North Carolina Medicaid Bulletin

Published as an Informational Service to Medicaid Providers by the Division of Medical Assistance and EDS, Fiscal Agent for the N.C. Medicaid Program

Number 6 June 2004

In This Issue . . .

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

Attention: All Providers

Checkwrite Schedule Change

The June 24, 2004 checkwrite date has changed to June 22, 2004. The electronic cut-off date for this checkwrite will remain June 18, 2004. A copy of the revised 2004 Checkwrite Schedule is available on the Division of Medical Assistance's website at http://www.dhhs.state.nc.us/dma/2003check.htm.

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

Attention: All Providers

Contract Awarded for Medicaid Fiscal Agent Services

In April 2004, the Department of Health and Human Services (DHHS) awarded the contract for the replacement of the North Carolina Medicaid Management Information System (NCMMIS) to ACS State Healthcare, LLC (ACS). ACS has extensive experience in delivering fiscal agent services. Their proposed base Medicaid system has been successfully implemented in four other states. Operations of the new NCMMIS are scheduled to begin no later than June 2006.

DHHS is fully committed to ensuring a smooth transition to the new fiscal agent contract. Following are some of the prudent measures being taken to avoid an adverse impact on provider reimbursement:

- involving provider community representatives during implementation phase,
- delivering thorough provider training at convenient locations,
- developing a contingency plan,
- assigning dedicated DHHS staff to the effort, and
- developing a comprehensive fiscal agent management plan to provide ongoing quality control.

With the ACS system, providers can continue to submit claims using current methods or by utilizing new web portal capabilities for claims submission with real-time adjudication, claims correction or inquiry, and the ability to void and adjust processed claims.

Providers who would like to participate in the user acceptance phase of the implementation process may e-mail Vivian.williamson@ncmail.net with their interest. Please indicate your provider type (e.g., physician, hospital, pharmacy, long-term care facility, etc.) in the subject line of your message.

Portia Asbridge, Communications Manager
NCMMIS+ Initiative, 919-855-3161

Attention: All Providers

Medicaid Denial of Medicare Covered Services

Effective with claims processed on or after July 1, 2004, Medicaid will deny claims for recipients age 65 and over who are entitled to Medicare benefits but fail to enroll. Providers may bill the recipient for Medicare covered services if they fail to enroll with Medicare. Medicaid recipients age 65 and older who are eligible for Medicare received notice with their June Medicaid card that they must enroll or the provider may bill them. Claims will be denied with EOB #1001, "Recipient is entitled to Medicare but failed to enroll. Bill the recipient."

Except for legal aliens who have not lived in the United States for five consecutive years, all Medicaid recipients age 65 or older are required to apply for Medicare coverage. Medicaid pays the Medicare Part B premium for Medicare-eligible recipients through the buy-in program.

If you determine that the recipient is not entitled to Medicare benefits because he/she is under age 65 or because he/she is a legal alien who has not lived in the United States for five years or more, submit a copy of the claim with documentation of age or alien status to:

Division of Medical Assistance
Claims Analysis Unit
2501 Mail Service Center
Raleigh, NC 27699-2501

The Division of Medical Assistance will determine if Medicaid payment can be made for these individuals.

Claims Analysis Unit
DMA, 919-855-4045

Attention: All Providers

Medicaid Family Planning Waiver Seminars and Teleconferences

The seminars and teleconferences for the Medicaid Family Planning Waiver program scheduled for June 2004 and July 2004 have been cancelled due to a delay in the implementation of the Waiver program.

Providers will be notified through the general Medicaid bulletin of the new implementation date and the new schedule for the seminars and teleconferences.

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

Attention: All Providers

West Nile Virus (and Other Arboviral Infections)

The following memo was issued by Jeffrey Engel, M.D., State Epidemiologist, and Lou F. Turner, Director, State Laboratory of Public Health on May 10, 2004 to all North Carolina physicians and laboratory service providers.

As we enter the summer season of 2004, the N.C. Division of Public Health is seeking your assistance in identifying and diagnosing suspected cases of arboviral encephalitis. In 2003, North Carolina reported 24 human cases of LaCrosse (LAC) encephalitis, 22 cases of West Nile Virus (WNV) infection, and 1 case of Eastern Equine encephalitis (EEE). In addition, hundreds of horses across the state were diagnosed with either WNV or EEE.

WNV is now endemic across North Carolina and primarily affects adults, whereas LAC is localized to the western region and primarily affects children. Human disease from both WNV and LAC peaks in late August and early September. Human EEE is rare in North Carolina. Recall that symptomatic WNV infection ranges from WNV fever (headache, lymphadenopathy, nausea, vomiting, and fatigue) to WNV neuroinvasive disease (meningitis, encephalitis, and /or acute flaccid paralysis resembling Guillian-Barre syndrome). Head CT scans are normal and brain MRI scans may show leptomeningeal enhancement. EMG studies show axonal degeneration and demyelination, not typical of Guillain-Barre. Cerebrospinal fluid analysis is consistent with aseptic meningitis with an elevated protein, normal glucose, and pleocytosis. Neuroinvasive disease is more common in people over age 50.

