Number 6 *June 1999*

North Carolina Medicaid Bulletin

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

Attention: Chiropractors

Clarification to Provider Listings for Modifiers

Chiropractor providers are included in the provider types required to bill modifiers beginning with claims received on and after June 25, 1999. "Chiropractors" have been listed in modifier related Medicaid bulletins over the past eight months when addressing policies and lists of codes to be billed with specific modifiers.

As clarification, there are no changes to the scope of covered Medicaid services for chiropractors as a result of the implementation of modifiers. Chiropractors were listed in the headings of these articles only because they will be required to bill modifiers in situations appropriate for modifier use.

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

Attention: Physicians

Correction to March 1999 Medicaid Bulletin

The March 1999 Medicaid Bulletin incorrectly stated that CPT code 90287 "Botulinum Antitoxin, equine, any route" replaced the code J0585 "Botulinum toxin type A."

Both codes are active codes.

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

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Attention: All Providers

NCECS Software Training

Previous bulletin articles (Jan-May 1999) informed providers that a new (NCECS) North Carolina Electronic Claims Submission program would replace the current NECS software. The new software will be year 2000 compliant and will use a new graphical user interface that is similar to a WEB browser. The functionality of the program will be the same as the current NECS software with screens looking similar to the current program. EDS will offer classes both at the Medicaid Fair on September 14, 1999 and in later dates to be announced in Raleigh, Charlotte, Winston-Salem, and Flat Rock. Details on the later locations will be provided in a subsequent bulletin article. Classes will emphasize training on how to navigate through the software and on installation tips.

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

Attention: All Providers of Psychiatric Services

Termination of Carolina Alternatives (CA)

The Division of Medical Assistance (DMA) and The Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS) have notified HCFA that the Carolina Alternatives Program was terminated effective March 1, 1999. The requested transition period ends June 30, 1999. This period will allow a seamless transition back to the fee-for-service method of billing in the 32 counties previously included under the Carolina Alternatives (CA) waiver.

Hospitals currently using First Mental Health (FMH) for pre-admission and concurrent review will need to contact FMH for children who are eligible in a former CA county. For Carolina Alternatives children already in the hospital on June 30, 1999, hospitals will need FMH approval for continued stay effective July 1, 1999.

Effective July 1, 1999, the area mental health centers will continue to provide outpatient services but will no longer receive capitation payments. Reimbursement will be made for retroactive eligibles using a fee-for-service method. The area mental health centers may continue to contract with external providers to promote continuity of care and avoid disruptions in treatment.

Physicians, Ph.D., and Masters-level Psychologists employed by physicians and who are not employed by area mental health centers will need to submit a "Request for Prior Approval Psychiatric Outpatient" form for prior approval for any outpatient care following the second visit. (Note: Telephone PA is not given for psychotherapy). The completed and signed request form should be mailed to:

EDS
ATTN: Prior Approval
P.O. Box 31188
Raleigh, NC 27622

Social Workers, Licensed Professional Counselors and Independent Psychologists cannot enroll as Medicaid providers. These mental health professionals will need to contract with their area mental health center to provide services to Medicaid recipients.

If there are questions, please contact Carolyn Wiser, RN or Callie Silver, RN at 919-857-4025.

Attention: All Providers

Stand-by Codes for Mother and Infant

The physician stand-by CPT code 99360 is reimbursable only for physician stand-by services at high risk deliveries. This code may be billed for stand-by service relating only to the mother. The service must be

requested by a physician and a diagnosis substantiating the high risk must be documented on the claim. Medical records documenting the high risk delivery and need for stand-by services are not required with the claim submission but must be available for DMA or its agents upon request. These records must be retained for a minimum of five years.

This code is not reimbursable when used to represent stand-by services of a physician or CRNA "standing-by"or being "on-call" in the event that general or monitored anesthesia may be required for a diagnostic or surgical procedure. Monitored anesthesia is effective with date of service June 25, 1999.

Use CPT 99436 for physician attendance at the delivery of the newborn by a physician other than the delivering physician.

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

Attention: All Providers

Change in Starred (*) Procedure Policy

Effective with claims received on or after June 25, 1999, Medicaid will align with Medicare in identifying surgical procedures as major or minor. Major surgery is assigned a 90 day post-operative period, while minor surgery is assigned either a 0 or 10 day post-operative period. Maternity services, specific to Medicaid, are assigned 60 post-operative days. Starred procedures, as recognized in the CPT book with a star (*) preceding the code, may not be billed with code 99025. The new procedure is: Separate payment for a procedure with 0 or 10 post-operative days will be considered when an Evaluation and Management (E&M) service is a significant, separately identifiable service by the same physician on the same day as a minor procedure. Reimbursement will be considered for both the Evaluation and Management code and the surgical procedure when modifier 25 is appended to the E&M code.

The complete list of Major and Minor codes and their assigned post-operative days was published in the April, 1999 Medicaid Bulletin.

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

Attention: Ambulatory Surgical Centers, Birthing Centers, Physicians, Chiropractors

Billing of X-Rays and EKGs in the Ambulatory Surgical Setting

Effective with date of service June 25, 1999, reimbursement for x-ray and EKG services performed in the ambulatory surgical setting will not be made to the ambulatory surgical or birthing center. The provider rendering the service must bill on a HCFA-1500 claim form using their physician or practitioners provider number.

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

Attention: Home Health Providers

Payer Source for Skilled Nursing Visits for Injections

Home Health agencies must bill Medicare for home health services whenever Medicare coverage is available. Refer to Section 5.10.I of the Community Care Manual for billing instructions for dually eligible recipients. The Medicare/Medicaid chart beginning on page 5-13 provides guidance on which payer to bill.

