Number 6 *June 2001*

North Carolina Medicaid Bulletin

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

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

Attention: Hospitals

Medicare Ambulance Crossover Billing

Medicaid requires hospital-based ambulances to have a separate ambulance provider number (see general Medicaid bulletin, April 1997). However, hospital-based ambulance providers should refrain from billing ambulance crossover services on paper whenever possible as a separate claim to Medicaid.

When hospital-based crossover claims are received by Medicaid via tape from Medicare, the Medicaid payment is remitted to the hospital provider number. When a hospital then submits a paper claim for the same ambulance service, duplicate payment may occur. Hospitals are required to refund the duplicate payment. To prevent this, hospitals must continue to bill ambulance services for regular Medicaid recipients (blue Medicaid identification card) using the hospital's ambulance provider number, but refrain from billing Medicare crossover ambulance services for dually eligible recipients on paper claims.

Janet Tudor, Medical Policy Section
DMA, 919-857-4020

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

Attention: Physicians

Rho (D) Immune Globulin for Intravenous Use (CPT Code 90386) – Billing Guidelines

The N.C. Medicaid program covers Rho (D) immune globulin (RhlgIV), human, for intravenous use, CPT code 90386. This product is given for the treatment of idiopathic thrombocytopenic purpura (ITP) and for the suppression of Rh isoimmunization.

Dosages may vary considerably, depending on the diagnosis. For example, for the treatment of ITP, the dosage may range from 125 to 300 international units (IU) per kilogram (kg) of body weight. To suppress Rh isoimmunization, the dosage usually ranges from 600 IU to 1500 IU.

Effective with date of processing, July 1, 2001, the unit of coverage for CPT 90386 is **1 unit = 100 international units (IU)**. Providers should indicate the number of units given in block 24G on the HCFA-1500 claim form by rounding up to the next higher number, if necessary. Listed below are two examples of how to bill for CPT code 90386.

- If 1500 IU are given, providers should enter a 15 in block 24G of the HCFA-1500 claim form.
- If 8491 IU are given, the provider should enter an 85 in block 24G of the HCFA-1500 claim form.

Diagnosis	**Dosage**	**Units Billed in Block 24G of the HCFA-1500**
Rh isoimmunization	1500 IU	15
ITP	8491 IU	85

The maximum reimbursement rate is $20.00 per each 100 international units (IU) of Rho (D) immune globulin for dates of processing July 1, 2001 and after.

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

Attention: Mental Health Providers

Credentialing Update for Direct-Enrolled Licensed Clinical Social Workers

Medicaid began direct enrollment of Licensed Clinical Social Workers (LCSWs) effective February 1, 2001. The credentials necessary for LCSWs to enroll are:

- a current license to practice as a clinical social worker in the state of practice, **and**
- a Master's Degree in Social Work (MSW) from a school of social work accredited by the Council on Social Work Education **or** proof of enrollment as a Medicare provider.

Because LCSWs who enrolled with **Medicare** prior to July 1, 2000 were not required to have an MSW, Medicaid will waive this requirement for these LCSWs who apply for enrollment with Medicaid. However, all other LCSWs must meet the requirements for enrollment with Medicaid as indicated above.

Darlene Pilkington, Provider Services
DMA, 919-857-4017

Attention: Health Departments, Developmental Evaluation Centers, Federally Qualified Health Centers, and Rural Health Clinics

Use of Codes Y2351 and Y2041

Effective with date of service July 1,2001, CPT codes 97802 and 97803 (see description below) must be used when billing for medical nutrition therapy for pregnant women and children birth through 20 years of age. State-created codes Y2351 and Y2041 will be end-dated with dates of service June 30, 2001 and will no longer be accepted.

