



North Carolina Medicaid Bulletin

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

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

Attention: All Providers

Holiday Observance

The Division of Medical Assistance (DMA) and EDS will be closed on Thursday, July 4, in observance of Independence Day.

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

<u>In This Issue.....</u>	<u>Page #</u>	<u>In This Issue.....</u>	<u>Page #</u>
<u>All Providers:</u>		<u>Health Departments:</u>	
◆ Billing for Labor and Delivery Anesthesia.....	3	◆ Training for Local Health Departments on New Codes....	13
◆ HIPAA Implementation Project Update.....	2	<u>Hospitals:</u>	
◆ HIPAA – Questions and Answers.....	4	◆ Criterion #5 Services	11
◆ Index to General and Special Bulletins for January 2002 through June 2002.....	18	◆ Vitrasert (Ganciclovir, 4.5 mg, Long-acting Implant, Code J7310).....	12
◆ NCECS Software Changes	8	<u>ICF/MR Facility Providers:</u>	
◆ Preferred Drug List.....	9	◆ 34-Day Grace Period for Prescription Drug PA.....	11
◆ Proposed Medical Coverage Policies.....	2	<u>Long Term Care Pharmacists:</u>	
<u>Adult Care Home Providers:</u>		◆ Long-Term Care Pharmacists May Seek Prescription Drug Prior Authorization	14
◆ 34-Day Grace Period for Prescription Drug PA.....	11	<u>Nursing Facility Providers:</u>	
<u>Ambulatory Surgical Centers:</u>		◆ 34-Day Grace Period for Prescription Drug PA.....	11
◆ Vitrasert (Ganciclovir, 4.5 mg, Long-acting Implant, Code J7310).....	12	<u>Prescribers and Pharmacists:</u>	
<u>Area Mental Health Centers:</u>		◆ 34-Day Grace Period for Prescription Drug PA.....	11
◆ Criterion #5 Services	11	◆ Exemptions to Prescription Drug PA Criteria.....	10
<u>Carolina ACCESS Primary Care Providers:</u>		◆ Long-Term Care Pharmacists May Seek Prescription Drug Prior Authorization	14
◆ Carolina ACCESS Provider Surveys	13	<u>Physicians:</u>	
<u>Durable Medical Equipment Providers:</u>		◆ Apnea Monitor Coverage Criteria and Billing Guidelines.....	14
◆ Apnea Monitor Coverage Criteria and Billing Guidelines.....	14	◆ Vitrasert (Ganciclovir, 4.5 mg, Long-acting Implant, Code J7310).....	12
<u>Health Check Providers:</u>			
◆ Health Check Seminar Schedule.....	15		
◆ Directions to the Health Check Seminars	16		

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

**Bold, italicized material is excerpted from the American Medical Association
Current Procedural Terminology (CPT) Codes. Descriptions and other data only are copyrighted
2001 American Medical Association. All rights reserved.**

Attention: All Providers

Proposed Medical Coverage Policies

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

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

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

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

Attention: All Providers

Health Insurance Portability and Accountability Act Implementation Project Update

N.C. Medicaid's Health Insurance Portability and Accountability Act (HIPAA) implementation project was originally developed to meet the goal of accepting and sending the standard transactions by October 16, 2002, as the first step in meeting full HIPAA compliance. Further analysis of the impact to the Medicaid Management Information System (MMIS) from implementing changes to accommodate HIPAA standard transactions has resulted in the decision to redirect the project.

Federal legislation allows states to apply for a one-year extension. Extending the implementation deadline to October 16, 2003 will allow N.C. Medicaid to complete cost savings initiatives that need to be implemented in the MMIS prior to implementing HIPAA changes.

N.C. Medicaid now plans to implement HIPAA standard transactions by May 1, 2003. **Providers must continue to submit electronic claims in the current format until May 1, 2003.** After May 1, 2003, Medicaid will accept electronic claims in the new HIPAA format. However, N.C. Medicaid will also accept claims in the current electronic format until October 16, 2003. After October 16, 2003, all claims submitted to N.C. Medicaid, must use the new HIPAA format.

For additional information on HIPAA, refer to *HIPAA – Questions and Answers* on page 4.

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

Attention: All Providers

Billing for Labor and Delivery Anesthesia

Procedure codes 00955 and 00857 were end-dated with date of service April 1, 2002 and replaced with anesthesia codes 01967, 01968, 01969, and 01961. Refer to the following table to determine the appropriate code to bill for labor and delivery services under epidural, spinal, and general anesthesia.