Skilled nursing visits for Vitamin B-12 and other injections may not be billed to Medicaid for dually eligible patients regardless of the frequency. Example: A dually eligible patient whose condition has reached a plateau receives monthly skilled nursing visits for observation and evaluation. These visits are billed to Medicaid. Every 90 days, the patient receives a Depo-Provera injection. This visit, including observation and evaluation must be billed to Medicare.

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

Attention: Home Health Services Providers

Policy Amendment

Home Health Services policy in Section 5.7 of the Community Care Manual states, "If providing home health aide services, the aide must be supervised by a RN with supervisory visits to the patient's home every two weeks." Effective with date of service June 1, 1999, the policy is amended to read:

"If providing home health aide services, the aide must be supervised by a RN with supervisory visits to the patient's home every two weeks. If the patient is not receiving skilled nursing care, but is receiving another skilled service (physical therapy, occupational therapy, or speech-language pathology services), supervision may be provided by the appropriate therapist."

This amendment is consistent with Medicare Conditions of Participation. Providers may not bill Medicaid for a visit only to supervise staff.

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

Attention: Oral Surgeons

Clarification to Modifier Billing

Oral surgeons, with the M.D. degree, performing CPT coded oral maxillofacial surgeries listed in the April 1999 Medicaid Bulletin must bill on the HCFA-1500 claim form with the appropriate modifier(s). The modifier billing requirements apply effective with claims received on or after June 25, 1999. If oral surgery is performed by a dentist, the billing should be on the dental claim form and is not included in the implementation of modifiers.

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

Attention: Anesthesiologists and CRNA

Monitored Anesthesia Care (MAC)

Effective with claims received on or after June 25, 1999 the Division of Medical Assistance will begin coverage of Monitored Anesthesia Care (MAC).

MAC involves patient monitoring in anticipation of the need for administration of general anesthesia during a surgical procedure. It involves the continuous evaluation of various vital physiological functions and the recognition and treatment of any adverse changes. MAC includes the performance of a pre-anesthetic examination and evaluation, prescription of the anesthesia care required, and administration of required medications. The administration of IV sedation alone is non-covered. If the administration of the IV sedation is followed by the **constant monitoring** of the patient by an anesthesiologist or CRNA who is in **constant attendance** during the surgical procedure, the anesthesia services should be billed as monitored anesthesia, not IV sedation. MAC requires the continuous actual presence of the anesthesiologist or CRNA, and provisions of indicated postoperative anesthesia care. Separate reimbursement is **not** available if the patient is monitored by the physician performing the surgical procedure or by other personnel, such as a circulating nurse for that surgical procedure.

- Monitored anesthesia care is identified by billing the procedure code plus modifier QS
- Monitored anesthesia care can be billed by an anesthesiologist or CRNA **only**
- When billing time, one minute = one unit
- Monitored anesthesia care involves **continuous actual physical presence** of the anesthesiologist or CRNA. The time starts when the anesthesiologist or CRNA begins to prepare the patient for anesthesia care in the operating room or equivalent area. Time ends when the anesthesiologist or CRNA is no longer in personal physical attendance (i.e., when the patient may be safely placed under postoperative supervision). If the surgery is delayed and the provider of anesthesia services is **not** in constant attendance, the time billed **must** be reduced to reflect the actual time spent with the patient
- The anesthesiologist or CRNA **must** bill the same procedure code as the surgeon
- Ocular and oral procedures may require MAC for a medically necessary covered service. For accurate reimbursement when appending modifier QS, an ocular and oral procedure code **must** be billed with an appropriate diagnosis code

Additional billing information on MAC can be found in the April 1999 Modifier Special Bulletin.

Providers rendering MAC are required to maintain documentation on file for a period of five years. This information **must** include documentation of the pre-anesthetic examination and evaluation, documentation of the monitoring of the patient's vital signs, and any postoperative anesthesia notes.

Billing for monitored anesthesia services includes the administration of fluids and/or blood and the usual monitoring services during the procedure. (Usual monitoring services include ECG, temperature, blood pressure, oximetry, capnography and mass spectrometry).

If these services are rendered and are unrelated to the administration of anesthesia, refer to modifier 59 for further information on page 32 of the April 1999 Modifier Special Bulletin.

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

Attention: All Providers

Medicaid Credit Balance Reporting

All providers participating in the Medicaid program are required to submit a **Quarterly Credit Balance Report** to the Division of Medical Assistance, Third Party Recovery Section. The report is required if the provider has OUTSTANDING credits owed to Medicaid that have not been reported previously on a Medicaid Credit Balance Report. (Hospital and Nursing Facility providers will continue to be required to submit a report every calendar quarter even if a zero ($0.00) credit balance exists.) The report is to be sent no later than 30 days following the end of the calendar quarter (March 31, June 30, September 30 and December 31).

The Medicaid Credit Balance Report is used to monitor and recover "credit balances" owed to the Medicaid program. A credit balance results from an improper or excess payment made to a provider. For example, refunds must be made to Medicaid if a provider is paid twice for the same services (i.e., by Medicaid and a medical insurance policy; by Medicare and Medicaid; by Medicaid and a liability insurance policy); if the patient liability was overlooked in the billing process; or when computer or billing errors occur.

For the purpose of completing the report, a Medicaid Credit Balance is the amount determined to be refundable to the Medicaid program. Generally, when a provider receives an improper or excess payment for a claim it is reflected in their accounting records (patient accounts receivable) as a "credit". However, credit balances include money due Medicaid regardless of its classification in a provider's accounting records. If a provider maintains a credit balance account for a stipulated period, i.e., 90 days, and then transfers the account or writes it off to a holding account, this does not relieve the provider of its liability to the program. The provider is responsible for identifying and repaying all the monies owed the Medicaid program.

