" codes. Continue to indicate diagnosis code V65.8 in block 21 on the claim form.

**Bill Hottel, Adult Care Home Services Unit, Medical Policy Section  
DMA, 919-857-4020**

## Attention: Area Mental Health Centers, Developmental Evaluation Centers, Independent Practitioners, Local Health Departments, and Physician Services

### Addition of V Code Diagnosis for Outpatient Specialized Therapies

All claims for physical therapy, occupational therapy, respiratory therapy, and speech therapy – including claim adjustments and resubmitted claims – submitted for billing June 1, 2003 or after, must include one of the discipline-specific ICD-9-CM diagnosis codes listed below as a secondary diagnosis on the claim. This allows EDS to correctly accrue the units billed for each specialized therapy authorized during the prior approval process.

- V57.0 – Respiratory Therapy
- V57.1 – Physical Therapy
- V57.2 – Occupational Therapy
- V57.3 – Speech Therapy

This does not change the requirement to bill the primary diagnosis that justifies the need for the specialized therapy. **Remember: The primary treatment ICD-9-CM diagnosis code must be entered first on the claim form. The discipline-specific V code should follow the primary treatment code.**

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

## Attention: Dental Providers (Excluding Health Departments)

### Dental Rate Change

Effective with dates of services April 1, 2003 the following dental rates are changed:

Procedure Code	Description	Rate
D0120	Periodic Oral Evaluation	\$ 27.01
D0140	Limited Oral Evaluation - Problem Focused	35.77
D0150	Comprehensive Oral Evaluation	52.56
D0220	Intraoral-Periapical - First Film	13.14
D0230	Intraoral-Periapical - Each Additional Film	11.68
D0240	Intraoral Occlusal Film	14.60
D0272	Two Bitewing X-rays	17.52
D0274	Four Bitewings for 13 Years of Age and Older	31.39
D0330	Panoramic Film	57.67

<b>Procedure Code</b>	<b>Description</b>	<b>Rate</b>
D1351	Pit and Fissure Sealant per Tooth	\$ 29.93
D1510	Space Maintainer – Fixed - Unilateral	208.05
D1515	Space Maintainer - Fixed - Bilateral	418.29
D2110	Amalgam - One Surface, Primary	56.21
D2120	Amalgam - Two Surfaces, Primary	74.46
D2140	Amalgam - One Surface, Permanent	62.78
D2150	Amalgam - Two Surfaces, Permanent	77.38
D2160	Amalgam - Three Surfaces, Permanent	91.25
D2330	Composite Resin - One Surface Restoration	62.78
D2331	Composite Resin - Two Surfaces Restoration	77.38
D2332	Composite Resin 3 - Surfaces Restoration	91.25
D2335	Composite Resin 4 - or More Surfaces	116.07
D2380	One Surface Resin, Primary Molar	73.00
D2381	Two Surface Resin, Primary Molar	109.50
D2385	Resin - One Surface, Posterior - Permanent	77.38
D2386	Resin-Two Surfaces, Posterior - Permanent	116.07
D2930	Prefabricated Stainless Steel Crown, Primary	127.75
D2933	Prefabricated Stainless Steel Crown, Resin Window	\$ 181.77
D2940	Fillings (Sedative)	77.38
D3220	Vital Pulpotomy	78.11
D4341	Periodontal Scaling and Root Planning per Quadrant	78.11
D7110	Extraction Single Tooth	51.10
D7120	Tooth Extraction Each Additional	48.91
D7210	Surgical Extraction of Tooth, Erupted	78.11
D7230	Removal of Impacted Tooth - Partial Bony	154.76
D9230	Analgesia	52.56
D9420	Hospital Call	113.88

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

## Attention: All Dental Providers and Health Department Dental Clinics

### ADA Code Updates for the Year 2003 and the New Dental Claim Form

In January 2003, the American Dental Association (ADA) updated the ADA claim form and the Current Dental Terminology (CDT-4) Users Manual. DMA and EDS are currently implementing system changes to comply with the new codes and claim form.

#### ADA Procedure Codes Must be Billed with the “D” Prefix

Effective with dates of service October 1, 2003, all dental procedure codes must be billed with the “D” prefix (such as D0120, D0150, etc) for electronic and paper claims. Dental ADA procedure codes will not be accepted with the numeric zero prefix after September 30, 2003. Services billed using the numeric zero prefix procedure codes will deny with the explanation of benefit (EOB) message 0024, which states: “Procedure code, procedure/modifier combination or revenue code is missing, invalid, or invalid for this bill type. Correct and rebill denied detail as a new claim.”