Specific laboratory arbovirus testing is available free at the State Laboratory for Public Health in Raleigh for patients manifesting clinical syndromes associated with arboviral infections. We encourage you to use the State Lab since it will expedite our public health surveillance efforts. Serum specimens should be sent for antibody detection during the acute illness. Acute CSF for antibody detection, if desired, **must be accompanied** by a companion serum collected at approximately the same time. For confirmation of probable cases, convalescent serum should be sent 2 to 3 weeks after onset of illness or at the time of hospital discharge. Samples should be sent with a **completed** form available on the web at http://slph.state.nc.us. Click on "West Nile Virus/Testing" to download the forms. Tests on hospitalized patients may be ordered as an "Arbovirus Panel" since the State Lab will automatically test for all mosquito-borne viral encephalitides. *(Molecular testing of acute phase sera or CSF has been proven to be of little value for WNV and other mosquito-borne viruses.)*

Your cooperation is appreciated. We understand that forms and convalescent samples are burdensome, however your efforts are needed for the health of your patients and the public at-large.

Epidemiology Section
Division of Public Health, 919-733-3421

Attention: All Providers

New Telephone Number for Claims Analysis Unit

When a claim denies with an EOB related to eligibility, providers may be instructed to contact the Division of Medical Assistance's Claims Analysis Unit for assistance. Effective May 25, 2004, the Claims Analysis Unit's telephone number was changed to 919-855-4045. Providers should note this change for future reference.

Claims Analysis Unit
DMA, 919-855-4045

Attention: Durable Medical Equipment Providers

FROM and TO Dates for DME-Related Supplies

Changes have been made to **Attachment A:** ***Completing the Certificate of Medical Necessity and Prior Approval Form*** of **Medical Coverage Policy #5*, Durable Medical Equipment***. (The policy is available on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm.) The instructions for completing the "FROM DATE" and "TO DATE" in Block 26 have been changed for DME-related supplies. These supplies are now entered on the Certificate of Medical Necessity and Prior Approval form in the same manner as national miscellaneous HCPCS codes A9900 and B9998. Thus, the instructions for FROM DATE and TO DATE are as follows:

Customized Equipment, Prosthetics and Orthotics: Enter the date of the physician's prescription in the FROM block. Enter a date six months after the FROM date in the TO block.

Other Purchased Equipment: Enter the date the item is expected to be delivered to the recipient in the FROM block. Enter a date six months after the FROM date in the TO block.

Rental Equipment: Enter the anticipated beginning of the rental period in the FROM block. Enter the expected end of the rental period in the TO block.

Service and Repairs: Enter the expected date that the item is to be serviced or repaired in the FROM block. Enter a date three months after the FROM date in the TO block.

DME-Related Supplies and National Miscellaneous HCPCS Codes A9900 and B9998: Enter the date that the item is expected to be delivered to the recipient in the FROM block. Enter a date one year after the FROM date in the TO block if the prescribing physician, physician's assistant or nurse practitioner writes the prescription for a year. Otherwise, the TO date must be the last effective date of the prescription. (The maximum length of time for the FROM date to the TO date must be one year.)

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

Attention: Health Check Providers

Developmental Screening and Surveillance

Developmental screening, including mental, emotional, and behavioral, is one of the many components of a complete Health Check visit. The current Health Check Billing Guide stipulates that three written developmental assessments should be performed: the first by 12 months, the second by 24 months, and the third by 60 months.

Effective July 1, 2004, Health Check screenings will require the use of a formal, standardized tool for developmental screening. The American Academy of Pediatrics Committee on Children with Disabilities recommends the use of standardized screening tests at well child visits.

The N.C. Pediatric Society has endorsed the following schedule for formal standardized developmental screenings: 6 months; 12 months; 18 or 24 months; and 3, 4, and 5 years of age. Developmental screening results must be documented in the medical record.

The developmental screening CPT code 96110 appended with the EP modifier must be listed in addition to the preventive medicine CPT codes. For additional information, please refer to the April 2004 Special Bulletin I, *Health Check Billing Guide 2004*, on DMA's website at http://www.dhhs.state.nc.us/dma/bulletin.htm.

Several primary care practices in North Carolina, with two different demonstrations projects, have put standardized screening tools "to the test" and have successfully integrated developmental screening and surveillance into their office workflow. To learn more about **what is practical and what works** contact Curtis Honeycutt at Curtis.Honeycutt@ncmail.net

Tammy Schneider, Health Check
DMA, 919-857-4022

Attention: Hospice Providers

Reimbursement Rate Increase for Hospice Services

Effective with date of service May 1, 2004, the maximum allowable rate for the following hospice services has increased. The hospice rates are as follows:

		Hospice ICF Care (Room and Board)	**Hospice SNF Care (Room and Board)**
Metropolitan Statistical Area	**SC**	**RC 658 Daily**	**RC 659 Daily**
Asheville	39	$ 131.14	$ 131.14
Charlotte/Gastonia/Rock Hill	41	131.14	131.14
Fayetteville	42	131.14	131.14
Greensboro/Winston-Salem/High Point	43	131.14	131.14
Hickory/Morganton/Lenoir	44	131.14	131.14
Jacksonville	45	131.14	131.14
Raleigh/Durham/Chapel Hill	46	131.14	131.14
Wilmington	47	131.14	131.14
Rural counties	53	131.14	131.14
Goldsboro	105	131.14	131.14
Greenville	106	131.14	131.14
Norfolk (Currituck County)	107	131.14	131.14
Rocky Mount	108	131.14	131.14

Note: At this time, the rates for RC651, RC 652, RC 655, and RC 656 have not changed. Providers may refer to the December 2003 general Medicaid bulletin for the most current rates.