The Medicaid Credit Balance Report (copy for reproduction immediately follows article) requires specific information on each credit balance on a claim-by-claim basis. This form provides space for 15 claims but may be reproduced as many times as necessary to accommodate all the credit balances being reported. Specific instructions for completing the report are on the reverse side of the reporting form.

Submit **ONLY** the completed Medicaid Credit Balance Report to:

Division of Medical Assistance
Third Party Recovery Section
Post Office Box 29551
Raleigh, NC 27626-0551

Submitting the Medicaid Credit Balance Report does not result in the credit balances automatically being reimbursed to the Medicaid program. If a check is the preferred form of satisfying the credit balances, the check should be made payable to EDS and sent to EDS with the required documentation for a refund payment. If an adjustment is to be made to satisfy the credit balance, an adjustment form must be completed and sent to EDS with all the supporting documentation for processing. **DO NOT** send refund checks or adjustment forms to the Division of Medical Assistance.

Failure to submit a Medicaid Credit Balance Report could result in the withholding of Medicaid payments until the report is received.

Marilyn Vail, Third Party Recovery Section
DMA, 919 733 6294

MEDICAID CREDIT BALANCE REPORT

PROVIDER NAME: _____CONTACT PERSON: _____

PROVIDER NUMBER: _____TELEPHONE NUMBER: (_____)_____

QUARTER ENDING: (Circle one) 3/31 6/30 9/30 12/31 YEAR:_____

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
RECIPIENT'S NAME	MEDICAID NUMBER	FROM DATE OF SERVICE	TO DATE OF SERVICE	DATE MEDICAID PAID	MEDICAID ICN	AMOUNT OF CREDIT BALANCE	REASON FOR CREDIT BALANCE
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							

(See back of form for instructions)

Circle one: Refund Adjustment

Revised 6/99

Instructions for Completing Medicaid Credit Balance Report

Complete the "Medicaid Credit Balance Report" as follows:

- Full name of facility as it appears on the Medicaid Records
- The facility's **Medicaid** provider number. If the facility has more than one provider number, use a separate sheet for each number. **DO NOT MIX**
- Circle the date of quarter end
- Enter year
- The name and telephone number of the person completing the report. This is needed in the event DMA has any questions regarding some item in the report

Complete the data fields for each Medicaid credit balance by providing the following information:

Column 1 - The last name and first name of the Medicaid recipient (e.g., Doe, Jane)

Column 2 - The individual Medicaid identification (MID) number

Column 3 - The month, day, and year of beginning service (e.g., 12/05/99)

Column 4 - The month, day, and year of ending service (e.g., 12/10/99)

Column 5 - The R/A date of Medicaid payment (not your posting date)

Column 6 - The Medicaid ICN (claim) number

Column 7 - The amount of the credit balance (not the amount your facility billed or the amount Medicaid paid)

Column 8 - The reason for the credit balance by entering: "81" if it is a result of a Medicare payment; "83" if it is the result of a health insurance payment; "84" if it is the result of a casualty insurance/attorney payment or "00" if it is for another reason. Please explain "00" credit balances on the back of the form.

After this report is completed, total column 7 and mail to DMA.

Attention: All Providers

Fee Schedules, Reimbursement Plans and Medicaid Bulletin Subscriptions

Request for Paper Schedules/Plans

There is no charge for fee schedules or reimbursement plans requested from the Division of Medical Assistance. However, all requests for publications **should be made on the form below** at the following address, **or** you can fax your request as indicated below:

Division of Medical Assistance
Financial Operations - Fee Schedules
1985 Umstead Drive
P. O. Box 29529
Raleigh, N. C. 27626-0529

PLEASE NOTE: PHONE REQUESTS ARE NOT ACCEPTED

You may fax your request to **(919) 715-0896/ DMA Financial Operations**.

Do not mail your requests for paper schedules to EDS.

- ☐ After Care Surgery Period
- ☐ Ambulatory Surgery Center
- ☐ Anesthesia Base Units
- ☐ Dental
- ☐ DME
- ☐ Home Health
- ☐ Home Infusion Therapy
- ☐ Hospital Reimbursement Plan
- ☐ ICF/MR Reimbursement Plan
- ☐ Laboratory
- ☐ Nurse Midwife
- ☐ Nursing Facility Reimbursement Plan
- ☐ Optical and Visual Aids
- ☐ Physician Fees (includes X-Ray)
- ☐ Prosthetics and Orthotics
- ☐ Portable X-Ray

Requestor:_____ Provider Type: _____

Address:_____

_____

_____ Contact:_____

Phone: _____

Request for Diskette of Physician Fee Schedule and Anesthesia Base Units Schedule

The **PHYSICIAN FEE SCHEDULE** and the **ANESTHESIA BASE UNIT SCHEDULE** are available on diskette or via email at no charge from **DMA**. The North Carolina Division of Medical Assistance stipulates that the information provided may be used only for your internal analysis. The actual billed amount on your claims must always contain your regular billed amount and not the price on the fee schedule unless the listed price represents what you normally bill another payor or patient. DMA considers the billed amount in their rate setting efforts.