#### Procedure Code Updates

Updates to the CDT-4 contain procedure code deletions, procedure code additions, and revised procedure code descriptions. The N.C. Medicaid Dental Program will implement the changes listed in the following tables. The following codes will be **end-dated** effective with dates of service after **September 30, 2003**.

Procedure Code	Description
D0501	Histopathologic examinations
D2110	Amalgam-one surface, primary
D2120	Amalgam-two surfaces, primary
D2130	Amalgam-three surfaces, primary
D2131	Amalgam-four or more surfaces, primary
D2336	Resin-based composite crown-anterior-primary
D2380	Resin-based composite-one surface, posterior-primary
D2381	Resin-based composite-two surfaces, posterior-primary
D2385	Resin-based composite-one surface, posterior-permanent
D2386	Resin-based composite-two surfaces, posterior- permanent
D2387	Resin-based composite-three surfaces, posterior- permanent
D2388	Resin-based composite-four or more surfaces, posterior- permanent
D7110	Single tooth
D7120	Each additional tooth
D7130	Root removal-exposed roots
D7420	Radical excision-lesion diameter greater than 1.25 cm
D7430	Excision of benign tumor-lesion diameter up to 1.25
D7431	Excision of benign tumor-lesion diameter greater than 1.25



**Note:** All end-dated codes will be replaced with new codes or revised codes.

The following codes will be **added** effective with dates of service **October 1, 2003**.

<b>Procedure Code</b>	<b>Description</b>
D2390	Resin-based composite crown-anterior
D2391	Resin-based composite-one surface, posterior
D2392	Resin-based composite-two surfaces, posterior
D2393	Resin-based composite-three surfaces, posterior
D2394	Resin-based composite-four or more surfaces, posterior
D6985	Pediatric partial denture, fixed
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7280	Surgical access of an unerupted tooth
D7411	Excision of benign lesion greater than 1.25 cm
D7472	Removal of torus palatinus
D7473	Removal of torus mandibularis
87205	Smear, primary source with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types

The following procedure code descriptions were **revised**. These new descriptions are effective with dates of service **October 1, 2003**.

<b>Procedure Code</b>	<b>Description</b>
D0150	Comprehensive oral evaluation – new or established patient
D2140	Amalgam-one surface, primary or permanent
D2150	Amalgam-two surfaces, primary or permanent
D2160	Amalgam-three surfaces, primary or permanent
D2161	Amalgam-four or more surfaces, primary or permanent
D4210	Gingivectomy or gingivoplasty-four or more contiguous teeth or bounded teeth spaces, per quadrant
D4240	Gingival flap procedure, including root planing-four or more contiguous teeth or bounded teeth spaces, per quadrant
D4341	Periodontal scaling and root planing-four or more contiguous teeth or bounded teeth spaces, per quadrant
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis
D4910	Periodontal maintenance
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7410	Excision of benign lesion up to 1.25 cm
D7450	Removal of benign odontogenic cyst or tumor-lesion diameter up to 1.25 cm
D7451	Removal of benign odontogenic cyst or tumor-lesion diameter greater than 1.25 cm

Procedure Code	Description
D7460	Removal of benign nonodontogenic cyst or tumor-lesion diameter up to 1.25 cm
D7461	Removal of benign nonodontogenic cyst or tumor-lesion diameter greater than 1.25 cm
D7471	Removal of lateral exostosis (maxilla or mandible)
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone
D7670	Alveolus-closed reduction, may include stabilization of teeth
D7770	Alveolus-open reduction stabilization of teeth
D9220	Deep sedation/general anesthesia-first 30 minutes
D9221	Deep sedation/general anesthesia-each additional 15 minutes
D9241	Intravenous conscious sedation/analgesia- first 30 minutes
D9242	Intravenous conscious sedation/analgesia- each additional 15 minutes

#### Clarification of Policy and Criteria Due to Procedure Code Revisions and Additions

Code	Description	Criteria
D0150	Comprehensive oral evaluation – new or established patient	This is allowed as the <b>initial exam</b> once per provider for each recipient.
D2390	Resin-based composite crown, anterior	This is allowed for <b>primary</b> anterior teeth only (C-H, M-R, 40).
D2393	Resin-based composite-three surfaces, posterior	This is allowed for <b>permanent</b> posterior teeth only (1-5, 12-21, 28-32, 40).
D2394	Resin-based composite-four or more surfaces, posterior	This is allowed for <b>permanent</b> posterior teeth only (1-5, 12-21, 28-32, 40).
D4210	Gingivectomy or gingivoplasty-four or more contiguous teeth or bounded teeth spaces, per quadrant	At least <b>four teeth</b> must be present to qualify for a quadrant.
D4240	Gingival flap procedure, including root planing-four or more contiguous teeth or bounded teeth spaces, per quadrant	At least <b>four teeth</b> must be present to qualify for a quadrant.
D4341	Periodontal scaling and root planning-four or more contiguous teeth or bounded teeth spaces, per quadrant	If <b>seven or less</b> teeth remain per arch, use UP or LO in the tooth number or surface field.
D7471	Removal of lateral exostosis (maxilla or mandible)	This is allowed as an <b>arch</b> procedure (UP, LO).
D7472	Removal of torus palatinus	This is allowed as an <b>upper arch</b> procedure (UP).
D7473	Removal of torus mandibularis	This is allowed as a <b>lower arch</b> procedure (LO).