Key to Hospice Rate Table

SC = Specialty Code
RC = Revenue Code

Note: Providers must bill their usual and customary charges. Adjustments will not be accepted for rate changes.

Carolyn Brown, Financial Operations
DMA, 919-857-4015

Attention: Hospital Providers

Patient Status Codes – Frequently Asked Questions

This article is reprinted with permission from the North Carolina Hospital Association and the National Uniform Billing Committee.

The patient's discharge status (Form Locator 22) is required on all institutional claims –inpatient, outpatient, hospice, home care, etc. Identifying the appropriate code is often confusing, as can be seen by the following questions and answers. A basic rule of thumb is to code to the highest level of care that is known. For example, an individual discharged to home with a home health plan of care is coded as 06, rather than 01.

1. A patient is discharged from facility (disposition code 01) and goes to a doctor's appointment the same day. The patient is then admitted to another hospital after seeing the doctor. What disposition code is appropriate, 01 or 02?

Based on the information the hospital had at discharge, the patient was discharged to home (01). If your facility was unaware of the planned admission at the second facility, it is likely that you will have to provide support for your coding decision when the fiscal intermediary receives the claim for admission to another hospital on the same day you discharged the patient.

2. If a patient leaves before triage, or is triaged and leaves without being seen by the physician, what is the appropriate discharge status? It does not seem right to use 07, left against medical advice, because no "medical advice" was provided.

The full definition of 07 is "Left against medical advice or discontinued care." Therefore, 07 is the appropriate code to use when the patient discontinues care.

3. What status code should be used for a patient transferred to a Skilled Nursing Facility (SNF) rehabilitation unit within the SNF. Is this considered a transfer to a SNF or to a rehabilitation facility?

A rehabilitation unit that is part of a skilled nursing facility is paid under the SNF prospective payment system. Moving a patient from one unit to another does not constitute a transfer for billing purposes and should not result in separate claims. If a patient is discharged from an acute inpatient hospital to a SNF, use 03. Status code 03 is also used if the patient moves from an acute inpatient hospital to a rehabilitation unit in a SNF.

4. What code is used for patients discharged on home oxygen?

Use discharge status 01, discharged to home or self care.

5. What code is used for patients discharged to partial hospitalization?

Use discharge status 01, discharged to home or self care.

6. What code is used for patients discharged to home with follow-up visiting nurses?

If the patient is discharged to home with a written plan of care for home care services– whether home attendant, nursing aides, certified attendants, etc. – use status code 06.

7. What code is used for patients discharged to home with services from a DME supplier?

Use discharge status 01, discharged to home or self care.

8. What code is used for patients discharged to court/law enforcement?

Use discharge status 01, discharged to home or self care.

9. What code is used for patients discharged/transferred to residential care?

Use discharge status 01, discharged to home or self care.

10. What code is used for patients discharged/transferred to a foster care facility?

Use discharge status 01, discharged to home or self care.

11. What code is used for patients discharged/transferred to a foster care facility with home care?

Use discharge status 06, discharged/transferred to home under care of organized home health services.

12. What code is used for patients discharged to home under a home health agency with oxygen?

Use discharge status 06, discharged/transferred to home under care of organized home health service. If the patient is discharged home with oxygen that is not provided through a home health plan of care, use status code 01, discharged to home or self care.

13. What code is used for patients discharged to home under a home health agency with DME?

Use status code 06, discharged/transferred to home under care of organized home health service.

14. How is a "long-term care hospital" (which the UB manual indicates should be coded to 63) different from a SNF (often called a long-term care facility)? Should it be coded 03 or 04?

A long-term care facility (63) provides acute inpatient care with an average length of stay greater than 25 days. A SNF certified by Medicare is coded with 03 and an intermediate care facility with 04. A nursing facility that is not Medicare-certified is coded with 64.

15. A facility may be licensed for multiple types of care. For example, a facility may hold licenses for both skilled nursing and hospice. If it is not documented in the medical record as to which type of care a patient is being discharged to, what code should be used?

Just like Medical Records follows up if there is no diagnosis, they should follow up on this, confirm where the patient is being placed, and code accordingly.

16. Code 04 is to be used for transfer to "state-designated assisted living facilities." What is the appropriate code if a patient is discharged/transferred to a skilled nursing component within an assisted living facility?

If the discharge plan suggests an assisted living facility, code with 04. If the plan identifies a skilled level of care in a Medicare-certified SNF, use 03.

17. What discharge status code should be used in Form Locator 22 if the patient is going from an inpatient hospital to an inpatient VA hospital?

Use status code 43, discharged/transferred to a federal hospital.

18. Are the codes 50 (hospice/home) and 51 (hospice/facility) used by the hospital when the patient is discharged from an inpatient bed or are they only to be used on hospice or home health type of bills?

Use 50 or 51 if the patient is discharged from an inpatient hospital to a hospice.