Please complete the information below with each request:

Requestor:_____

Address:_____ E-mail Address_____

_____

Phone: _____

Type of File:
3 1/2" PC Diskette (circle one):

TEXT FILE Excel Spreadsheet

Type of Schedule (check one): Diskette

☐ Physician Fee Schedule

☐ Anesthesia Base Units

Please submit this request to**:**

Division of Medical Assistance
Financial Operations
P. O. Box 29529
Raleigh, North Carolina 27626-0529

Medicaid Bulletin Subscriptions

N. C. Medicaid bulletins are mailed to all enrolled providers. Non providers (i.e. billing agencies) may subscribe to the bulletin for an annual subscription fee of $12.00. To subscribe, send a letter requesting the subscription, including the subscriber's mailing address and a check for $12.00 payable to EDS. Mail the request to:

EDS
Attention: Provider Enrollment
P. O. Box 300009
Raleigh, N. C. 27622

Contact: DMA – Financial Operations for schedules
EDS – Provider Enrollment for Bulletin Subscriptions

Attention: All Providers

Acceptance of Medicaid Payment as Payment in Full

The Health Care Financing Administration has informed State Medicaid Programs of providers inappropriately requiring Medicaid patients to make cash payments for Medicaid covered services. There have been reports from States of incidents where an anesthesiologist would not provide an epidural to a Medicaid patient in childbirth unless she paid in advance, with her own funds, for the procedure. In one instance, the obstetrician ordered the epidural in advance but when the woman was in active labor, she was refused the service for lack of pre-payment. Providers are reminded that enrollment in a State Medicaid Program as a provider of health services and acceptance of Medicaid recipients as patients, requires the provider to accept payment by the State Medicaid agency as payment in full. The regulation states:

42 CFR 447.15

> **"A State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or co-payment required by the plan to be paid by the individual. However, the provider may not deny services to any eligible individual on account of the individual's inability to pay the cost-sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) or 42 CFR 447.53. The previous sentence does not apply to an individual who is able to pay. An individual's inability to pay does not eliminate his or her liability for the cost sharing charge."**

Each provider makes a determination whether or not to accept an individual Medicaid recipient for treatment. Agreement to treat that individual may not require a co-payment for his or her services, but the provider must accept payment by the NC Medicaid agency as payment in full. Services excluded from co-payment include but are not limited to: persons under age 21, services related to pregnancy, family planning, hospital inpatient and emergency room services. For a complete list, refer to page 7 of the December 1995 Medicaid Bulletin. A provider enrolled as a NC Medicaid provider **cannot** under federal Medicaid law demand these additional payments. However, when a provider agrees to treat a Medicaid recipient as a private patient and the Medicaid beneficiary accepts the arrangement as a condition of treatment, the arrangement is not governed by Medicaid program requirements.

Hospital Responsibilities

A hospital accepting a Medicaid patient for treatment accepts the responsibility for making sure the patient receives all medically necessary services. The conditions of participation governing hospitals providing care to Medicaid and Medicare patients require the governing body of the hospital to assure accountability of the medical staff for the quality of care provided to patients. This means an effective hospital-wide quality assurance program must be in place to evaluate the provision of patient care. All organized services related to patient care, including services furnished by a contractor must be evaluated and where deficiencies are identified, remedial action must be taken. **(42 CFR 482.12, 21 & 22).**

The NC Medicaid agency (Division of Medical Assistance) may place appropriate limits on a service based on medical necessity or utilization control criteria **(42 CFR 440.230(d)).** If providers (including but not limited to anesthesiologists) do not accept a particular patient for treatment, the hospital has the responsibility of assuring delivery of these medically necessary services. Where epidurals are a covered benefit under a State's Medicaid program and the service is determined to be medically necessary, a pregnant Medicaid beneficiary or any other Medicaid beneficiary, is entitled to receive the service from a provider who has accepted them as a patient. The pregnant Medicaid beneficiary is not liable for deductibles, cost sharing or similar charges.

Physician Responsibilities

Each physician determines whether or not to accept an individual patient for treatment. A doctor participating in the NC Medicaid program, and agreeing to treat a Medicaid patient covered by the state

plan, may not require a co-payment for the services rendered, but must accept payment by the NC Medicaid agency as payment in full. Participating physician's demand for these additional payments would be in violation of the law. Where a physician accepts an individual for treatment not as a Medicaid patient but as a private patient, and the Medicaid beneficiary accepts the arrangement as a condition of treatment through pregnancy and delivery, the arrangement is not governed by Medicaid program requirements.

For example, in such a physician non-Medicaid patient arrangement, where a routine delivery is anticipated, as part of her prenatal counseling, the patient's options for pain relief medication during childbirth may be explained to her. If she requests an epidural, it is explained that the anesthesiologist's fee for this procedure must be paid in advance, prior to the time of hospitalization and delivery. This is not a situation covered by Medicaid program requirements.

As a provider of health services to **all** Medicaid recipients, especially services administered to pregnant Medicaid recipients, be aware of the responsibilities for services rendered.

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

Attention: Podiatrists, Physicians, Nurse Practitioners

Foot Care

Section 1862(a) (13) (c) of the Social Security Act prohibits payment for routine foot care. These services, including cutting or removal of corns and calluses, trimming, cutting, clipping, and debriding of nails and other hygienic care, are normally considered routine and are not covered by Medicaid. These services, prohibited from payment, are recognized by appending modifier YR to the CPT procedure code. The only circumstances in which routine foot care services can be reimbursed are those which are medically necessary and are an integral part of otherwise covered services (such as plantar warts); and/or there exists the presence of metabolic, neurological, and/or peripheral vascular diseases; and/or there is evidence of mycotic nails that, in the absence of a systemic condition, result in pain or secondary infection. In these special circumstances modifier YR should never be appended to the CPT code since reimbursement is allowed.

The new procedure is to use the following guidelines to bill for medically necessary routine foot care services. Procedure codes 11055, 11056, 11057, and 11719 will process to pay only when:

1. there is a systemic condition,
2. there is active care by a physician for the systemic condition, and
3. there is physical and/or clinical findings (herein known as class findings) that are consistent with the diagnosis and indicative of severe peripheral involvement.

Modifiers Q7, Q8, and Q9 were developed to allow providers to report these class findings without having to submit additional documentation on the claim. These modifiers indicate the severity of the patient's condition and enhance the medical necessity for routine foot care services. Each category represents conditions or findings that are grouped into class "A", "B", or "C".