For a complete list of criteria specific to these procedure codes, refer to Medical Coverage Policy #4A, Dental Services (dental services provider manual) on DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm>.

**Eight-Digit Dates Required for Dental Paper Claims**

Effective October 1, 2003, all dates on the dental paper claim form must be formatted with eight digits (October 1, 2003 would be listed as 10012003). Using six digits for the date of service will no longer be accepted. Beginning October 1, 2003, dental claims that are submitted without eight-digit dates will deny as missing or invalid.

**New Dental ADA Claim Form**

DMA and EDS are currently updating the system to accept the 2002 ADA claim form. The anticipated implementation date for the new form is October 1, 2003. However, providers should continue to use the 2000 ADA claim form until the final implementation date is confirmed. Please refer to future general Medicaid bulletin for notification of the final implementation date. Once the system has been updated to accept the 2002 ADA claim form, providers will be given a three-month transition period to begin using the new form. During the transition period, both the 2000 and 2002 ADA claim form will be accepted.

A sample of the 2002 ADA claim form is available on page 19 of this bulletin. Forms can be ordered from the ADA. Listed below is the ADA address and toll-free telephone number:

American Dental Association  
Attn: Salable Materials Office  
211 E. Chicago Avenue  
Chicago, IL 60611  
1-800-947-4746

The form is available as a single or two-part form. The single form must be used when submitting claims for payment. The two-part form must be used when requesting prior approval. The original is returned to the provider and serves as the prior approval/claim copy. The second page is retained by EDS.

Review upcoming general Medicaid bulletins for exact dates and additional information regarding implementation of the 2002 ADA claim form and 2003 ADA procedure code updates.

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

**ADA Dental Claim Form**

HEADER INFORMATION																			
1. Type of Transaction (Check all applicable boxes) <input type="checkbox"/> Statement of Actual Services – OR – <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT/ Title XIX																			
2. Predetermination/Preauthorization Number					<b>PRIMARY SUBSCRIBER INFORMATION</b>														
<b>PRIMARY PAYER INFORMATION</b>																			
3. Name, Address, City, State, Zip Code																			
<b>OTHER COVERAGE</b>					12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code														
4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11)																			
5. Subscriber Name (Last, First, Middle Initial, Suffix)																			
6. Date of Birth (MM/DD/CCYY)		7. Gender <input type="checkbox"/> M <input type="checkbox"/> F		8. Subscriber Identifier (SSN or ID#)															
9. Plan/Group Number					10. Relationship to Primary Subscriber (Check applicable box) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other														
11. Other Carrier Name, Address, City, State, Zip Code																			
<b>PATIENT INFORMATION</b>					16. Plan/Group Number														
18. Relationship to Primary Subscriber (Check applicable box) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other					17. Employer Name														
19. Student Status <input type="checkbox"/> FTS <input type="checkbox"/> PTS					20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code														
21. Date of Birth (MM/DD/CCYY)					22. Gender <input type="checkbox"/> M <input type="checkbox"/> F		23. Patient ID/Account # (Assigned by Dentist)												
RECORD OF SERVICES PROVIDED																			
24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee												
1																			
2																			
3																			
4																			
5																			
6																			
7																			
8																			
9																			
10																			
MISSING TEETH INFORMATION																			
34. (Place an 'X' on each missing tooth)																32. Other Fee(s)			
35. Remarks																33. Total Fee			
AUTHORIZATIONS										ANCILLARY CLAIM/TREATMENT INFORMATION									
36. 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 prohibited by law, or 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 by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.										38. Place of Treatment (Check applicable box) <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other					39. Number of Enclosures (00 to 99) Radiograph(s) <input type="checkbox"/> Oral Image(s) <input type="checkbox"/> Model(s) <input type="checkbox"/>				
X Patient/Guardian signature _____ Date _____										40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)					41. Date Appliance Placed (MM/DD/CCYY)				
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.										42. Months of Treatment Remaining <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)					43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)				
X Subscriber signature _____ Date _____										45. Treatment Resulting from (Check applicable box) <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident					44. Date Prior Placement (MM/DD/CCYY)				
<b>BILLING DENTIST OR DENTAL ENTITY</b> (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)										<b>TREATING DENTIST AND TREATMENT LOCATION INFORMATION</b>									
48. Name, Address, City, State, Zip Code										53. 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.									
49. Provider ID										50. License Number					51. SSN or TIN				
52. Phone Number ( ) -										54. Provider ID					55. License Number				
57. Phone Number ( ) -										56. Address, City, State, Zip Code					58. Treating Provider Specialty				