19. What if a doctor indicates a discharge status that is different from what the discharge planner indicates? What should be coded?

Judgment must be used to determine the most accurate source of the patient's current status. In most cases, the discharge planner provides the most current status.

20. What code should be used by a home health agency when a patient has moved without notice and the agency is unable to complete the plan of care?

Use status code 07, left against medical advice or discontinued care.

For additional information from the National Uniform Billing Committee about the use of patient discharge status codes, send an e-mail to tomundson@aha.org.

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

Attention: Federally Qualified Health Centers, Health Departments, Nurse Midwives, Nurse Practitioners, Physicians, and Rural Health Clinics

Intrauterine Devices Billable on the CMS-1500 Claim Form – Reimbursement Rates

The intrauterine devices (IUDs) listed in the table below are covered by the N.C. Medicaid program. These can be billed on the CMS-1500 claim form. The new maximum reimbursement rates are effective with date of service June 1, 2004.

Procedure Code	Description	Maximum Reimbursement Rate
J7300	Intrauterine Copper Contraceptive (Paragard T380A)	$ 358.80
J7302	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg (Mirena)	471.88

Providers must bill their usual and customary rates.

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

Attention: Maternity Care Coordinators

Maternity Care Coordination Services Seminar Schedule

Maternity Care Coordination Services seminars are scheduled for July 2004. The site locations and dates for the seminars are listed below. **Because new policy guidelines will be implemented on August 1, 2004, attendance at these seminars is mandatory for both current and new Maternity Care Coordinators**.

The seminars will use the July 2004 Special Bulletin IV, *Maternity Care Coordination Services*, as the primary handout for the session. Providers must access and print the PDF version of the special bulletin from DMA's website at http://www.dhhs.state.nc.us/dma/bulletin.htm and bring it to the session. The special bulletin will be available on July 1, 2004.

Preregistration is required. Please indicate on the registration form the session you plan to attend. Seminars are scheduled to begin at 10:00 a.m. and end at 1:00 p.m. or earlier. Lunch will not be served. Providers are encouraged to arrive by 9:45 a.m. to complete registration.

Wednesday, July 7, 2004
Jane S. McKimmon Center
1101 Gorman St.
Raleigh, NC

Thursday, July 8, 2004
Greenville Hilton
207 Greenville Blvd SW
Greenville, NC

Tuesday, July 13, 2004
Bo Thomas Auditorium
Blue Ridge Community College
College Drive
Flat Rock, NC

Wednesday, July 14, 2004
Holiday Inn Conference Center
530 Jake Alexander Blvd., S.
Salisbury, NC

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

Directions to the Maternity Care Coordination Services Seminars

Jane S. McKimmon Center – Raleigh
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 at 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 before you reach Western Boulevard.

Greenville Hilton – Greenville
Take US 64 east to US 264 east. Follow 264 east to Greenville. Once you enter Greenville, turn right on Allen Road. After traveling approximately 2 miles, Allen Road becomes Greenville Boulevard/Alternate 264. Follow Greenville Boulevard for approximately 2½ miles. The Greenville Hilton is located on the right.

Blue Ridge Community College, Bo Thomas Auditorium – Flat Rock
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.

Holiday Inn Conference Center – Salisbury
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.

(cut and return registration form only)

Maternity Care Coordination Services
Seminar Registration Form
(No Fee)

Provider Name _____ Provider Number _____

Address _____

City, Zip Code _____ County _____

Contact Person _____ E-mail Address _____

Telephone Number (____) _____ Fax Number (____) _____

Number of attendees _____ who will attend the seminar at _____ on _____
(location) (date)

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

Attention: Nurse Practitioners and Physicians

Bevacizumab (Avastin, J9999) – Billing Guidelines

Effective with date of service June 1, 2004, the N.C. Medicaid program covers bevacizumab (Avastin) for use in the Physician's Drug Program. Avastin, in combination with intravenous 5-fluorouracil-based chemotherapy, is indicated for the first-line treatment of patients with metastatic colorectal carcinoma. The FDA's recommended dosing schedule is 5 mg/kg once every 14 days as an IV infusion until disease progression is detected.

The ICD-9-CM diagnosis codes required when billing for Avastin are:

- **V58.1** – admission or encounter for chemotherapy

  and

- a diagnosis code in the range of **153.0 through 154.8**

Providers must bill J9999, the unclassified drug code for antineoplastic agents, with an invoice attached to the CMS-1500 claim form. **An invoice must be submitted with each claim.** The paper invoice must indicate the recipient's name and Medicaid identification number, the name of the medication, the dosage given, the National Drug Code (NDC) number from the vial(s) used, the number of vials used, and the cost per dose.

Providers must indicate the number of units given in block 24G on the CMS-1500 claim form. For Medicaid billing, one unit of coverage is the 4 ml vial. The maximum reimbursement rate per unit is $584.38. Providers must bill their usual and customary charge.

Add this drug to the list of injectable drugs published in the April 2004 general Medicaid bulletin.