97802 *Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes*

97803 *Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes*

The following guidelines replace those published in the *Technical Manual for Maternity Care Coordination*, May 1999; the Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) workshop handout, August 1998; and any other materials from other sources. Please note that these codes apply to services to pregnant women and individuals from birth through age 20. When billing, remember that:

- Each 15 to 20 minutes of service equals 1 billing unit.
- There is a maximum of 4 units per date of service.
- There is a maximum of 4 units per 270 days for CPT code 97802.
- There is a maximum of 20 units per 365 days for CPT code 97803.
- For recipients 21 years of age and older, use one of the following primary diagnosis codes for billing:

V22.0	V22.1	V22.2	V23.0	V23.1	V23.2	V23.2	V23.4
V23.5	V23.7	V23.81	V23.82	V23.83	V23.84	V23.89	V23.9

- Nutrition therapy is considered part of the counseling component of evaluation and management or preventive medicine CPT codes when billed by other providers.

Service Provider

Medical nutrition therapy **MUST** be provided by:

- a Licensed Dietitian/Nutritionist, licensed by the North Carolina Board of Dietetics/Nutrition (a provisional license is not acceptable); or
- a Registered Dietitian, registered with the Commission of Dietetic Registration (registration eligibility is not acceptable).

Time spent providing medical nutrition therapy billed to Medicaid may not be charged to the WIC Program.

Service Eligibility

Pregnant and Postpartum Women

In order to receive medical nutrition therapy reimbursement, the recipient must:

- be pregnant or postpartum (for Medicaid billing purposes, postpartum is defined as the period from the last day of pregnancy through the last day of the month in which the 60th post-delivery day occurs);
- be a Medicaid recipient; and
- have one or more medical/nutritional risk indicators (see **Referral Criteria for Pregnant and Postpartum Women** on page 6).

Children and Adolescents

In order to receive medical nutrition therapy, a child must:

- be aged birth through age 20;
- be a Medicaid recipient; and,
- have a nutrition-related health problem (see **Referral Criteria for Children and Adolescents** on page 6).

Service Description

Pregnant and Postpartum Women

This service is appropriate for women whose pregnancies are threatened by chronic, episodic or acute conditions for which nutrition therapy is a critical component of medical management, and for postpartum women who need follow-up for these conditions or who develop such conditions early in the postpartum period. The service requires consultation with a patient having a specific disease or requiring a diagnostic nutrition assessment, and may be provided throughout the pregnancy and until the end of the month in which the 60th postpartum day occurs.

Children and Adolescents

This service is appropriate for the treatment of children and adolescents with chronic, episodic or acute conditions for which nutrition therapy is a critical component of medical management or with preventable conditions for which nutrition/diet is the primary therapy.

All Recipients

For both women and children, the nutrition service may include the following components:

1. a review of medical management and an evaluation of medical and psychosocial history, and treatment plan, as they impact nutrition interventions
2. a diagnostic nutritional assessment which may include:
    - review and interpretation of pertinent laboratory and anthropometric data
    - analysis of dietary and nutrient intake
    - determination of nutrient-drug interactions
    - assessment of feeding skills and methods
3. development of an individualized nutrition care plan, which may include:
    - recommendations for nutrient and calorie modifications
    - calculation of a therapeutic diet for disease states such as diabetes, renal disease, and galactosemia
    - referral to other health care providers

4. counseling on nutritional/dietary management of nutrition-related medical conditions
5. consultation with primary care provider

Components 2, 3, and 4 are critical to medical nutrition therapy. The provider must complete at least two of these in order for the service to be billed to Medicaid. In addition, all individuals categorically eligible for the WIC Program must be referred to the WIC Program for routine nutrition education and food supplements.

Medical nutrition therapy must be a face-to-face encounter with an individual or their caretaker. Group classes/instruction (i.e., weight management or diabetes education) are not billable medical nutrition therapy services.

Documentation of Services

A clinical record for each recipient of Medicaid-reimbursed medical nutrition therapy must be maintained. For health departments, this documentation will be part of the client's medical record. **Documentation must include, at a minimum, the date of service, presenting problem, summary of the required nutrition service components, and the signature of the qualified nutritionist providing the service.** Medicaid requires that records of medical nutrition counseling must be maintained for a minimum of five years.