Labor and Delivery Billing

Service	Code	Modifier	Units
Vaginal delivery only under general anesthesia	59409	Modifier YA	1 min = 1 unit
C-section delivery only under general anesthesia	59514	Modifier YA	1 min = 1 unit
Planned vaginal labor and delivery under epidural or spinal anesthesia	01967	No modifier	1 unit (Flat rate)
C-section after planned vaginal labor under epidural or spinal anesthesia	01967 and 01968	No modifier No modifier	1 unit (Flat rate) 1 unit (Flat rate)
Planned C-section delivery under epidural or spinal anesthesia	01961	No modifier	1 unit (Flat rate)
Labor under epidural or spinal anesthesia, and vaginal delivery under general	01967 and 59409	No modifier YA	1 unit (Flat rate) 1 min = 1 unit
Labor under epidural or spinal anesthesia, and C-section delivery under general	01967 and 59514	No modifier Modifier YA	1 unit (Flat rate) 1 min = 1 unit
C-section hysterectomy after labor under epidural or spinal anesthesia	01967 and 01969	No modifier No modifier	1 unit (Flat rate) 1 unit (Flat rate)
C-section delivery following Intrathecal block, same date of service	01961 and 62311	No modifier Modifier 59	1 unit (Flat rate) 1 unit (Flat rate)
C-section delivery following Intrathecal block, different dates of service	01961 and 62311	No modifier No modifier	1 unit (Flat rate) 1 unit (Flat rate)

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

Attention: All Providers

H Health Insurance Portability and Accountability Act – Questions and Answers

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

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

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

General Questions

1. Who is responsible for training providers about HIPAA?

Although provider education will be sponsored for North Carolina's Medicaid providers, providers must understand that education will be limited to general HIPAA information and its outcome and effects as it relates to the N.C. Medicaid program only.

Training and information offered by the N.C. Medicaid program does not relieve providers from the responsibility of educating their staff on HIPAA regulations regarding transaction and code set standards, privacy regulations, and security regulations. Providers are encouraged to review the HIPAA rules and discuss required changes with their billing departments, billing agents, and clearinghouses.

2. How will providers be notified of changes in the N.C. Medicaid program?

Specific changes implemented by N.C. Medicaid to comply with HIPAA regulations will be published in Medicaid bulletins. The Medicaid bulletin is available online at <http://www.dhhs.state.nc.us/dma>.

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

3. Is there one final rule for health plans and providers?

Yes. There is one final rule for transactions and code sets. The HIPAA Transaction and Code Set Final Rule, published August 17, 2000 in the Federal Register, applies to all covered entities. The rule (CFR 160 and 162) can be accessed at http://www.access.gpo.gov/su_docs.

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

According to regulation, the deadline to implement the HIPAA electronic transaction and code set standards is October 16, 2002.

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

N.C. Medicaid plans to be fully compliant by May 1, 2003. Some transaction sets may be implemented at an earlier date. Please pay close attention to future Medicaid bulletins and to DMA's HIPAA webpage at <http://www.dhhs.state.nc.us/dma/prov.htm> for additional information.

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

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

7. Will billing requirements change?

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

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

Paper claims will continue to be accepted by N.C. Medicaid. However, providers are encouraged to use electronic claims submission and remittance advice (RA) receipt for expedient claims processing. HIPAA does not require providers to submit claims electronically.

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

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

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

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

Changes may be required as a result of HIPAA code sets, which essentially delete local codes and require payers to recognize standard billing codes such as ICD-9-CM, CPT-4, CDT-3, NDC, and HCPCS. Any changes made to North Carolina's local codes will be communicated in future Medicaid bulletins.

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

We will continue to support PA requests on paper. It is the provider's decision to elect using the 278 Health Care Services Review Request and Response (electronic prior authorization) transaction.

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

12. Will the Automated Voice Response (AVR) system still be available after October 16, 2002?

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

13. What is taxonomy?

The provider taxonomy is a code set that codifies provider type and provider area of specialization for all medical related providers. The National Uniform Claim Committee maintains the taxonomy code set. A provider may have more than one taxonomy code, depending on the provider's area of specialization. The taxonomy is a required data element on the 837 institutional claim, 837 professional claim, and 278 prior authorization transactions. The taxonomy is not a unique number per provider. A full provider taxonomy code set can be found at <http://www.wpc-edi.com>.