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

Attention: Nurse Practitioners and Physicians

Cetuximab (Erbitux, J9999) – Billing Guidelines

Effective with date of service June 1, 2004, the N.C. Medicaid program covers cetuximab (Erbitux) for use in the Physician's Drug Program. Erbitux, a human/mouse chimeric monoclonal antibody, used in combination with irinotecan, is indicated for the treatment of EGFR-expressing, metastatic colorectal carcinoma in patients who are refractory to irinotecan-based chemotherapy. Erbitux administered as a single agent, is indicated for the treatment of EGFR-expressing, metastatic colorectal carcinoma in patients who are intolerant to irinotecan-based chemotherapy.

The FDA-approved dose of Erbitux in combination with irinotecan or as monotherapy, is 400 mg/m_2 as an initial loading dose (first infusion) administered as a 120-minute IV infusion (maximum infusion rate 5 ml per minute). The recommended weekly maintenance dose is 250 mg/m_2 over 60 minutes (maximum infusion rate 5 ml per minute).

The ICD-9-CM diagnosis codes required when billing for Erbitux are:

- **V58.1** – admission or encounter for chemotherapy

  and

- a diagnosis code in the range of **153.0 through 154.8**

Providers must bill J9999, the unclassified drug code for antineoplastic agents, with an invoice attached to the CMS-1500 claim form. **An invoice must be submitted with each claim.** The paper invoice must indicate the recipient's name and Medicaid identification number, the name of the medication, the dosage given, the National Drug Code (NDC) number from the vial(s) used, the number of vials used, and the cost per dose.

Providers must indicate the number of units given in block 24G on the CMS-1500 claim form. For Medicaid billing, one unit of coverage is the 100 mg/50 ml vial. The maximum reimbursement rate per unit is $489.60. Providers must bill their usual and customary charge.

Add this drug to the list of injectable drugs published in the April 2004 general Medicaid bulletin.

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

Attention: Nurse Practitioners and Physicians

Pemetrexed (Alimta, J9999) – Billing Guidelines

Effective with date of service June 1, 2004, the N.C. Medicaid program covers pemetrexed (Alimta) for use in the Physician's Drug Program. Alimta is an antifolate, antineoplastic agent. The FDA states that, in combination with cisplatin, it is indicated for the first-line treatment of patients with malignant pleural mesothelioma, whose disease is either unresectable or who are otherwise not candidates for curative surgery. The FDA indicates that the usual adult dose is 500 mg/m_2 infused over 10 minutes on day 1 of each 21-day cycle.
The ICD-9-CM diagnosis codes required when billing for Alimta are:

- **V58.1** – admission or encounter for chemotherapy

  and

- a diagnosis code in the range of **163.0 through 163.8**

Providers must bill J9999, the unclassified drug code for antineoplastic agents, with an invoice attached to the CMS-1500 claim form. **An invoice must be submitted with each claim.** The paper invoice must indicate the recipient's name and Medicaid identification number, the name of the medication, the dosage given, the National Drug Code (NDC) number from the vial(s) used, the number of vials used, and the cost per dose.

Providers must indicate the number of units given in block 24G on the CMS-1500 claim form. For Medicaid billing, one unit of coverage is 500 mg. The maximum reimbursement rate per unit is $2,071.88. Providers must bill their usual and customary charge.

Add this drug to the list of injectable drugs published in the April 2004 general Medicaid bulletin.

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

Attention: Nursing Facility Providers

Retroactive Prior Approval

Effective July 1, 2004, the Division of Medical Assistance will no longer accept or review retroactive records for admission. It is the nursing facility's responsibility to obtain prior approval for all residents upon admission. EDS will continue to review requests for retroactive approval back to 90 days. EDS will only review retroactive requests back to 180 days where eligibility is an issue.

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

Attention: Nursing Facility Providers

Nursing Facility Rate Change

On May 10, 2004, the Division of Medical Assistance (DMA) implemented the new nursing facility reimbursement methodology third quarter reimbursement rates as directed by N.C. General Assembly House Bill 397 10.28. These rates are effective with dates of service May 1, 2004. Claims submitted for dates of service May 1, 2004 and after will automatically be reimbursed under the new case mix system rates utilizing the final facility roster snapshot date of December 31, 2003 – Avg. CMI for Medicaid residents.

Until otherwise notified, all providers must continue to bill using the level of care approved on the FL-2. New provider rates are currently being paid on both levels of care. For example, if the resident's last approval was for ICF level of care, then the provider must use an ICF provider number and an ICF bill type. Providers will be notified of changes to this process in a future general Medicaid bulletin.

For an updated version of the Prospective Reimbursement Plan for Nursing Care Facilities, refer to Attachment 4.19-D, page 1 through 4.19-D, page 28 of the State Plan on DMA's website at http://www.dhhs.state.nc.us/dma/sp.htm. The new case mix methodology reimbursement system is supported by a provider assessment and through the implementation of the new rates as a part of the ongoing operations process.

The provider assessment component also becomes effective on May 1, 2004. Refer to page 17 for a copy of the provider assessment worksheet and instructions for completing the worksheet.

Note: The May 2004 provider assessment and report are due to DMA no later than June 15, 2004. Failure to submit the assessment in a timely manner will result in recoupment and penalties per the Department of Health and Human Services' Controller Case Management Plan.

Please contact DMA's Nursing Facility Rate Setting staff at 919-857-4015 with questions about the provider assessment worksheet or reimbursement rates. For billing questions, please contact EDS at 1-800-688-6696 or 919-851-8888.

