Number 6 *June 2003*

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

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

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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.

Additional information about HIPAA transactions, guidance and assistance is available in the June 2003 Special Bulletin II, *HIPAA Update* available on DMA's website at http://www.dhhs.state.nc.us/dma/bulletin.htm.

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

Attention: All Providers

New Address for Medical Review of N.C.

Effective June 20, 2003, the street address and mailing address for Medical Review of N.C. (MRNC) will change to:

MRNC
Suite 200
100 Regency Forest Drive
Cary, NC 27511

MRNC's toll-free telephone number (1-800-228-3365) and fax number (1-800-228-1437) will not change. MRNC's local phone number will change. All of the phone lines will be unavailable for a short time around the time of the move. Please consult MRNC's website at http://www.MRNC.org on June 19, 2003 for information regarding phone service. MRNC will include the new local phone number when it becomes available on authorization forms returned to providers by fax.

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

Attention: All Providers

Ambulatory Visit Limits and Diagnosis Code V900

To comply with the implementation of the Health Insurance Portability and Accountability Act (HIPAA), effective with date of service October 1, 2003, ICD-9-CM diagnosis code V82.9 will replace diagnosis code V900. Diagnosis code V82.9 must be billed to indicate that the recipient is being treated for an illness that is eminently life threatening and, as such, the recipient should be exempted from the legislated 24 ambulatory visit limit. The primary diagnosis code listed on the claim **must** be the specific ICD-9-CM diagnosis code that describes the reason for the encounter **and** the secondary diagnosis code must be listed as V82.9. When a provider submits a claim with diagnosis code V82.9, a medical review is performed to determine if additional documentation is required to support the exemption. Claims for visits that exceed the 24-visit limit and do not list V82.9 as the secondary diagnosis will deny.

Ambulatory medical visits are limited to 24 visits per year beginning July 1 of each year through June 30 of the next year. These include any one or a combination of visits to the following: physicians, clinics, hospital outpatient other than emergency room, optometrists, chiropractors, and podiatrists. Once this limit has been reached, claims will deny with EOB 525, "Exceeds legislative limits for provider visits for fiscal year." Providers may bill the patient the usual and customary charge for the office visit.

Exemptions to the 24-visit limit include:

1. End stage renal disease.
2. Chemotherapy and/or radiation therapy for malignancy.
3. Acute sickle cell disease, hemophilia or other blood clotting disorders.
4. Services rendered to recipients under age 21.
5. Prenatal services.
6. Dental services.
7. Physician inpatient visits to patients in intermediate care facilities or skilled nursing facilities.
8. Mental health center services are exempt because the services are subject to independent utilization review.
9. Recipients receiving Community Alternatives Program (CAP) services.

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

Attention: All Providers

Transplants: Submitting Claims for Reimbursement

Effective with date of service June 1, 2003, providers may submit claims for reimbursement for **approved** transplants electronically to EDS. It is no longer necessary to submit paper claims for approved transplants. Paper claims for approved transplants will continue to be accepted for processing.

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

Attention: All Providers

Provider Information Update

The N.C. Medicaid program is updating provider files to include a fax number and an e-mail address. These two methods of communication will complement the already existing methods of communication and provide a quick avenue for providers to receive information. Because only one e-mail address and one fax number can be entered for a provider number, please submit the most appropriate information for the provider number given. Please complete and return the following form to EDS Provider Enrollment at the address listed below.

To report a change of ownership, name, address, tax identification number changes, group member or licensure status, please use the Notification of Change in Provider Status form. Managed Care providers (Carolina ACCESS, ACCESS II, and ACCESS III) must also report changes, including changes in daytime or after-hours phone numbers, using the Carolina ACCESS Provider Information Change form.

Date _____

Provider Number: _____

Provider Name: _____

Site Address: Street _____

City _____

State _____ Zip Code _____

Contact Person: _____

Phone Number: ( ) _____

Fax Number: ( ) _____

E-Mail Address: _____

Return completed form to:

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

Fax: 919-851-4014

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/prov.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: Anesthesiologists

Anesthesia Guidelines Replacement Article

This article **replaces** the December 2002 general Medicaid bulletin article titled *Billing for Certified Registered Nurse Anesthetist Services*.