Definitions of the Class Findings:

Q7 represents "One Class A Finding". A Class "A" finding is a nontraumatic amputation of the foot or integral skeletal portion thereof.

Q8 represents "Two Class B Findings". Class "B" findings include:

- absent posterior tibial pulse
- absent dorsalis pedis pulse
- advanced trophic changes such as hair growth (decrease or absence), nail changes (thickening), pigmentary changes (discoloration), skin texture (thin, shiny), and skin color (elevation pallor or dependence rubor). Three of these trophic changes are required to equal one class "B" finding.

Q9 represents "One Class B Finding" and "Two Class C Findings". Class "C" findings include:

- claudication
- temperature changes (i.e., cold feet)
- edema
- paresthesias (abnormal spontaneous sensations in the feet)
- burning
- markedly diminished or absent sensation in the foot, secondary to systemic disease or injury resulting in damage to the sensory nerves to the lower extremity

When billing for procedure codes 11055, 11056, 11057, and 11719, one of these class finding modifiers must be appended. In addition, there must be a diagnosis describing the patient's systemic condition.

Debridement of nail(s) for a patient with infected mycotic nails and a systemic condition or marked ambulatory limitations due to pain or infection, procedure codes 11720 and 11721 must be billed with diagnosis code **110.1** (mycotic nail). In addition there must be a second diagnosis code representing a systemic condition **or** one of the following diagnosis codes: 681.10, 681.11, 719.77, 729.5, 781.2. In either instance, at a minimum, two diagnosis codes are required.

The diagnosis of Planter's warts will no longer be an acceptable diagnosis for billing procedure codes 11055, 11056, and 11057. Per CPT directive, Planter's warts must be billed with procedure codes 17000, 17003, and 17004.

Documentation to substantiate the condition for which these modifiers are used must be present in the medical record and kept on file for a period of not less than five years.

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

Attention: Ambulatory Surgical Centers, Certified Registered Nurse Anesthetists, Birthing Centers, Chiropractors, Independent Labs, Independent Nurse Midwives, Independent Nurse Practitioners, Optometrists, Physician Services in Federally Qualified Health Centers, Physician Services in Rural Health Clinics, Physician Specialties (All), Planned Parenthood (non M.D.), Podiatrists, Portable X-ray

HCPCS Level II and 1999 CPT Codes Added to Modifier Lists

Several lists of codes applicable to modifier usage have been published in conjunction with implementation of modifiers effective with date of receipt, June 25, 1999.

The following Level II and new 1999 CPT codes should be added to the modifier lists indicated in these publications:

CPT Code	Modifier	Publication	Page
27347	Modifier 80, 82	Medicaid Bulletin, April, 1999	7
28289	Modifier 80, 82	Medicaid Bulletin, April, 1999	7
35500	Modifier 80, 82	Medicaid Bulletin, April, 1999	7
35682	Modifier 80, 82	Medicaid Bulletin, April ,1999	7
35683	Modifier 80, 82	Medicaid Bulletin, April, 1999	7
36831	Modifier 80, 82	Medicaid Bulletin, April, 1999	7
36833	Modifier 80, 82	Medicaid Bulletin, April, 1999	7
45126	Modifier 80, 82	Medicaid Bulletin, April, 1999	7
57106	Modifier 80, 82	Medicaid Bulletin, April, 1999	7
57107	Modifier 80, 82	Medicaid Bulletin, April, 1999	7
57109	Modifier 80, 82	Medicaid Bulletin, April, 1999	7
57111	Modifier 80, 82	Medicaid Bulletin, April, 1999	7
57112	Modifier 80, 82	Medicaid Bulletin, April, 1999	7
W5075	Modifier 80, 82	Medicaid Bulletin, April, 1999	7
15001	Global Surgery (0)	Medicaid Bulletin, April ,1999	13
15351	Global Surgery (0)	Medicaid Bulletin, April ,1999	13
15401	Global Surgery (0)	Medicaid Bulletin, April ,1999	13
27347	Global Surgery (90)	Medicaid Bulletin, April ,1999	13
28289	Global Surgery (90)	Medicaid Bulletin, April ,1999	13
35682	Global Surgery (0)	Medicaid Bulletin, April ,1999	13
31623	Global Surgery (0)	Medicaid Bulletin, April ,1999	13
31624	Global Surgery (0)	Medicaid Bulletin, April ,1999	13
31643	Global Surgery (0)	Medicaid Bulletin, April ,1999	13
32001	Global Surgery (0)	Medicaid Bulletin, April ,1999	13
35500	Global Surgery (0)	Medicaid Bulletin, April ,1999	13
35682	Global Surgery (0)	Medicaid Bulletin, April ,1999	13
35683	Global Surgery (0)	Medicaid Bulletin, April ,1999	13
36831	Global Surgery (90)	Medicaid Bulletin, April ,1999	13
36833	Global Surgery (90)	Medicaid Bulletin, April ,1999	13
38792	Global Surgery (0)	Medicaid Bulletin, April ,1999	13
45126	Global Surgery (90)	Medicaid Bulletin, April ,1999	13
57106	Global Surgery (90)	Medicaid Bulletin, April ,1999	13
57107	Global Surgery (90)	Medicaid Bulletin, April ,1999	13
57109	Global Surgery (90)	Medicaid Bulletin, April ,1999	13
57111	Global Surgery (90)	Medicaid Bulletin, April ,1999	13
67220	Global Surgery (90)	Medicaid Bulletin, April 1999	13
69990	Global Surgery (0)	Medicaid Bulletin, April 1999	13
W8001	Modifier 25/57	Medicaid Bulletin, April 1999	9/10
67220	Multiple Session Codes	Modifier Special Bulletin, April 1999	15
31623	Procedure Codes Included in Anesthesia	Modifier Special Bulletin, April 1999	24
31624	Procedure Codes Included in Anesthesia	Modifier Special Bulletin, April 1999	24
31643	Procedure Codes Included in Anesthesia	Modifier Special Bulletin, April 1999	24
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15001	Modifier 53	Modifier Special Bulletin, April 1999	48
15351	Modifier 53	Modifier Special Bulletin, April 1999	48
15401	Modifier 53	Modifier Special Bulletin, April 1999	48
27347	Modifier 53	Modifier Special Bulletin, April 1999	48
28289	Modifier 53	Modifier Special Bulletin, April 1999	48
31623	Modifier 53	Modifier Special Bulletin, April 1999	48
31624	Modifier 53	Modifier Special Bulletin, April 1999	48
31643	Modifier 53	Modifier Special Bulletin, April 1999	48
32001	Modifier 53	Modifier Special Bulletin, April 1999	48
35500	Modifier 53	Modifier Special Bulletin, April 1999	48
35682	Modifier 53	Modifier Special Bulletin, April 1999	48
35683	Modifier 53	Modifier Special Bulletin, April 1999	48
36831	Modifier 53	Modifier Special Bulletin, April 1999	48
36833	Modifier 53	Modifier Special Bulletin, April 1999	48
38792	Modifier 53	Modifier Special Bulletin, April 1999	48
45126	Modifier 53	Modifier Special Bulletin, April 1999	48
57106	Modifier 53	Modifier Special Bulletin, April 1999	48
57107	Modifier 53	Modifier Special Bulletin, April 1999	48
57109	Modifier 53	Modifier Special Bulletin, April 1999	48
57111	Modifier 53	Modifier Special Bulletin, April 1999	48
57112	Modifier 53	Modifier Special Bulletin, April 1999	48
67220	Modifier 53	Modifier Special Bulletin, April 1999	48
69990	Modifier 53	Modifier Special Bulletin, April 1999	48
W5075	Modifier 53	Modifier Special Bulletin, April 1999	48
W5131	Modifier 53	Modifier Special Bulletin, April 1999	48
W5132	Modifier 53	Modifier Special Bulletin, April 1999	48
W5133	Modifier 53	Modifier Special Bulletin, April 1999	48
W8206	Modifier 53	Modifier Special Bulletin, April 1999	48
W8207	Modifier 53	Modifier Special Bulletin, April 1999	48
Q0124	Modifiers 76/77	Modifier Special Bulletin, April 1999	49/50
Q0136	Modifiers 76/77	Modifier Special Bulletin, April 1999	49/50
R0007	Modifiers 76/77	Modifier Special Bulletin, April 1999	49/50