Financial Operations
DMA, 919-857-4015

North Carolina Department of Health and Human Services
Division of Medical Assistance
Finance Management

Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

Gary Fuquay, Director

STATEMENT DUE DATE:
Monthly Assessment Fee Statement

Nursing Facility Name: (1) _____

Provider Number: (2) _____

Federal Tax ID Number (3) _____

Please complete and return this form along with your monthly fee payment to the address below. It is imperative that you complete all data fields on this statement. Failure to submit the completed provider fee report and full payment by the due date shall result in penalties and interest as stated in the North Carolina Provider Agreement and Controller Cash Management Plan. ***Retain the bottom (canary) copy for your records. If you should have any*** *questions regarding this form or the reporting requirements, please contact DMA Nursing Home Rate Setting staff at (919) 857-4015.*

Please Make Check Payable to:
DHHS Accounts Receivable

*****indicate***
"Nursing Facility Assessment Fee"
on the memo line of the check

Mailing Address:
DHHS Accounts Receivable
2022 Mail Service Center
Raleigh, NC 27699-2022

Provider Assessment Worksheet -

		Current Month Ended Total	Documented Prior Period Adjustments	Adjusted Monthly Total	Year to Date Cumulative
A	Total Medicaid Patient Days	(4)	(9)	(14)	(21)
B	Total Private / Other Non Medicare Days	(5)	(10)	(15)	(22)
C	Total Non - Medicare Days (A+B)	(6)	(11)	(16)	(23)
D	Provider Assessment Daily Rate			* (17)	
E	**Monthly Provider Fee Due (C*D)**			(18)	
F	Total Medicare Patient Days	(7)	(12)	(19)	(24)
G	Total Patient Days (C + F)	(8)	(13)	(20)	(25)

Signed By (26) _____, Title (27) _____
(Must Be Owner, Partner, Officer or Administrator)

Print Name: (28) _____, Telephone/Email (29) _____

White - Financial Management Copy * Do not remove
Green – Controller's Office Copy * Do not remove
Canary – Provider's Copy * Retain Before Sending

Instructions and Detail to Accompany the North Carolina Nursing Home Monthly Assessment Statement

These expanded instructions and explanations should be used to assist in the accurate completion of the Monthly Assessment Fee Statement.

- Report all nursing facility bed days. Do not include independent living, assisted living, adult care home or rest home bed days in these amounts.

- Provider's Month End and Year End Totals (patient days) must agree with the provider's midnight census.

1. Nursing Facility Name: Enter the Nursing Facility Name as it appears on the Nursing Home License. Enter the name consistently on each month's report.

2. Provider Number: Enter the facility's skilled provider number.

3. Federal Tax ID Number: Enter the Federal Tax Identification number.

4. Total Medicaid Patient Days, Current Month Ended Total: Enter the number of nursing facility days paid or payable by North Carolina Medicaid through the nursing facility reimbursement program for the current month based on dates of service. This number should include any Medicaid pending days as well as Therapeutic Leave days. Certified Medicaid Ventilator Bed Days with negotiated rates and Certified Medicaid Head Injury Program Days are not considered nursing program days for this assessment and should not be included in this total.

5. Total Private/Other Non-Medicare Days, Current Month Ended Total: Enter the number of any nursing facility patient days not paid or payable by either Medicare or Medicaid as a nursing facility day for the current month based on dates of service. This includes all nursing days that are paid for privately by the patients through cash or private long-term care insurance. Hospice, VA, Bed Hold days and all other facility days that are not expressly paid for as a nursing facility day through North Carolina Medicaid or Medicare as the primary payer source should also be included in this total.

6. Total Non-Medicare Days, Current Month Ended Total: Add items 4 and 5 and enter the result here.

7. Total Medicare Patient Days, Current Month Ended Total: Enter the number of any nursing facility patient days for the current month based on dates of service paid or payable by Medicare Part A under the traditional fee for service agreement or under a Medicare Health Maintenance Organization (HMO) Contract.

8. Total Patient Days, Current Month Ended Total: Add items 6 and 7 and enter the result here.

9. Total Medicaid Patient Days, Documented Prior Period Adjustments: Enter the net number of previously unreported Medicaid patient day adjustments from prior periods. These adjustments would include patient days classified as Medicaid days that have been reclassified to non-Medicaid days as well as days that were previously classified as non-Medicaid days that were reclassified to Medicaid days.

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Example:
Patient A was originally classified as Medicaid for 10 days in the previous month. A determination has been made that Patient A was actually private pay. These 10 days should be reclassified from Medicaid to Private/Other Non-Medicare days. The Medicaid days impact for this would be a decrease of 10 days (-10).

Patient B was originally classified as Medicare for 2 days in the previous month. A determination has been made that those days should have been covered by Medicaid. These 2 days should be reclassified from Medicare to Medicaid. The Medicaid days impact for this would be an increase of 2 days (+2).

The net number of previously unreported Medicaid patient day adjustments from prior periods would be –8 (-10 plus +2).

A sample worksheet showing this example and a blank sample worksheet are attached. This worksheet is not required, but is merely a sample that you may use if you desire. All prior period adjustments must be supported with documentation. The attached sample worksheet is not considered supporting documentation. Supporting documentation may include and FL-2, Medicaid Remittance Advice, or other official documentation.