14. What is WEDI?

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

Coding

1. Will local codes be eliminated?

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

2. Is the National Drug Code (NDC) rule requirement going forward?

The August 17, 2000 HIPAA Transaction and Code Sets final rule named the NDC as the required code set for reporting all drugs and biologics on all HIPAA transactions. It is anticipated that the final rule will be amended to rescind the initial ruling regarding the NDC. N.C. Medicaid will continue to require the NDC to be billed on retail pharmacy claims. However, N.C. Medicaid will continue to accept HCPCS J-codes on professional and institutional claims. In the event the final rule is not amended or payment policies for N.C. Medicaid change, the NDC may be required on these claim types at a later time.

Remittance Advice

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

The ERA consists of two transactions: the 835 claim payment/advice transaction and the 277 pending (unsolicited) claim status transaction. These two transactions provide information on paid claims, adjusted claims, refunds, and pending claims payments. The ERA transactions and the 277 unsolicited claims status are intended to be used as an aid to account balancing and direct posting to patient accounts.

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

ERAs in the tape format currently produced by N.C. Medicaid will be discontinued on October 16, 2003.

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

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

Claims Software Vendors and Clearinghouses

1. What is the process for providers who work with a clearinghouse?

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

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

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

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

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

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

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

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

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

5. When will testing with providers begin?

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

For more information regarding third party certification, please refer to the WEDI/SNIP Testing and Certification white paper at <http://snip.wedi.org>. Additional information will be provided in future Medicaid bulletins and on DMA's website at <http://www.dhhs.state.nc.us/dma>.

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

Attention: All Providers

NCECS Software Changes

The N.C. Medicaid program is currently developing a web-based version of the North Carolina Electronic Claims Submission (NCECS) software. No revision or upgrades will be made to the current version of the NCECS software. It is anticipated that the NCECS web-based application will be available in May 2003. N.C. Medicaid will continue to support the current NCECS software through October 2003 to allow adequate time for provider transition. Additional information will be published in future Medicaid bulletins.

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

Attention: All Providers

Preferred Drug List

To control costs and guarantee quality care, the N.C. Department of Health and Human Services is creating a preferred drug list. This list will ensure that Medicaid patients have prescription drugs that are both clinically effective and cost effective. Without cost controls, the state will have to cut services to children, the disabled, the poor and the elderly, or further reduce payments to doctors, pharmacists, and other health care providers. The preferred drug list will save the state an estimated \$15 million a year.

The list will be phased in over time, with the first classes of drugs scheduled to be implemented in December 2002.

An impartial Physicians Advisory Group will identify clinically effective, brand-name drugs for each drug class, regardless of cost. They will recommend to N.C. Medicaid that these drugs be considered for creating the preferred drug list. N.C. Medicaid will choose the two most cost-effective of the recommended drugs for the preferred drug list, plus all other drugs in that class that are less expensive.

The 40-member Physicians Advisory Group has an 11-member board of directors, plus three committees, including a Pharmacy Advisory Committee, who will be involved with the preferred drug list. They will hold public hearings regarding the drugs they recommend as the most clinically effective drugs.

The Physicians Advisory Group will start by looking at classes of drugs that are the most expensive. Thereafter, new classes of drugs will be added to the preferred drug list on a quarterly basis.

The preferred drug list also allows N.C. Medicaid to negotiate for better prices. If a drug company wants an expensive drug to be included on the preferred drug list, they will have the opportunity to offer the state a **supplemental rebate** to make that drug more cost effective.

Doctors may still prescribe drugs that are not on the list, but they must first obtain prior authorization. Medicaid will still pay for the higher cost drug, provided there is no lower cost drug that will provide the same benefit.

Because of the difficulty in finding a medication or combination of medications that work for each individual patient, all drugs to treat HIV will automatically be preferred. Also, patients taking drugs to treat psychosis and depression will be grandfathered into the program: that is, physicians who have already prescribed non-preferred drugs for Medicaid patients will not have to get approval for those prescriptions.

The medication regimen for Medicaid patients in long-term care facilities will not be affected. This population will be grandfathered into the program.

We pledge to you that we will provide prompt, easy service when you seek approval for drugs not on the list. The program will be run alongside our prior authorization program, with similar procedures. You will have 30 days after decisions are made regarding preferred drugs in each class before the change is implemented.