SAMPLE

**General Instructions:**

The form is designed so that the Primary Payer's name and address (Item 3) is visible in a standard #10 window envelope. Please fold the form using the 'tick-marks' printed in the left and right margins. The upper-right blank space is provided for insertion of the third-party payer's claim or control number.

- a) All data elements are required unless noted to the contrary on the face of the form, or in the Data Element Specific Instructions that follow.
- b) When a name and address field is required, the full entity or individual name, address and zip code must be entered (i.e., Items 3, 11, 12, 20 and 48).
- c) All dates must include the four-digit year (i.e., Items 6, 13, 21, 24, 36, 37, 41, 44, and 53).
- d) If the number of procedures being reported exceeds the number of lines available on one claim form the remaining procedures must be listed on a separate, fully completed claim form. Both claim forms are submitted to the third-party payer.

**Data Element Specific Instructions**

- 1. **EPSDT / Title XIX** -- Mark box if patient is covered by state Medicaid's Early and Periodic Screening, Diagnosis and Treatment program for persons under age 21.
- 2. Enter number provided by the payer when submitting a claim for services that have been predetermined or preauthorized.
- 4-11. Leave blank if no other coverage.
- 8. The subscriber's Social Security Number (SSN) or other identifier (ID#) assigned by the payer.
- 15. The subscriber's Social Security Number (SSN) or other identifier (ID#) assigned by the payer.
- 16. Subscriber's or employer group's Plan or Policy Number. May also be known as the Certificate Number. [Not the subscriber's identification number.]
- 19-23. Complete only if the patient is **not** the Primary Subscriber. (i.e., "Self" not checked in Item 18)
- 19. Check "FTS" if patient is a dependent and full-time student; "PTS" if a part-time student. Otherwise, leave blank.
- 23. Enter if dentist's office assigns a unique number to identify the patient that is **not** the same as the Subscriber Identifier number assigned by the payer (e.g., Chart #).
- 25. Designate tooth number or letter when procedure code directly involves a tooth. Use area of the oral cavity code set from ANSI/ADA/ISO Specification No. 3950 'Designation System for Teeth and Areas of the Oral Cavity'.
- 26. Enter applicable ANSI ASC X12 code list qualifier: Use "**JP**" when designating teeth using the ADA's Universal/National Tooth Designation System. Use "**JO**" when using the ANSI/ADA/ISO Specification No. 3950.
- 27. Designate tooth number when procedure code reported directly involves a tooth. If a range of teeth is being reported use a hyphen (-) to separate the first and last tooth in the range. Commas are used to separate individual tooth numbers or ranges applicable to the procedure code reported.
- 28. Designate tooth surface(s) when procedure code reported directly involves one or more tooth surfaces. Enter up to five of the following codes, without spaces: **B** = Buccal; **D** = Distal; **F** = Facial; **L** = Lingual; **M** = Mesial; and **O** = Occlusal.
- 29. Use appropriate dental procedure code from current version of *Code on Dental Procedures and Nomenclature*.
- 31. Dentist's full fee for the dental procedure reported.
- 32. Used when other fees applicable to dental services provided must be recorded. Such fees include state taxes, where applicable, and other fees imposed by regulatory bodies.
- 33. Total of all fees listed on the claim form.
- 34. Report missing teeth on each claim submission.
- 35. Use "Remarks" space for additional information such as 'reports' for '999' codes or multiple supernumerary teeth.
- 36. **Patient Signature:** The patient is defined as an individual who has established a professional relationship with the dentist for the delivery of dental health care. For matters relating to communication of information and consent, this term includes the patient's parent, caretaker, guardian, or other individual as appropriate under state law and the circumstances of the case.
- 37. **Subscriber Signature:** Necessary when the patient/insured and dentist wish to have benefits paid directly to the provider. This is an authorization of payment. It does not create a contractual relationship between the dentist and the payer.
- 38. ECF is the acronym for **Extended Care Facility** (e.g., nursing home).
- 48-52. Leave blank if dentist or dental entity is **not** submitting claim on behalf of the patient or insured/subscriber.
- 48. The individual dentist's name or the name of the group practice/corporation responsible for billing and other pertinent information. This may differ from the actual treating dentist's name. This is the information that should appear on any payments or correspondence that will be remitted to the billing dentist.
- 49. Identifier assigned to Billing Dentist of Dental Entity other than the SSN or TIN. Necessary when assigned by carrier receiving the claim
- 50. Refers to the license number of the billing dentist. This may differ from that of the treating (rendering) dentist that appears in the treating dentist's signature block.
- 52. The Internal Revenue Service requires that either the Social Security Number (SSN) or Tax Identification Number (TIN) of the billing dentist or dental entity be supplied **only** if the provider accepts payment directly from the third-party payer. When the payment is being accepted directly report the: 1) SSN if the billing dentist in unincorporated; 2) Corporation TIN if the billing dentist is incorporated; or 3) Entity TIN when the billing entity is a group practice or clinic.
- 53. The treating, or rendering, dentist's signature and date the claim form was signed. Dentists should be aware that they have ethical and legal obligations to refund fees for services that are paid in advance but not completed.
- 56. Full address, including city, state and zip code, where treatment performed by treating (rendering) dentist.
- 58. Enter the code that indicates the type of dental professional rendering the service from the 'Dental Service Providers' section of the *Healthcare Providers Taxonomy* code list. The current list is posted at: <http://www.wpc-edi.com/codes/codes.asp>. The available taxonomy codes, as of the first printing of this claim form, follow printed in **boldface**.