10. Total Private/Other Non-Medicare Days, Documented Prior Period Adjustments: Enter the number of previously unreported Private/Other Non-Medicare patient day adjustments from prior periods. These adjustments would include patient days classified as Private/Other Non-Medicare days that have been reclassified to either Medicare or Medicaid as well as days that were previously classified as Medicare or Medicaid days that were reclassified to Private/Other Non-Medicare days.

Example:
Patient A was originally classified as Medicaid for 10 days in the previous month. A determination has been made that Patient A was actually private pay. These 10 days should be reclassified from Medicaid to Private/Other Non-Medicare days. The Private/Other Non-Medicare days impact for this would be an increase of 10 days (+10).

Patient C was originally classified as Private/Other Non-Medicare for 4 days in the previous month. A determination has been made that those days should have been classified as Medicare. These 4 days will be reclassified from Private/Other Non-Medicare to Medicare. The Private/Other Non-Medicare days impact for this would be a decrease of 4 days (-4).

The net number of previously unreported Private/Other Non-Medicare patient day adjustments from prior periods would be +6 (+10 plus -4).

A sample worksheet showing this example and a blank sample worksheet are attached. This worksheet is not required, but is merely a sample that you may use if you desire. All prior period adjustments must be supported with documentation. The attached sample worksheet is not considered supporting documentation. Supporting documentation may include and FL-2, Medicaid Remittance Advice, or other official documentation.

11. Total Non-Medicare Days, Documented Prior Period Adjustments: Add items 9 and 10 and enter the result here.

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12. Total Medicare Patient Days, Documented Prior Period Adjustments: Enter the number of previously unreported Medicare patient day adjustments from prior periods. These adjustments would include patient days classified as Medicare days that have been reclassified to either Medicaid or Private/Other Non-Medicare as well as days that were previously classified as Medicaid or Private/Other Non-Medicare days that were reclassified to Medicare days.

    Example:
    Patient B was originally classified as Medicare for 2 days in the previous month. A determination has been made that those days should have been covered by Medicaid. These 2 days will be reclassified from Medicare to Medicaid. The Medicare days impact for this would be a decrease of 2 days (-2).

    Patient C was originally classified as Private/Other Non-Medicare for 4 days in the previous month. A determination has been made that those days should have been classified as Medicare. These 4 days will be reclassified from Private/Other Non-Medicare to Medicare. The Medicare days impact for this would be an increase of 4 days (+4).

    The net number of previously unreported Medicare patient day adjustments from prior periods would be +2 (-2 plus +4).

    A sample worksheet showing this example and a blank sample worksheet are attached. This worksheet is not required, but is merely a sample that you may use if you desire. All prior period adjustments must be supported with documentation. The attached sample worksheet is not considered supporting documentation. Supporting documentation may include and FL-2, Medicaid Remittance Advice, or other official documentation.

13. Total Patient Days, Documented Prior Period Adjustments: Add items 12 and 13 and enter the result here. A result of zero indicates that days were only reclassified. A positive number would indicate that adjustments have resulted in an increase in total days. A negative number would indicate that adjustments have resulted in a decrease in total days.

14. Total Medicaid Patient Days, Adjusted Monthly Total: Add items 4 and 9 and enter the result here.

15. Total Private/Other Non-Medicare Days, Adjusted Monthly Total: Add items 5 and 10 and enter the result here.

16. Total Non-Medicare Days, Adjusted Monthly Total: Add items 14 and 15 and enter the result here.

17. Provider Assessment Daily Rate: This is the assessment rate as indicated on the cover letter that accompanied the reporting packet.

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18. Monthly Provider Fee Due: Multiply item 16 by item 17 and enter the result here. This is the amount of assessment due on or before the 15th of the month following the reporting period. Failure to submit the completed provider fee report and full payment by the due date shall result in penalties and interest as stated in the North Carolina Provider Agreement and Controller Cash Management Plan.

19. Total Medicare Patient Days, Adjusted Monthly Total: Add items 7 and 12 and enter the result here.

20. Total Patient Days, Adjusted Monthly Total: Add items 16 and 19 and enter the result here.

21. Total Medicaid Patient Days, Year to Date Cumulative: Add item 14 from the current period report to item 14 from the previous period report and enter the result here.

22. Total Private/Other Non-Medicare Days, Year to Date Cumulative: Add item 15 from the current period report to item 15 from the previous period report and enter the result here.

23. Total Non-Medicare Days, Year to Date Cumulative: Add items 21 and 22 and enter the result here.

24. Total Medicare Patient Days, Year to Date Cumulative: Add item 19 from the current period report to item 19 from the previous period report.

25. Total Patient Days, Year to Date Cumulative: Add items 23 and 24 and enter the result here.

26. Signed by: Upon completion, this form must be signed by an Owner, Partner, Officer or Administrator of the reporting facility. If not signed, the form will be considered incomplete.

27. Title: Title of the individual who signed the form.

28. Print Name: Legibly print the name of the individual who signed the form.

29. Telephone/E-mail: Enter the Telephone number and the e-mail address of the individual who signed the form.

Attention: Physicians

Physician's Drug Program List Update

The April 2004 general Medicaid bulletin published an article listing the FDA-approved drugs currently covered by the N.C. Medicaid program when the drugs are provided in a physician's office for the FDA-approved indications. Rates were effective with date of service April 1, 2004. Please make the following additions/corrections to that list.