Medicaid covers anesthesia services when personally performed by an anesthesiologist or certified registered nurse anesthetist (CRNA) or when the anesthesiologist is physically and personally involved in the care of the patient simultaneously with the CRNA. In order to bill concurrent care, the anesthesiologist must be physically present in the operating suite for the duration of the procedure and must be directly involved in the delivery of the service to the recipient. The anesthesiologist must:

1. perform the pre-anesthesia evaluation and exam;
2. prescribe the anesthesia;
3. participate personally in the induction and emergence of the anesthesia procedure;
4. ensure that any part of the anesthesia plan not personally performed by the anesthesiologist is performed by a qualified CRNA;
5. monitor the course of anesthesia administration at frequent intervals;
6. remain physically present to provide diagnosis and treatment in an emergency situation;
7. provide post-anesthesia care;
8. participate in no more than four concurrent anesthesia cases simultaneously; and
9. be physically present in the operating suite for the duration of the procedures.

Limitations

The anesthesiologist may **not** bill for services performed simultaneously with a CRNA:

- when concurrent care is **not** being rendered
- if the anesthesiologist leaves the area of the operating room for more than a short duration
- if the anesthesiologist involvement becomes extensive in one anesthesia case, not allowing the anesthesiologist to personally and physically respond to the immediate needs of the other recipient(s)
- if the anesthesiologist is not physically present to respond to the immediate needs of the recipient(s)

Documentation

The Division of Medical Assistance (DMA) requires that documentation to support services billed to Medicaid must be sufficient to substantiate the service billed. There must be documentation in the medical record to document that the anesthesiologist was involved in concurrent care and met all criteria. In the event of record review by DMA or its agents, lack of documentation places the provider's claim payment at risk of recoupment.

Current Billing Requirements

- Hospitals that employ CRNAs bill their professional services under the hospital professional number on the CMS-1500 claim form. Hospitals bill their facility charge for the anesthesia service on the UB-92 claim form.
- Anesthesiologists who employ CRNAs bill for the CRNA services on the CMS-1500 claim form with the anesthesiologist and the group number in block 33 of the form.
- CRNAs who are under no employment arrangement bill their services on the CMS-1500 claim form using their separate provider number.

Modifiers and Coding

The **only** anesthesia modifiers available since June 1999 are QS and YA. The YA modifier will be end-dated October 1, 2003 in order to comply with the Health Insurance Portability and Accountability Act (HIPAA) code set requirements. Beginning October 1, 2003, anesthesia services must be billed with CPT anesthesia codes. After September 30, 2003, anesthesia services billed using surgical procedure codes will be denied.

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

Attention: Carolina ACCESS Providers

Carolina ACCESS Medical Records Guidelines

Medical records should reflect the quality of care received by the client, but many times medical records documentation for the level of care provided varies from provider to provider. Therefore, in order to promote quality and continuity of care, a guideline for medical record keeping has been established by the Carolina ACCESS (CA) program and approved by the Physician Advisory Group. All primary care providers (PCPs) must implement the following guidelines as the standards for medical record keeping.

These guidelines are intended for CA PCPs. Medical records standards applying to all providers are documented in the January 1997 general Medicaid bulletin.

It is expected that the medical record should include the following whenever possible for the benefit of the patient and the physician:

1. Each page, or electronic file in the record, contains the patient's name or patient ID number.
2. All entries are dated.
3. All entries are identified as to the author.
4. The record is legible to someone other than the writer, including the author.
5. Medication allergies and adverse reactions are prominently noted and easily identifiable as well as the absence of allergies.
6. Personal and biographical data is recorded and includes age, sex, address, employer, home and work telephone numbers, and marital status.
7. Past medical history is easily identified including serious accidents, operations, and illnesses. For children, past medical history relates to prenatal care and birth.
8. There is a completed immunization record. For pediatric (ages twelve [12] and under) there is a complete record with dates of immunization administration.
9. Diagnostic information, medication, medical conditions, significant illnesses, and health maintenance concerns are recorded in the medical record.
10. Notation concerning smoking, alcohol, and other substance abuse is present for patients age twelve (12) and over at the routine visit.
11. Notes from consultations are in the record. Consultation, lab, and X-ray reports filed in the chart have the ordering provider's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging results have an explicit notation in the record of the follow-up plans
12. Emergency care is documented in the record.
13. Discharge summaries are included as part of the medical record for all hospital admissions which occur while the patient is enrolled in the Plan.
14. Documentation of individual encounters which provide adequate evidence of appropriate history, physical examination, diagnosis, diagnostic test, therapies, and other prescribed regimen, follow-up care, referrals and results thereof, and all other aspects of patient care, including ancillary services.