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

Attention: All Providers

Health Check Reminder Letters

Health Care Financing Administration (HCFA) requires that 80% of all Medicaid recipients under the age of 21 receive Health Check screenings by the year 2000. To accomplish this goal, the Division of Medical Assistance sends reminder letters to the parents/guardians to:

1) Emphasize well child check-ups (Health Check screenings) are available as a Medicaid covered service;

2) Remind parents/guardians to take their children for scheduled screenings;

3) Notify parents/guardians of their scheduled appointment for a Health Check screening

Effective July 1, 1999, these letters will also list the name of the recipients' Primary Care Providers (PCPs) or HMO if applicable. These reminders will assist in educating recipients about Managed Care and will remind them of the PCP/HMO they selected for the child.

This information will assist PCPs/HMOs in getting their new patients established with their practice. However, PCPs and HMOs should also continue their efforts to get their patients established by using the monthly enrollment report to identify and contact "New Enrollees".

If there are any questions, please contact the local Managed Care Representative in your county or contact the State Managed Care Section at (919) 857-402

Attention: All Providers

Income Limits for Medicaid and N.C. Health Choice For Children

Medicaid income limits that are based on the federal poverty level have increased. The new amounts are shown in the following tables.

Please encourage any of your non-Medicaid patients who do not appear to have the financial ability to pay for medical care and fit into any of the groups listed below to go to the county Department of Social Services to file an application for Medicaid or N.C. Health Choice for Children.

Families and Children:

Pregnant Women and Infants under Age 1
185% of Poverty (No asset test)
Effective 4/1/99

Family Size	Monthly Income Limit
1	$1271
2	$1706
3	$2140
4	$2575

Children Ages 1 to 6
133% of Poverty (No asset test)
Effective 4/1/99

Monthly Income Limit
$914
$1226
$1539
$1851

Children Ages 6 to 19
100% of Poverty (No asset test)
Effective 4/1/99

Family Size	Monthly Income Limit
1	$687
2	$922
3	$1157
4	$1392

NC Health Choice for Children
Ages 0 to 18, 200% Poverty
Effective 4/1/99

Monthly Income Limit
$1374
$1844
$2314
$2784

Pregnant women who meet the income limits are eligible for pregnancy related services including labor and delivery. They receive a pink Medicaid identification (MID) card.

Children under age 19 who meet the income limit are eligible for all Medicaid covered services. They receive a blue MID card.

In order to receive NC Health Choice for Children, the child cannot be eligible for Medicaid, or be covered by private health insurance. The family may be required to pay an enrollment fee of $50 per child who is covered ($100 maximum per family) per year and pay a copayment for medical services.