Invoice Required	Procedure Code	Description	Maximum Reimbursement Rate
	J0475	Baclofen, Kit 1(one) 20 ml. Amp. (10 mg/20 ml. 500 mcg/ml	$ 209.10
*	J3490	Baclofen, Kit 2 (two) 5 ml. Amp. (10 mg/5 ml. 2000 mcg/ml)	438.60
*	J3490	Baclofen, Kit 4 (four) 5 ml. Amp. (10 mg/5 ml. 2000 mcg/ml.)	770.10
	J0476	Baclofen, for intrathecal trial, 50 mcg (Lioresal for intrathecal trial)	71.40
*	J3490	Risperdone 25 mg (Risperdal Consta)	235.96
*	J3490	Risperdone 37.5 mg (Risperdal Consta)	353.95
*	J3490	Risperdone 50 mg (Risperdal Consta)	471.93

Physicians will continue to bill on the CMS-1500 claim form using the appropriate drug code and indicating the specified number of units administered. Providers must bill their usual and customary charges.

(*) Designates that an invoice must be submitted with each CMS-1500 claim form. The paper invoice must indicate the name of the recipient, the recipient's Medicaid identification number, the name of the medication, the dosage given, the National Drug Code (NDC) number from the vial(s) used, the number of vials used, and the **cost per dose**. Providers must indicate the number of units given in block 24G on the CMS-1500 claim form. Payment is based in accordance with Medicaid's State Plan for reimbursement. Providers will be reimbursed the lower of the invoice price or maximum allowable fee on file.

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

Attention: Laboratory Services Providers

Billing Panel Codes

The Division of Medical Assistance has laboratory panel audits in place that replicate the Correct Coding Initiative (CCI) audits. The CCI has two types of audits: **mutually exclusive** and **bundling**. Mutually exclusive codes are combinations of codes not expected to be performed in conjunction with each other on the same date of service. The CCI bundling audits designate which components of a comprehensive code cannot be reimbursed when billed on the same date of service as the comprehensive code. These audits will sometimes allow a modifier, appended to the component code, to bypass the audit. Modifiers can be used to designate that a procedure was a completely separate service performed in addition to a basic service. The decision as to whether a modifier is allowed is set within the CCI audit.

The following laboratory panel audits are in place.

Comprehensive Panel Code	Component Code
80048	82310, 82374, 82435, 82565, 82947, 84132, 84295, 84520, 80051
80051	82374, 82435, 84132, 84295
80053	80048, 80051, 80069, 80076, 82040, 82247,82310, 82374, 82435, 82565, 82947, 84075,84132, 84155, 84295, 84450, 84460, 84520
80061	80500, 80502, 82465, 83718, 83721, 84478
80069	80048, 80051, 82040, 82310, 82374, 82435, 82565, 82947, 84100, 84132, 84295, 84520
80074	86705, 86709, 86803, 87340
80076	82040, 82247, 82248, 84075, 84155, 84450, 84460

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

Attention: Swing Beds and Lower Levels of Care Providers

Reimbursement Rate for Swing Beds and Lower Levels of Care Services

Effective with date of service May 1, 2004, the maximum allowable rate for the following swing beds and lower levels of care services has been modified. The swing beds and lower levels of care rates are as follows:

Swing Beds and Lower Levels of Care (Room and Board)	**Specialty 086**	**Specialty 086**	**Specialty 086**	**Specialty 086**
Type	**15 (INC)**	**16 (SNC)**	**17 (H-INC)**	**18 (H-SNC)**
004	$ 121.57	$ 121.57	$ 121.57	$ 121.57
008	121.57	121.57	121.57	121.57
059	121.57	121.57	121.57	121.57
060	121.57	121.57	121.57	121.57
063	121.57	121.57	121.57	121.57
068	121.57	121.57	121.57	121.57
069	121.57	121.57	121.57	121.57
076	121.57	121.57	121.57	121.57
090	121.57	121.57	121.57	121.57

Note: At this time, swing beds and lower levels of care (INC, SNC, H-INC, and H-SNC) are reimbursed at the same rate.

Providers must bill their usual and customary charges. Adjustments will not be accepted for rate changes.

Carolyn Brown, Financial Operations
DMA, 919-857-4015

Proposed Medical Coverage Policies

In accordance with Session Law 2003-284, 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
Division of Medical Assistance
Medical Policy Section
2501 Mail Service Center
Raleigh, NC 27699-2501

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.

Checkwrite Schedule

June 8, 2004	July 12, 2004	August 10, 2004
June 15, 2004	July 20, 2004	August 17, 2004
June 22, 2004	July 29, 2004	August 26, 2004
June 29, 2004		

Electronic Cut-Off Schedule

June 4, 2004	July 9, 2004	August 6, 2004
June 11, 2004	July 16, 2004	August 13, 2004
June 18, 2004	July 23, 2004	August 20, 2004
June 25, 2004		

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.

Gary H. Fuguay, Director
Division of Medical Assistance
Department of Health and Human Services

Cheryll Collier
Executive Director
EDS