Reba Hamm, Managed Care Section
DMA, 919-857-4021

Attention: Durable Medical Equipment Providers

Deletion of Codes E0452 and E0453 and Addition of Codes K0532 and K0533

Effective with date of service June 1, 2003, codes E0452 and E0453 were deleted from the DME Fee Schedule and replaced with codes K0532 and K0533, respectively.

Code K0532, respiratory assist device, bi-level pressure capability, without backup rate feature, used with non-invasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device), has been placed in the capped rental section of the fee schedule. The maximum reimbursement rates are $247.24 for monthly rental, $2,472.42 for new purchase, and $1,854.31 for used purchase. Prior approval is required.

For initial approval, the physician, physician assistant or nurse practitioner must document one of the following diagnoses in block 11 of the Certificate of Medical Necessity/Prior Approval form (CMN/PA):

1. obstructive sleep apnea
2. upper airway resistance syndrome
3. central sleep apnea

In addition, the results of a sleep study recorded for 480 minutes or less must be submitted that documents:

1. a respiratory disturbance index (RDI) or apnea/hypopnea index (AHI) equal to or greater than 10 per hour of recorded sleep, and
2. at least 30 apneas and/or hypopneas within the sleep study period.

For children age birth to 18, an RDI or AHI between 5 and 10 is acceptable if the physician, who is a sleep specialist, provides appropriate documentation on the physician's letterhead stationery of medical necessity for the CPAP in each individual case. The total of 30 apneas and/or hypopneas within the sleep study period is also required for this age group.

In addition, the prescribing physician, physician assistant, or nurse practitioner must document that the patient meets one of the following conditions:

1. has had an unsuccessful trial on continuous airway pressure (CPAP) device , OR
2. is unable to tolerate CPAP, OR
3. is 5 years of age or younger, OR
4. has special needs that have been documented on the physician’s letterhead stationery by a physician who is a sleep physician.

In order for patients with a diagnosis of nocturnal hypoventilation syndrome to qualify for bi-level therapy, the physician, physician assistant or nurse practitioner must document pCO2 equal to or greater than 50 mm Hg. During sleep.

To renew approval, a statement is needed from the physician, physician assistant or nurse practitioner indicating that the recipient's overall condition has not changed and that bi-level therapy is still medically indicated. The statement may be entered in block 25 of the CMN/PA or attach documentation. This information is acceptable in lieu of a sleep study for prior approval renewal only.

Code K0533, respiratory assist device, bi-level pressure capability, with backup rate feature, used with non-invasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device), has been placed in the Frequently Serviced Items category of the fee schedule. The maximum monthly rental rate will be $580.30. Prior approval is required.

For initial approval, the physician, physician assistant or nurse practitioner must document medical necessity for non-continuous ventilatory assistance in block 25 of the CMN/PA form or attach documentation. There must also be documentation that the patient has one of the following diagnoses:

1. a chronic obstructive airway disease, such as emphysema or cystic fibrosis
2. a neuromuscular disease, such as muscular dystrophy, multiple sclerosis or amyotrophic lateral sclerosis
3. hypoventilation syndrome

The documentation requirements are the same for requests to renew approval.

Medical Coverage Policy #5, Durable Medical Equipment, has been revised to reflect this change. The policy is available online at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm.

Melody B. Yeargan, P.T., Medical Policy
DMA, 919-857-4020

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 July 31, 2003. New codes will become effective August 1, 2003.

Home Health Supplies				
Deleted Codes	**New Codes**	**Description**	**Billing Unit**	**Maximum Rate**
W4616	A4458	Enema bag with tubing, reusable	Each	$ 3.45
W4625	A6440	Zinc paste impregnated bandage, non-elastic, knit or woven, width greater than or equal to 3 in. and less than 5 in. (at least 10 yds. unstretched)	Roll	11.60

Providers must bill their usual and customary charges.

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

Attention: HIV Case Management Services Providers

Billing Code Change for HIV Case Management Services

Effective with date of service September 1, 2003, HIV Case Management Services (HIV CMS) providers must use procedure code T1017, Targeted Case Management (HIV), to bill for HIV CMS. The billing unit remains 15 minutes. There is no change in the rate. Providers must bill their usual and customary charges. The Division of Medical Assistance (DMA) is making this code conversion to comply with the implementation of national code sets mandated by the Health Insurance Portability and Accountability Act (HIPAA).