122300000X Dentist -- A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.

Many dentists are general practitioners who handle a wide variety of dental needs.

**1223G0001X** General Practice

Other dentists practice in one of nine specialty areas recognized by the American Dental Association:

- 1223D0001X** Dental Public Health
- 1223E0200X** Endodontics
- 1223P0106X** Oral & Maxillofacial Pathology
- 1223D0008X** Oral and Maxillofacial Radiology
- 1223S0112X** Oral & Maxillofacial Surgery
- 1223X0400X** Orthodontics
- 1223P0221X** Pediatric Dentistry (Pedodontics)
- 1223P0300X** Periodontics
- 1223P0700X** Prosthodontics

## Attention: All Providers

**M**anaged Care Seminar Schedule

Managed Care seminars are scheduled for June 2003. Seminars are intended for providers who serve Carolina ACCESS, ACCESS II, and ACCESS III enrollees. Topics to be discussed will include, but are not limited to, provider enrollment requirements, recipient enrollment requirements, obtaining referrals and authorization, and new Managed Care initiatives.

Due to limited seating, preregistration is required and limited to two staff members per office. Unregistered providers are welcome to attend when reserved space is adequate to accommodate. Providers may register for the Managed Care seminars by completing and submitting the Managed Care seminar registration form on page 25, or providers can register online beginning May 1, 2003 at <http://www.dhhs.state.nc.us/dma/provsem.htm>. Seminars begin at 10:00a.m. and end at 1:00 p.m. Providers are encouraged to arrive by 9:45 a.m. to complete registration.

Providers must access and print the PDF version of May 2003 General Medicaid Billing/Carolina ACCESS Policies and Procedures Guide from DMA's website at <http://www.dhhs.state.nc.us/dma/bulletin.htm> and bring it to the seminar. The Managed Care Provider Information section of the guide will be used as the handout for this seminar.

**Tuesday, June 10, 2003**

WakeMed  
Andrews Conference Center  
3000 New Bern Ave.  
Raleigh, NC

**Wednesday, June 11, 2003**

Ramada Inn Plaza  
3050 University Pkwy.  
Winston-Salem, NC

**Tuesday, June 17, 2003**

College of the Albemarle  
Auditorium  
Elizabeth City, NC

**Thursday, June 19, 2003**

Coast Line Convention Center  
501 Nutt St.  
Wilmington, NC

**Tuesday, June 24, 2003**

Blue Ridge Community College  
Bo Thomas Auditorium  
College Dr.  
Flat Rock, NC

**Thursday, June 26, 2003**

Holiday Inn Conference Center  
530 Jake Alexander Blvd., S.  
Salisbury, NC

Directions to the Managed Care Seminars are on page 23.

The registration form for the Managed Care Seminars is on page 25.

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

## Attention: Electronic Billers

# North Carolina Electronic Claims Submission Software Seminar Schedule

The current North Carolina Electronic Claims Submission (NCECS) software obtained by providers at no cost from EDS will be replaced with a web-based version to comply with the implementation of data content standards mandated by the Health Insurance Portability and Accountability Act (HIPAA).