Aged, Blind, Disabled and Medicare Beneficiaries:

Medicaid for the Aged, Blind, and Disabled
100% of Poverty
Effective 5/1/99

Family Size	Monthly Income Limit
1	$687
2	$922

Asset Limit for Aged, Blind or Disabled for 1 -$2000

Asset Limit for Aged, Blind or Disabled for 2 -$3000

Qualifying Medicare Beneficiaries
(MQB-Q)
Effective 5/1/99

Monthly Income Limit
$687
$922

Asset Limit for Medicare Beneficiaries for 1- $4000

Asset Limit for Medicare Beneficiaries for 2- $6000

Special Low Income Medicare Beneficiaries
(MQB-B)
Effective 5/1/99

Family Size	Monthly Income Limits
1	$824
2	$1106

Qualifying Individuals – Group 1
(MQB-E)
Effective 5/1/99

Monthly Income Limits
$927
$1245

Qualifying Individuals – Group 2
(MQB-QI2)
Effective 5/1/99

Family Size	Monthly Income Limits
1	$1202
2	$1613

The Aged (65 years old and older), Blind or Disabled who meet the income and asset limits are eligible for all Medicaid covered services. They receive a Blue MID card.

Medicare Part A beneficiaries who meet the income and assets limits for "Qualified Medicare Beneficiary Coverage" are eligible for Medicaid payment of their Medicare premiums, deductibles, and coinsurance for Medicare covered services. They usually receive a buff colored MID card. Some individuals are dually eligible as Medicaid and as Qualified Medicare Beneficiary. In those cases, a blue MID card is issued and recipients are eligible for all Medicaid covered services, including payment of the Medicare deductibles and coinsurance.

Individuals who have Medicare but are over the income limit for Medicaid may be eligible under the "Special Low Income Beneficiary" group or the "Qualifying Individuals Group 1". Medicaid will pay for all of the Medicare Part B premium for these individuals. For those eligible as "Qualifying Individuals Group 2" Medicaid pays for $2.23 of the Medicare Part B premium. These individuals do not receive a Medicaid card.

Medicaid Eligibility Unit
DMA, 919-857-4019

Attention: Health Check Providers

Health Check Modifier Changes (Effective July 1 1999)

Health Check modifiers are changing to meet the HCFA Level III local code requirements. In the process of making this change, DMA seeks to simplify the billing process for the providers. EDS will cross-reference the modifiers for six months (7-1-99 through 12-31-99) to give providers a period of time to learn the new billing requirements. Providers may bill using both old and new modifiers during the transition period only. The tables below represent the current Health Check modifiers and the new modifiers that go into effect July 1, 1999.

Current Required Diagnosis Modifiers

No Treatment Initiated	Mod	Treatment Initiated	Mod
New Diagnosis – Screening provider will follow-up	A	New Diagnosis – Screening provider will follow-up	E
Existing Diagnosis – Screening provider will follow-up	B	Existing Diagnosis – Screening provider will follow-up	F
New Diagnosis – Referred to another provider	C	New Diagnosis – Referred to another provider	G
Existing Diagnosis – Referred to another provider	D	Existing Diagnosis – Referred to another provider	H

New Required Diagnosis Modifiers (effective July 1, 1999)

Abnormal/Sick Diagnosis Outcome	Mod
Follow-up with screening provider	**XF**
Referred to another provider	**XO**
No follow-up necessary	**ZF**

Note "1N" will continue to be used when all findings are normal.

The next table represents the changes in the screening modifiers. These modifiers are only listed when applicable and are used in addition to the diagnosis modifiers.

Current Screening Modifiers

New Screening Modifiers (effective July 1, 1999)

Modifier	**Explanation**	**Modifier**	**Explanation**
D1	Referral for dental care	ZD	Referral for dental Care
L1	Blood lead screening test drawn	ZL	Blood level screening test drawn
R1	Referral to the WIC Program	Z1	Referral to the WIC program
R2	Referral to the Head Start Program		
R3	Referral to the CSC (Child Service Coordination) Program		
R4	Referral to the CSHS (Children's Special Health Services)		
R5	Referral to the Department of Social Services		
R6	Referral to the Developmental Evaluation Center (DEC)		
R7	Referral to another social services or community agency		

The following are changes to the immunization and contraindication modifiers. The categories have not changed; the modifiers have been changed to reflect the HCFA Level III codes.

Immunization Modifiers

Current Modifiers	New Modifiers (**effective July 1, 1999**)
Purchased Dose - **P**	Purchased Dose – **Y**
Free Dose – **F**	Free Dose - **X**

Contraindication Modifiers

Current Modifiers		New Modifiers (**effective July 1, 1999**)
Temporary	**C1**	**ZT**
Permanent	**C2**	**ZP**
Religious	**C3**	**ZR**

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

Attention: All providers

Fee Schedule Modifications

Effective June 25, 1999, the Division of Medical Assistance (DMA) will implement modifier processing for physician and practitioner claims submitted on the HCFA-1500 claim. Paper fee schedules created after this date will be changed to incorporate modifiers.

A modifier field will be added to the paper fee schedules. This new field will immediately follow the procedure code. Procedure codes requiring a modifier will no longer carry the type of service (TOS). When the code requires a technical component or professional component modifier, a 'TC' or '26' modifier will appear in the modifier field. The TOS field will be blank in this case. All other codes requiring modifiers will appear with blanks in both the TOS and modifier fields. TOS will still be noted for providers who are not required to utilize modifiers for billing.

In addition to the changes above, the report will not be sorted by type of service (TOS). Procedure codes with multiple modifier or TOS combinations will be grouped together. The report columns will be in order from the top of the page to the bottom, instead of from left to right.

TOS	PROC/MOD	DATE	CHRG
	71020	990101	28.24
	71020TC	990101	18.17
	7102026	990101	10.17
	71030	990101	88.11
	71030TC	990101	45.28
3	40650	990101	243.47

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

Attention: Ambulatory Surgical Centers, Birthing Centers, CRNA, Chiropractors, Independent Labs, Independent Nurse Midwives, Independent Nurse Practitioners, Optometrists, Physician Services in Federally Qualified Health Center, Physician Services in Rural Health Centers, All Physician Specialties, Planned Parenthood (non MD), Podiatrists, Portable X-Ray

Quick Reference to Modifier Bulletin Articles

The Division of Medical Assistance and EDS are in the final stages of implementing changes required to accommodate the billing of modifiers. Billing with select modifiers will be mandatory for the above listed providers for claims received on or after June 25, 1999. The service will be denied if modifiers not recognized by Medicaid are billed or if valid modifiers are used inappropriately.