This letter is meant to provide you with general information regarding the preferred drug list. Updates will be available on the Medicaid pharmacy program website at <http://www.ncmedicaidpbm.com> and in upcoming Medicaid bulletins.

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

Attention: Prescribers

Exemptions to Prescription Drug Prior Authorization Criteria

Effective March 4, 2002, Medicaid implemented a prior authorization (PA) process for certain prescription drugs. A list of the drugs requiring PA and the PA criteria are available online at <http://www.ncmedicaidpbm.com>. ACS State Healthcare administers the Prescription Drug PA program.

Prescribers may request exemptions to PA when they believe that the prescribed drug is medically necessary for the patient but ACS State HealthCare has determined that the PA request does not meet the criteria for approval. Requests must be on a case-by-case basis and follow the process outlined below.

1. The prescriber, or designee, or long-term care pharmacist contacts ACS at 1-866-246-8505 for PA.
2. ACS does not approve the request because it does not meet the PA criteria.
3. The prescriber either:
 - a. Makes a change in the medication prescribed and withdraws the PA request or;
 - b. **Informs** ACS that he/she will complete a Request for Patient Exemption from Prior Authorization Criteria form (available online at <http://www.ncmedicaidpbm.com>) by documenting the patient's need for the medication and faxing or mailing it as directed on the form, **within 30 days**. The use of the form is not mandatory. However, failure to provide all the information requested on the form may prevent prompt action on the request.
4. ACS authorizes a one-month (34-day) supply of the requested medication, if the prescriber verbally commits to forwarding a justification for exemption.
5. ACS sends both the prescriber and the Medicaid recipient a letter informing them that the PA request did not meet Medicaid's criteria for approval. The letter to the prescriber indicates that an exemption may be requested within 30 days by submitting written justification to ACS. The recipient's letter informs him/her of the ability to request a reconsideration review of the denial of prior approval.
6. If ACS receives the exemption justification within 30 days, PA is granted for the timeframe requested or the maximum duration specified by the PA criteria, whichever is less. If the recipient requested a reconsideration review, the request is dismissed.
7. If ACS does not receive the exemption justification within 30 days, PA is not granted. If the recipient requested a [reconsideration review](#), a hearing is scheduled.

Note: Exemptions for Synagis and RespiGam will be granted only during RSV season as established by the Centers for Disease Control (CDC) guidelines.

ACS State Healthcare
1-866-246-8505

Attention: Prescribers, Nursing Facilities, Adult Care Homes, Intermediate Care Facilities for Persons with Mental Retardation, and Pharmacists

34-Day Grace Period for Prescription Drug Prior Authorization

Effective May 1, 2002, a 34-day grace period is available for obtaining prescription drug prior authorization (PA) for Medicaid recipients in nursing facilities, adult care homes, and intermediate care facilities for persons with mental retardation. A single 34-day grace period per prescription will be granted and applies to recipients already residing in these facilities as well as newly admitted recipients.

This grace period allows additional time to gather the medical information necessary to request PA from ACS State Healthcare, the contractor administering the Prescription Drug PA program. If ACS determines that the request does not meet the PA criteria, the prescriber may submit a request for exemption according to the instructions outlined on page 10 of this bulletin.

Changes to the Medicaid claims payment system will automate this 34-day grace period. Until these changes are finalized, it is necessary to contact ACS at 1-866-246-8505 (telephone) or 1-866-246-8507 (fax) to initiate the 34-day grace period. The caller must identify the patient as a resident of one of the long-term care facilities listed above and must provide the information requested on the top part of the Miscellaneous Drug Request form. The form can be obtained online at <http://www.ncmedicaidpbm.com>.

**ACS State Healthcare
1-866-246-8505**

Attention: General Hospitals, Psychiatric Hospitals, and Local Management Entities (Area Mental Health Centers)

Criterion #5 Services (N.C. Medicaid Criteria for Continued Acute Stay in an Inpatient Psychiatric Facility)

Effective July 1, 2002, hospitals providing Criterion #5 services must submit claims for reimbursement to Medicaid through EDS and not through local management entities (LMEs). Contracts between hospitals and LMEs for Criterion #5 services are no longer necessary.

Criterion #5 services can only be provided if community placement is not available at the discharge date and both the hospital and LME are actively working on discharge planning. This service requires prior approval from the Program Accountability Section in the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services at 919-881-2446.