Providers must continue to use procedure code Y2331, HIV Case Management Services, when billing for dates of service prior to September 1, 2003.

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

Attention: Independent Practitioners, Developmental Evaluation Centers, Health Departments, Home Health Agencies, Hospital Outpatient Clinics, Physician Services, and Area Mental Health Centers

Clarification of Billing Instructions for Outpatient Specialized Therapies

The time period to request prior approval for treatment for patients between the age of birth and five years of age who have been evaluated by a Developmental Evaluation Center (DEC) or have received a DEC-approved evaluation and have an Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP) is six months after the physician's order. The initial claim and requests for continued services must list the date of the physician's order for services.

For the CMS-1500 claim form (HCFA-1500) enter the date of the physician's orders for services in block 15. For the UB-92 form, use either form locator 32, 33, 34 or 35 and enter the date of the physician's order for services in the date block and the number "28" in the code block. **Do not change the date once it is entered on the claim form.** If the date is not included on the claim, the claim is subject to the same prior approval requirements as those for the six unmanaged visits.

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

Attention: Optical Providers

Making Medicare Part B Optical Claims Medicaid Ready

Effective with dates of service October 1, 2002, billing and payment guidelines changed for Medicaid claims when Medicare Part B is the recipient's primary payer. For any recipient with Medicare Part B coverage in addition to Medicaid coverage, providers must file claims to Medicare, receive Medicare payment or denial, and then submit the claim directly to Medicaid. **Claims filed to Medicare after October 1, 2002 no longer crossover automatically to Medicaid for payment**. Once the provider receives the Medicare voucher, the provider is required to submit a claim for those Medicaid covered services directly to Medicaid indicating the Medicare payment as a third party payment in block 29 of the CMS-1500 claim form. These claims are referred to as Medicare TPL claims. Claims can be submitted to Medicaid either electronically or on paper.

The Balanced Budget Act of 1997 permits states to limit payment for dually eligible recipients (Medicare/Medicaid eligible) to no more than Medicaid's maximum allowable rate. The Division of Medical Assistance (DMA) implemented this change to ensure that all claims, including claims for Medicaid recipients who have Medicare as the primary payer, are processed based on Medicaid policy editing, auditing, and pricing, and that services rendered to dually eligible recipients are reimbursed at the same rate as services rendered to straight Medicaid fee-for-service recipients. In order to process these claims through Medicaid policies, the claim must be submitted according to all Medicaid billing requirements, including codes, modifiers, etc. Completing a claim according to Medicaid guidelines is referred to as making a claim "Medicaid ready."

Optical claims must be "Medicaid ready" before billing Medicaid.

Eye Exam with Medical Diagnosis

Medicare requires CPT codes 92004 and 92014 to be billed with a medical diagnosis. Medicaid claims deny when billed in this manner. Therefore, when filing the claim to Medicaid for an eye exam/office visit only, these CPT codes must be changed to an appropriate office visit code and billed with the original medical diagnosis that was billed to Medicare. The Medicare payment will be placed in block 29 on the CMS-1500 claim form.

Medicare and Medicaid require CPT codes 92002 and 92012 to be billed with a medical diagnosis. Therefore, it is not necessary to change these CPT codes when billing the balance to Medicaid after Medicare payment is received.

Previously denied claims may be resubmitted as new claims.

Note: Claims submitted for an office visit and refraction will deny when submitted with the same dates of service. Claims will also deny if CPT code 92002, 92004, 92012 or 92014 are billed in conjunction with CPT code 92015 using the same dates of service.

Eye Exam and Refraction with Medical Diagnosis

Effective with date of service October 1, 2002, providers cannot bill CPT code 92015 in conjunction with CPT codes 92004 or 92014 for Medicaid claims when Medicare is the primary payer. Medicaid reimbursement rates for CPT codes 92004 and 92014 include both the refraction and the eye exam. If an eye exam/office visit and a refraction are completed on the same day and the office visit is billed to Medicare with a medical diagnosis, then the claim must be made Medicaid ready. In order to comply, CPT codes 92004 and 92014 must be billed to Medicaid with a refractive diagnosis to denote that an eye exam and a refraction were performed. Please refer to the December 2001 *N.C. Medicaid Optical Services Manual* on DMA's website (http://www.dhhs.state.nc.us/dma/bulletin.htm) for the list of accepted refractive diagnosis codes.

Note: When billing CPT codes 92004 and 92014 to Medicaid, routine eye examinations with a refraction are still be limited to once a year for recipients under 25 years of age and once every two years for recipients 25 years of age and older, even though Medicare covers the eye exam. Prior approval must be obtained for refractions over this limit.