Seminars on the new web-based NCECS program are scheduled at the locations listed below. **Preregistration is required and limited to providers currently using NCECS and providers who choose to begin using the new web-based NCECS program.** Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

Providers may register for the NCECS seminars by completing and submitting the registration form on page 25 or by registering online beginning May 1, 2003 at <http://www/dhhs/state.nc.us/dma/provsem.htm>. Please indicate on the registration form the session you plan to attend. Seminars begin at 9:00 a.m. and end at 5:00 p.m. Providers are encouraged to arrive by 8:45 a.m. to complete registration.

**Tuesday, June 17, 2003**  
Jane S. McKimmon Center  
1101 Gorman Street  
Raleigh, NC

**Wednesday, June 18, 2003**  
Coast Line Convention Center  
501 Nutt Street  
Wilmington, NC

**Tuesday, June 24, 2003**  
Park Inn  
Gateway Conference Center  
909 US Highway 70 SW  
Hickory, NC

**Thursday, June 26, 2003**  
Ramada Inn Plaza  
3050 University Parkway  
Winston-Salem, NC

**Tuesday, July 1, 2003**  
Holiday Inn-Bordeaux  
1707 Owen Drive  
Fayetteville, NC

**Tuesday, July 8, 2003**  
Holiday Inn Conference Center  
530 Jake Alexander Blvd., S.  
Salisbury, NC

**Thursday, July 10, 2003**  
Blue Ridge Community College  
Bo Thomas Auditorium  
College Drive  
Flat Rock, NC

**Tuesday, July 15, 2003**  
College of the Albemarle  
1208 N. Road Street  
Elizabeth City, NC

**Wednesday, July 16, 2003**  
Hilton Greenville  
207 Greenville Blvd SW  
Greenville, NC

**Tuesday, July 22, 2003**  
Ramada Inn  
2703 Ramada Road  
Burlington, NC

Directions to the NCECS Seminars are on page 23.

The registration form for the NCECS Seminars is on page 25.

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



## Directions to the Managed Care Seminars and the NCECS Seminars

### ***Blue Ridge Community College, Bo Thomas Auditorium – Flat Rock, North Carolina***

Take I-40 to Asheville. Travel east on I-26 to exit 22. Turn right and then take the next right. Follow the signs to Blue Ridge Community College. Turn left at the large Blue Ridge Community College sign. The college is located on the right. Take the first right-hand turn into the parking lot for the Bo Thomas Auditorium.

### ***Coast Line Convention Center – Wilmington, North Carolina***

Take I-40 east to Wilmington. Take the Highway 17 exit. Turn left onto Market Street. Travel approximately 4 or 5 miles to Water Street. Turn right onto Water Street. The Coast Line Inn is located one block from the Hilton on Nutt Street behind the Railroad Museum.

### ***College of the Albemarle – Elizabeth City, North Carolina***

Take US 17 to the US 17 Bypass. The College of the Albemarle is located on the Bypass, next door to Albemarle Hospital.

### ***Hilton Greenville – Greenville, North Carolina***

Take Highway 264 East to Greenville. Turn right onto Allen Road in Greenville. Travel approximately 2 miles. Allen Road becomes Greenville Boulevard/Alternate 264. Follow Greenville Boulevard for 2½ miles to the Hilton Greenville, which is located on the right.

### ***Holiday Inn-Bordeaux – Fayetteville, North Carolina***

#### Traveling South on I-95

Take exit 56 to Hwy 301 to Owen Drive. Turn right at the light.

#### Traveling North on I-95

Take exit 40 to Hwy 301 to Owen Drive. Turn left at the light.

### ***Holiday Inn Conference Center – Salisbury, North Carolina***

#### Traveling South on I-85

Take exit 75. Turn right onto Jake Alexander Boulevard. Travel approximately ½ mile. The Holiday Inn is located on the right.

#### Traveling North on I-85

Take exit 75. Turn left onto Jake Alexander Boulevard. Travel approximately ½ mile. The Holiday Inn is located on the right.

### ***Jane S. McKimmon Center – Raleigh, North Carolina***

#### Traveling East on I-40

Take exit 295 and turn left onto Gorman Street. Travel approximately one mile. The McKimmon Center is located on the right on the corner of Gorman Street and Western Boulevard.

#### Traveling West on I-40

Take exit 295 and turn right onto Gorman Street. Travel approximately one mile. The McKimmon Center is located on the right between Avent Ferry Road and Western Boulevard.