Billing for Medical Nutrition Therapy

FQHCs and RHCs must bill using their provider number and the alpha suffix "C." All agencies must bill the same fee for all recipients who receive the same service. If a recipient is covered by a private insurance as well as by Medicaid, the third party insurance should be billed first.

Coordination with Other Programs

WIC Program Services

For agencies that also administer a WIC Program, the nutrition education contacts required by the WIC Program must be provided prior to billing Medicaid for medical nutrition therapy. The staff time utilized to provide a Medicaid-reimbursable nutrition service may not be charged to WIC Program funds. **A WIC referral must be initiated for all categorically eligible clients.**

Care Coordination

Dietitians/nutritionists providing medical nutrition therapy **must** refer eligible clients to the Maternity Care Coordination or Child Service Coordination programs as indicated.

Referral Criteria for Pregnant and Postpartum Women

Pregnant or postpartum women who have one or more of the following high-risk indicators should be referred to a qualified provider of medical nutrition therapy services:

- conditions which impact the length of gestation or the birth weight, where nutrition is an underlying cause, such as:
  - severe anemia (HGB <10 M/DL or HCT <30)
  - preconceptionally underweight (<90% standard weight for height)
  - inadequate weight gain during pregnancy
  - intrauterine growth retardation
  - very young maternal age (under the age of 16)
  - multiple gestation
  - substance abuse
- metabolic disorders such as diabetes, thyroid dysfunction, maternal PKU or other inborn errors of metabolism
- chronic medical conditions such as cancer, heart disease, hypertension, hyperlipidemia, inflammatory bowel disease, malabsorption syndromes or renal disease
- autoimmune diseases of nutritional significance such as systemic lupus erythematosus
- eating disorders such as severe pica, anorexia nervosa or bulimia nervosa

Referral Criteria for Children and Adolescents

Referral to a qualified provider may be made for **any** medical condition requiring nutrition intervention, including but not limited to:

- inappropriate growth/weight gain such as inadequate weight gain, inappropriate weight loss, underweight, obesity, inadequate linear growth or short stature
- nutritional anemia
- eating or feeding disorders that result in a medical condition such as failure to thrive, anorexia nervosa or bulimia nervosa
- physical conditions that impact growth and feeding such as very low birth weight, necrotizing enterocolitis, cleft palate, cerebral palsy, and neural tube defects
- chronic or prolonged infections that have a nutritional treatment component such as HIV or hepatitis
- genetic conditions that impact on growth and feeding such as cystic fibrosis, Prader-Willi Syndrome or Down Syndrome
- chronic medical conditions such as cancer, chronic or congenital cardiac disease, hypertension, hyperlipidemia, gastrointestinal diseases, liver disease, pulmonary disease, malabsorption syndromes, renal disease, significant food allergies, and diseases of the immune system
- metabolic disorders such as inborn errors of metabolism (e.g., PKU, galactosemia, etc.) and endocrine disorders (e.g., diabetes)

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

Attention: Personal Care Services Providers

Personal Care Services Seminars

Personal Care Services (PCS) seminars are scheduled for August 2001. The July general Medicaid bulletin will have the registration form and a list of site locations for the seminars. Please list any issues you would like addressed at the seminars. Return form to:

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

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

Checkwrite Schedule

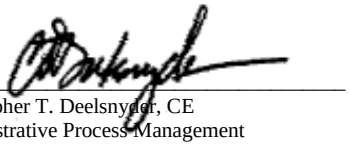
June 12, 2001	July 10, 2001	August 7, 2001
June 19, 2001	July 17, 2001	August 14, 2001
June 28, 2001	July 26, 2001	August 23, 2001

Electronic Cut-Off Schedule

June 8, 2001	July 6, 2001	August 3, 2001
June 15, 2001	July 13, 2001	August 10, 2001
June 22, 2001	July 20, 2001	August 17, 2001

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

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



Christopher T. Deelsnyder, CE
Administrative Process Management
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