The following modifier related information has been published in the Medicaid Bulletins listed below:

June 1999

Footcare

Fee Schedule Changes

Chiropractic Clarification

Oral Surgeon Clarification

Change in Starred Procedure Policy

Monitored Anesthesia Care

HCPCS Level II and 1999 CPT Additions to Modifier Published Lists

May 1999
Interventional Cardiology

Global Anesthesia Policy

Endoscopy Base Codes and Their Related Procedures-originally Published in November, 1998

CLIA "Waived tests"

April/May 1999
Modifier Special Bulletin (Distributed at modifier workshops in April and May and mailed to providers in May who did not attend workshops.)

April 1999
Assistant at Surgery Policy and Codes

Global Surgery Policy-Major and Minor Procedures

March 1999
Modifier Dates for Implementation

February 1999
Modifiers and Y2K Readiness Disclosure

Modifiers

December 1998
Remittance Advice Changes

November 1998
Billing for Multiple Endoscopies

Modifiers

October 1998
Clinical Laboratory Improvements Amendment Number Required on HCFA-1500 Claim

Assistant Surgeon Reimbursement

There are many changes associated with the implementation of modifier billing. It is imperative that providers read all the material and understand the changes required in their billing practices. To answer questions about modifier billing, EDS Provider Services Unit is available to receive phone calls or visit upon request.

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

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Attention: Nursing Facility Providers

Nursing Facility Seminar Schedule

Seminars for nursing facility providers will be held in July 1999. These seminars will focus on nursing facility guidelines and policies, prior approval, FL2 completion, UB-92 instructions, and denial resolution.

Please select the most convenient site and return the completed registration form to EDS as soon as possible. Seminars begin at 10:00 a.m. and end at 1:00 p.m. Providers are encouraged to arrive by 9:45 a.m. to complete registration. **Preregistration is strongly recommended**.

Note: **Providers should bring their most current issue of the Nursing Facility Manual to the workshop for reference. Additional manuals will be available for purchase at $6.00.**

Directions are available on page 27 of this bulletin.

Wednesday, July 7, 1999
Ramada Inn Airport Central 1
515 Clanton Road
Charlotte, NC

Friday, July 9, 1999
Blue Ridge Community College
College Drive
Flat Rock, NC
Auditorium

Wednesday, July 14, 1999
WakeMed
MEI Conference Center
3000 New Bern Avenue
Raleigh, NC
Park at East Park Medical Plaza

Tuesday, July 20, 1999
Four Points Sheraton
(Previously known as Howard Johnson)
5032 Market Street
Wilmington, NC

Thursday, July 22, 1999
Ramada Inn
3050 University Parkway
Winston-Salem, NC

(cut and return registration form only)

Nursing Facility Provider Seminar Registration Form

(No Fee)

Provider Name _____ Provider Number _____

Address _____ Contact Person _____

City, Zip Code _____ County _____

Telephone Number _____ Date _____

List any specific issues you would like addressed in the space provided below:

_____

_____

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

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Attention: Personal Care Services (PCS) Providers

Personal Care Services Seminars

Personal care services (PCS) seminars will be held in August 1999. The July 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

_____

_____

_____

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

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Directions to the Nursing Facility Seminar

The Registration form for the Nursing Facility workshops is on page 23 of this bulletin.

CHARLOTTE, NORTH CAROLINA

RAMADA INN AIRPORT CENTRAL 1

Wednesday, July 7, 1999

I-77 to Exit 7. Ramada Inn is located right off I-77 on Clanton Road. Signs will be posted with room locations.

FLAT ROCK, NORTH CAROLINA

BLUE RIDGE COMMUNITY COLLEGE

Friday, July 9, 1999

I-40 to Asheville. Head East on I-26 to Exit 22 and follow signs to Blue Ridge Community College. Auditorium is located in the Patton Building.

RALEIGH, NORTH CAROLINA

WAKEMED MEI CONFERENCE CENTER

Wednesday, July 14, 1999

Directions to the Parking Lot:

Take the I-440 Raleigh Beltline to New Bern Avenue, Exit 13A (New Bern Avenue, Downtown). Go toward WakeMed. Turn left at Sunnybrook road and park at the East Square Medical Plaza which is a short walk to the conference facility. Vehicles will be towed if not parked in appropriate parking spaces designated for the Conference Center.

Directions to the MEI Conference Center from Parking Lot:

Cross the street and ascend steps from sidewalk up to Wake County Health Department. Cross Health Department parking lot and ascend steps with a blue handrail to MEI Conference Center. Entrance doors at left.

WILMINGTON, NORTH CAROLINA

FOUR POINTS SHERATON

(Previously known as the Howard Johnson Plaza)

Tuesday, July 20, 1999

I-40 East into Wilmington to Highway 17 - just off of I-40. Turn left onto Market Street and the Four Points Sheraton *(Previously known as the Howard Johnson Plaza)* is located on the left.

WINSTON-SALEM, NORTH CAROLINA

RAMADA INN PLAZA
Thursday, July 22, 1999

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

Checkwrite Schedule

June 8, 1999	July 7, 1999	August 10, 1999
June 15, 1999	July 13, 1999	August 17, 1999
June 24, 1999	July 22, 1999	August 26, 1999

Electronic Cut-Off Schedule *

June 4, 1999	July 2, 1999	August 6, 1999
June 11, 1999	July 9, 1999	August 13, 1999
June 18, 1999	July 16, 1999	August 20, 1999

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

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

James R. Clayton
Executive Director
EDS

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