***Park Inn Gateway Conference Center – Hickory, North Carolina***

Take I-40 to exit 123. Follow signs to Highway 321 North. Take the first exit (Hickory exit) and follow the ramp to the stoplight. Turn right at the light onto Highway 70. The Gateway Conference Center is on the right.

***Ramada Inn – Burlington, North Carolina***

Take I-40 to exit 143. Turn left at the first stop light onto Ramada Road. The Ramada Inn is on the right.

***Ramada Inn Plaza – Winston-Salem, North Carolina***

Take I-40 Business to the Cherry Street exit. Continue on Cherry Street for approximately 2 to 3 miles. Turn left at the IHOP Restaurant. The Ramada Inn Plaza is located on the right.

***WakeMed Andrews Conference Center – Raleigh, North Carolina***

**Driving and Parking Directions**

Take the I-440 Raleigh Beltline to exit 13A, New Bern Avenue.

Paid parking (\$3.00 maximum per day) is available on the **top two levels** of parking deck P3. To reach the parking deck, turn left at the fourth stoplight on New Bern Avenue, and then turn left at the first stop sign. Parking for oversized vehicles is available in the overflow lot for parking deck P3. Handicapped accessible parking is available in parking lot P4, directly in front of the conference center.

To enter the Andrews Conference Center, follow the sidewalk toward New Bern Avenue past the Medical Office Building to entrance E2 of the William F. Andrews Center for Medical Education. A map of the WakeMed campus is available online at <http://www.wakemed.org/maps/>.

**Illegally parked vehicles will be towed.** Parking is **not** permitted at East Square Medical Plaza, Wake County Human Services or in parking lot P4 (except for handicapped accessible parking).

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

# Managed Care Seminar Registration Form

(cut and return registration form only)

-----  
**Managed Care Seminars**  
(No Fee)

Provider Name \_\_\_\_\_ Provider Number \_\_\_\_\_

Address \_\_\_\_\_

City, Zip Code \_\_\_\_\_ County \_\_\_\_\_

Contact Person \_\_\_\_\_ E-mail Address \_\_\_\_\_

Telephone Number (\_\_\_\_) \_\_\_\_\_ Fax Number (\_\_\_\_) \_\_\_\_\_

**1** or **2** (circle one) person(s) will attend the seminar at \_\_\_\_\_ on \_\_\_\_\_

(location) (date)

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

# NCECS Seminar Registration Form

(cut and return registration form only)

-----  
**NCECS Seminar Registration Form**  
(No Fee)

Provider Name \_\_\_\_\_ Provider Number \_\_\_\_\_

Address \_\_\_\_\_

City, Zip Code \_\_\_\_\_ County \_\_\_\_\_

Contact Person \_\_\_\_\_ E-mail Address \_\_\_\_\_

Telephone Number (\_\_\_\_) \_\_\_\_\_ Fax Number (\_\_\_\_) \_\_\_\_\_

**1** or **2** (circle one) person(s) will attend the seminar at \_\_\_\_\_ on \_\_\_\_\_

(location) (date)

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

## Attention: Home Health Agencies, Private Duty Nursing Providers, and Community Alternatives Program Case Managers

### HCPCS Code Changes for Home Health Supplies

The following HCPCS codes will be end-dated effective with date of service June 30, 2003. New codes will become effective with date of service July 1, 2003.

<b>Home Health Supplies</b>				
<b>Deleted Codes</b>	<b>New Codes</b>	<b>Description</b>	<b>Billing Unit</b>	<b>Maximum Rate</b>
<b>Dressing Supplies</b>				
A4454	A4450	Tape, non-waterproof	18 sq. in.	\$ .09
K0573	A4452	Tape, waterproof	18 sq. in.	.47
A4460 A6263 A6405	A6430	Light compression bandage, elastic, knitted/woven, load resistance less than 1.25 foot pounds at 50% maximum stretch, width greater than or equal to 3 in. and less than 5 in., at least 3 yards, unstretched	Roll	1.00
A4460 A6263 A6405	A6432	Light compression bandage, elastic, knitted/woven, load resistance less than 1.25 foot pounds at 50% maximum stretch, width greater than or equal to 5 in., at least 3 yards, unstretched	Roll	1.00
A6264	A6422	Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to 3 in. and less than 5 in., at least 3 yards, unstretched	Roll	1.50
A6264	A6424	Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to 5 in., at least 3 yards, unstretched	Roll	1.50
A6406	A6426	Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to 3 in. and less than 5 in., at least 3 yards, unstretched	Roll	2.37
A6406	A6428	Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to 5 in., at least 3 yards, unstretched	Roll	2.37
<b>Ostomy Supplies</b>				
A4370	A4405	Ostomy skin barrier, non-pectin based, paste	1 oz.	\$ 3.50
A4370	A4406	Ostomy skin barrier, pectin-based, paste	1 oz.	3.50
A5123	A4407	Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, 4x4 inches or smaller	Each	4.92
A5123	A4410	Ostomy skin barrier, with flange (solid flexible or accordion) extended wear, without built-in convexity, larger than 4x4 inches	Each	4.92