Claims must be submitted on a UB-92 form (hospital outpatient claim type M) using Revenue Center code 902, procedure code Y2343 and bill type 141. The Medicaid rate is \$248.40 per day. Only one (1) unit is allowable per date of service. Only physician visits and case management may be billed in addition to procedure code Y2343.

**Carol Robertson, Behavioral Health Services
DMA, 919-857-4020**

Attention: Ambulatory Surgical Centers, Hospitals, and Physicians

Vitraser (Ganciclovir, 4.5 mg, Long-acting Implant, Code J7310)

Effective with date of service August 1, 2002, procedure code W5162 will be end-dated to comply with the implementation of national procedure codes mandated by the Health Insurance Portability and Accountability Act (HIPAA).

Coverage for Vitraser (Ganciclovir) is limited to recipients with a diagnosis of AIDS-related cytomegalovirus (CMV) retinitis. Both ICD-9-CM diagnosis codes 363.20, chorioretinitis, unspecified and 042, Human Immunodeficiency Virus (HIV) disease must, be entered on the claim. Claims without both diagnoses will deny.

Billing Instructions for Hospitals

Effective with date of service, August 1, 2002, bill Revenue Center code 636 in form locator 42 of the UB-92 claim form and HCPCS procedure code J7310, Ganciclovir, 4.5mg, long-acting implant, in form locator 44.

- When Vitraser is implanted into one eye, bill one unit.
- When Vitraser is implanted into both eyes on the same date of service, bill one detail with two units.

Billing Instructions for Ambulatory Surgical Centers

Effective with date of service, August 1, 2002, bill HCPCS code J7310 without a modifier.

- When Vitraser is implanted into one eye, bill one unit.
- When Vitraser is implanted into both eyes on the same date of service, bill one detail with two units.

Billing Instructions for Physicians

Physicians are to bill CPT code 67027, *Implantation of intravitreal drug delivery system (eg, ganciclovir implant), includes concomitant removal of vitreous*.

- When an implantation is performed on one eye, bill one unit.
- When an implantation is performed on both eyes during the same operative session, bill on one detail with modifier 50 and one unit. Modifier 50 signifies the procedure was performed bilaterally during the same operative session and will reimburse the lesser of the submitted charge or 150 percent of the fee schedule amount.

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

Attention: Carolina ACCESS Primary Care Providers

Carolina ACCESS Provider Surveys

The Managed Care section conducted a Provider Satisfaction Survey and a Contractual Compliance Survey from March through May 2002 on a random sample of Carolina ACCESS primary care providers (PCPs). The Division of Medical Assistance (DMA) would like to take this opportunity to thank those providers who participated in one of the surveys.

The surveys provided the Managed Care section with information necessary to ensure Medicaid recipients have access to quality medical care. In addition, the Provider Satisfaction Survey gave PCPs an opportunity to provide feedback to DMA regarding the effectiveness of Carolina ACCESS and make suggestions to improve quality and access to care.

Survey results will be shared in an upcoming Medicaid bulletin.

**Laurie Giles, Managed Care Section
DMA, 919-857-4022**

Attention: Health Departments

Training for Local Health Departments on New Codes

There will be a training session for local health department staff on August 13, 2002 from 1:00 p.m. to 5:00 p.m. via the Public Health Training and Information Network (PHTIN). This session, entitled *Crosswalk – Round II*, will cover the transition of the following Y and W codes currently in use for local health departments: W8002, W8003, W8010, W8012, W8016, W8201, W8202, W8203, W8204, Y2012, Y2013, Y2034, Y2044, Y2046, Y2047, Y2048, Y2049, Y2155, Y2525, Y2526, and Y2527.

Registration information for this session has been sent to local health departments. If you did not receive registration information, please contact the office of Public Health Nursing and Professional Development, Division of Public Health at 919-733-6850. Space will be limited due to site capacity. We encourage you to register early and limit the number of participants from each agency so that all health departments can send staff to this critical session.