Eye Exam Without Medical Diagnosis

When a recipient presents for a routine eye exam and no medical condition exists, bill both Medicare and Medicaid using CPT code 92004 or 92014 with a refractive diagnosis.

Eyeglasses

The majority of Medicaid eyeglasses are made by the optical contractor laboratory. Occasionally, there is a need to go outside of the Medicaid selection for frames and/or lenses. When this occurs and the recipient has straight Medicaid fee-for-service coverage, prior approval is required. The invoice cost for the frame and/or lens and the dispensing fees are billed to Medicaid.

For dually eligible recipients, prior approval is not required if Medicare made payment on the claim, or if 100 percent of the Medicare allowable has been applied toward the deductible. The maximum Medicaid allowable is the invoice cost of the frame (up to approximately $20), the invoice cost of covered lens services, and the dispensing fees. Claims submitted for non-covered services (progressive lenses, anti-reflective coating, etc.) will deny. The amount paid by Medicare (shown in block 29 of the CMS-1500 claim form) is deducted from the total allowed invoice amount and the dispensing fees prior to Medicaid payment. There is no Medicaid payment if the Medicare paid amount is greater than the invoice for the covered services and the dispensing fees.

Billing for Frames, Lenses or Aphakic Contact Lenses

- Submit the claim to Medicare with appropriate codes.
- Once the Medicare claim has adjudicated, if the Medicare payment does **NOT** exceed the total invoice amounts for covered services and dispensing fees, submit a "Medicaid ready" CMS-1500 claim form to Medicaid using the appropriate frame, lens or contact lens code, and the coinciding dispensing fee codes.
- Bill the "Medicaid ready" claim with invoices and enter the amount that Medicare paid in block 29 of the CMS-1500 form. (The claim will deny if no dollar amount is recorded in block 29.)
- If the service is covered by Medicare and the payment is received, it is not necessary to attach the Medicare voucher.
- If 100 percent of the Medicare allowed amount is applied toward the deductible, submit the "Medicaid ready" claim form with invoices **and** the Medicare voucher.

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

Attention: Physicians and Hospital Providers

Prior Approval for Non-Emergency Out-of-State Services

Prior approval is required for out-of-state (beyond the 40-mile border of North Carolina) non-emergency evaluation and/or treatment services provided to North Carolina Medicaid recipients. Requests for prior approval for out-of-state non-emergency services are submitted by the recipient's physician to EDS by fax at 919-233-6834 using the general Request for Prior Approval form (372-118). (The original request must be submitted by mail to EDS within 10 days of the faxed request.) The request must include full clinical patient information and documentation showing that the treatment or service is not available in North Carolina. No referrals should be made until the prior approval request has been reviewed and a decision has been rendered.

Debbie Garrett, RNC, Hospital Consultant, Medical Policy Section
DMA, 919-851-4020

Attention: Prescribers and Pharmacists

Recipient Lock-In to One Pharmacy Per Month

DMA has implemented a Recipient Lock-In (Restricted Pharmacy Services) Program. Recipients are restricted to a single pharmacy each month except for emergencies. The following recipients are exempt from the mandatory pharmacy lock-in:

- recipients who are less than 21 years of age,
- recipients participating in the Community Alternatives Program (CAP), and
- recipients who reside on campuses attending either Schools for the Deaf and/or Blind during the week

Melissa Weeks, Medical Policy Section
DMA, 919-857-4020

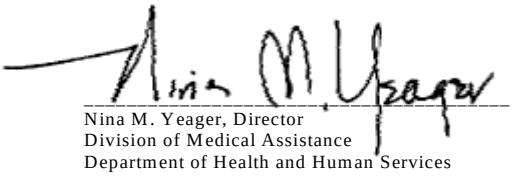
Checkwrite Schedule

June 10, 2003	July 15, 2003	August 12, 2003
June 17, 2003	July 22, 2003	August 19, 2003
June 26, 2003	July 31, 2003	August 28, 2003

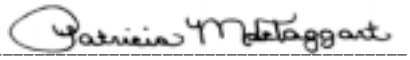
Electronic Cut-Off Schedule

June 6, 2003	July 11, 2003	August 8, 2003
June 13, 2003	July 18, 2003	August 15, 2003
June 20, 2003	July 25, 2003	August 22, 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.



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



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Executive Director
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