## Home Health Supplies, continued

Deleted Codes	New Codes	Description	Billing Unit	Maximum Rate
<b>Catheter Supplies</b>				
A5074	<i>Not covered</i>	Pouch, urinary with face plate attached, plastic or rubber		
<b>Tracheostomy Supplies</b>				
W4153	S8189	Tracheostomy supply not otherwise classified ( <i>tracheostomy ties, twill</i> )	Each	\$ .30
<b>Miscellaneous Supplies</b>				
W4609	A4550	Surgical trays ( <i>suture removal set</i> )	Each	\$ 4.16
W4626	<i>Not covered</i>	Gowns		
W4655	T1999	Miscellaneous therapeutic items and supplies ( <i>covered supplies not elsewhere classified</i> )		
W4659	A4335	Incontinence supply, misc. ( <i>catheter care kit</i> )	Each	\$ 4.08
W4665	<i>Not covered</i>	Specimen containers		
<b>Solutions</b>				
W4666	A4321	Therapeutic agent for urinary catheter irrigation ( <i>acetic acid – 250 to 1000 cc</i> )	Bottle	\$ 7.09
<b>Intravenous Supplies</b>				
	A4657	Syringe, with or without needle ( <i>less than 20 cc</i> )	Each	\$ .31

Providers must bill their usual and customary charges.

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

## Attention: Mecklenburg County Providers

### Injectable Drug Clarification

Injectable drugs are included in the monthly capitation rates paid to HMOs. Therefore, providers must submit claims for injectable drugs directly to their HMO.

Injectable drug claims submitted to Medicaid have been returned to the HMO for processing.

This action affects claims submitted to United HealthCare through November 30, 2002, and all claims submitted to SouthCare/Coventry to date.

**Julia McCollum, Managed Care Section**  
DMA, 919-857-4022

## Attention: Local Education Agencies

### Outpatient Specialized Therapies

Please refer to the Division of Medical Assistance web page at <http://www.dhhs.state.nc.us/dma/prov.htm> for an announcement about Outpatient Specialized Therapies.

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

## Attention: Hospital Providers

### New Patient Status Codes

The National Uniform Billing Committee (NUBC) has revised the instructions for completing the UB-92 claim form to include three new patient status codes. These codes are entered in form locator 22 on the UB-92. The following patient status codes became effective January 1, 2002:

- 62 Discharged/transferred to another rehabilitation facility including rehabilitation distinct part units of a hospital.
- 63 Discharged/transferred to a long term care hospital.

The following patient status code became effective October 1, 2002:

- 64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare.

Providers may begin using these codes immediately.

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

## Attention: Independent Practitioner Providers

### Respiratory Therapists

In accordance with the North Carolina Respiratory Care Practice Act, the N.C. Medicaid State Plan has been amended to require that respiratory therapists be licensed in order to provide Medicaid reimbursed respiratory therapy services.

Medical coverage policy 8G – Independent Practitioners, has been revised to reflect this change. A copy of the revised policy is available on the Division of Medical Assistance’s website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm>.

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

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## Holiday Closing

The Division of Medical Assistance (DMA) and EDS will be closed on Monday, May 26, 2003, in observance of Memorial Day.

## Checkwrite Schedule

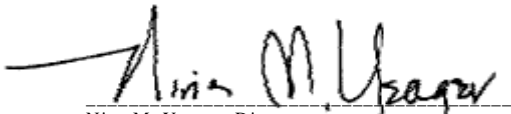
April 8, 2003	May 6, 2003	June 10, 2003
April 15, 2003	May 13, 2003	June 17, 2003
April 22, 2003	May 20, 2003	June 26, 2003
	May 29, 2003	

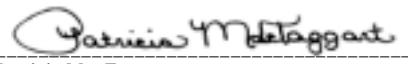
## Electronic Cut-Off Schedule

April 4, 2003	May 2, 2003	June 6, 2003
April 11, 2003	May 9, 2003	June 13, 2003
April 17, 2003	May 16, 2003	June 20, 2003
	May 23, 2003	

*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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Nina M. Yeager, Director  
Division of Medical Assistance  
Department of Health and Human Services

  
Patricia MacTaggart  
Executive Director  
EDS



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