The August 2002 Special Bulletin for Local Health Departments will serve as the primary handout for the session. The July 2002 Special Bulletin, Health Check Billing Guide, will also be used. **Providers must access and print the PDF versions of both the August 2002 Special Bulletin IV and the July 2002 Special Bulletin III, Health Check Billing Guide, from DMA's website at <http://www.dhhs.state.nc.us/dma> under the heading Provider Links and bring them to the seminar.**

**Joy Reed, Public Health Nursing and Professional Development
Division of Public Health, 919-715-4385**

Attention: Durable Medical Equipment Providers and Physicians

Apnea Monitor Coverage Criteria and Billing Guidelines

The N.C. Medicaid program covers apnea monitors when one of the following prior approval criteria is met:

1. An observed or recorded episode of prolonged apnea (> 10 seconds) within the last three months is documented by medical personnel and associated with bradycardia, reflux, cyanosis or pallor.
2. A sibling of a sudden infant death syndrome (SIDS) child is covered for a maximum of six months or up to three months beyond the age of the sibling at the time of his/her death from SIDS.
3. An event or events requiring vigorous stimulation or resuscitation documented within the past three months.
4. An infant with bronchopulmonary dysplasia requiring supplemental oxygen and displays medical instability.
5. A child with a tracheostomy is covered up to the age of two. Beyond two years of age, additional documentation is required from the prescribing physician justifying extended medical necessity for the apnea monitor.

The initial authorization for the apnea monitor is given for a maximum of six months. Reauthorizations will allow a maximum of three months per prior approval request.

Durable Medical Equipment (DME) providers should bill HCPCS code E0608, Apnea monitor, which includes all items required for the intended operation of the monitor, from receipt of the physician order to downloading and submitting the data to the physician for review and interpretation. The DME provider must provide initial and ongoing support services.

Physicians must bill CPT code 93272, *Patient demand single or multiple event recording with presymptom memory loop, per 30-day period of time; physician review and interpretation only.*

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

Attention: Prescribers and Long-Term Care Pharmacists

Long-Term Care Pharmacists May Seek Prescription Drug Prior Authorization

Effective May 1, 2002, pharmacists serving nursing facilities, adult care homes, and intermediate care facilities for persons with mental retardation are now allowed to request prior authorization (PA) for prescription drugs covered under Medicaid's Prescription Drug PA program. Previously, only the prescriber or prescriber's designee was authorized to make a PA request. The list of drugs requiring PA is available online at <http://ww.ncmedicaidpbm.com>.

ACS State Healthcare
1-866-246-8505

Attention: Health Check Providers

Health Check Seminar Schedule

Seminars for Health Check providers are scheduled for August 2002. Attendance at these seminars is very important because Health Check billing requirements will change on October 1, 2002 to meet requirements mandated by the Health Insurance Portability and Accountability Act (HIPAA). Due to the magnitude of the changes in Health Check billing, these seminars will only focus on the new Health Check billing requirements and not include any basic Medicaid billing instructions. A separate teleconference sponsored by the Division of Public Health is scheduled for health department providers (see page 13 for more information).

The Health Check billing requirements will be published in the July 2002 Health Check Special Bulletin III for use in the Health Check seminar. However, the Division of Medical Assistance (DMA) is unable to print copies of special and general Medicaid bulletins for distribution to providers due to the State's severe budget problems. The Health Check Special Bulletin will not be distributed to providers attending the seminars. **Providers must access and print the PDF version of the July 2002 Special Bulletin III, Health Check Billing Guide, from DMA's website at <http://www.dhhs.state.nc.us/dma> under the heading Provider Links and bring it to the seminar.**

Due to limited seating, preregistration is required and limited to two staff members per office. Unregistered providers are welcome to attend when reserved space is adequate to accommodate. Providers may register for the Health Check seminars by completing and submitting the Health Check Registration form on page 17, or providers can register online at <http://www.dhhs.state.nc.us/dma> under the heading Provider Links. 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.

Directions to the sites are available on page 16 of this bulletin.

Thursday, August 1

WakeMed
Andrews Conference Center
3000 New Bern Avenue
Raleigh, NC

Friday, August 2

WakeMed
Andrews Conference Center
3000 New Bern Avenue
Raleigh, NC

Tuesday, August 6

Auditorium
Catawba Valley Technical
College
Highway 64-70
Hickory, NC

Thursday, August 8

Auditorium
Martin Community College
Kehakee Park Road
Williamston, NC

Tuesday, August 13

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

Thursday, August 15

Ramada Inn Plaza
3050 University Parkway
Winston-Salem, NC

Tuesday, August 20

Blue Ridge Community
College
College Drive
Flat Rock, NC

Directions to the Health Check Seminars

The registration form for the Health Check seminar is on page 17 of this bulletin.

RALEIGH, NORTH CAROLINA

WAKEMED ANDREWS CONFERENCE CENTER

Driving and Parking Directions

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

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

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

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

HICKORY, NORTH CAROLINA

CATAWBA VALLEY TECHNICAL COLLEGE

Take I-40 to exit 125. Travel approximately ½ mile to Highway 70. Travel east on Highway 70. The college is located approximately 1½ miles on the right. Ample parking is available in the rear lower parking areas. The entrance to the Auditorium is between Student Services and the Maintenance Center. Follow sidewalk (toward satellite dish) and turn right to Auditorium entrance.

WILLIAMSTON, NORTH CAROLINA

MARTIN COMMUNITY COLLEGE

Take Highway 64 into Williamston. Martin Community College is located approximately 1 to 2 miles west of Williamston. The Auditorium is located in Building 2.

SALISBURY, NORTH CAROLINA

HOLIDAY INN CONFERENCE CENTER

Traveling South on I-85

Take exit 75. Turn right onto Jake Alexander Boulevard. Travel approximately 1/2 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 1/2 mile. The Holiday Inn is located on the right.

WINSTON-SALEM, NORTH CAROLINA

RAMADA INN PLAZA

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

FLAT ROCK, NORTH CAROLINA

BLUE RIDGE COMMUNITY COLLEGE

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. Pass the college's main entrance and turn right into the college entrance past the pond. The parking lot is on the left. The Auditorium entrance is located to the right of the Patton Building main entrance.

(cut and return registration form only)

Health Check Provider Seminar Registration Form

(No Fee)

Provider Name _____ Provider Number _____

Address _____ Contact Person _____

City, Zip Code _____ County _____

Telephone Number (____) _____ Fax Number (____) _____ E-mail Address _____

1 or 2 (circle one) person(s) will attend the seminar at _____ on _____

(location)

(date)

Return to:

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

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

Attention: All Providers**I**ndex to General and Special Bulletins for January 2002 through June 2002**All Providers**

Basic Medicaid Seminar Schedule, 02/02, pg. 9; 03/02, pg. 6
Breast and Cervical Cancer Control Program Guidelines, 01/02, pg. 14
Carolina ACCESS Override Request Form, 04/02, pg. 15
Carolina ACCESS Override Requests, 04/02, pg. 14
Carolina ACCESS Provider Application Available on the Internet, 04/02, pg. 2
Changes to the Initial Hemoglobin or Hematocrit Health Check Screening Component, 04/02, pg. 5
Copayment Amounts for Recipients, 04/02, pg. 10
Corrected 1099 Requests – Action Required by March 1, 2002, 01/02, pg. 28; 02/02, pg. 4
CPT Code Bundling, 04/02, pg. 6
CPT Code Update 2002, 01/02, pg. 2; 04/02, pg. 9
CPT Code Update 2002 – Code Description Correction, 06/02, pg. 2
CPT Codes End-Dated for 2002, 04/02, pg. 8
Directions to the Basic Medicaid Seminars, 03/02, pg. 7
Electronic Funds Transfer Form – Fax Number Change for Submittals, 01/02, pg. 26
Electronic Funds Transfer Form, 01/02, pg. 27
Extracorporeal Shock Wave Lithotripsy, 05/02, pg. 7
Fee Schedules and Reimbursement Plans, 06/02, pg. 13
Fluoroscopy, CPT Code 76000, 05/02, pg. 6
Health Insurance Portability and Accountability Act Compliance Survey, 04/02, pg. 11
Health Insurance Portability and Accountability Act Compliance Training, 03/02, pg. 4
Holiday Observance, 05/02, pg. 2
Index to General and Special Medicaid Bulletins for 2001, 01/02, pg. 21
Medicaid Identification Cards, 01/02, pg. 10
Medicare Crossover Reference Request Form, 01/02, pg. 13
Medicare Crossovers, 01/02, pg. 12
Medicare Part B Crossover Payment Method Change, Special Bulletin I, 03/02
Preventive Medicine Annual Health Assessments, 05/02, pg. 3
Prior Approval Process for Outpatient Therapy Services, 05/02, pg. 1
Prior Authorization for Prescription Drugs, Special Bulletin II, 04/02
Proposed Medical Coverage Policies, 06/02, pg. 1
Referrals and Service Coordination for the Community Alternatives Program for Disabled Adults, 01/02, pg. 3
Routine Newborn Circumcision Coverage Policy, 02/02, pg. 3
Synagis Policy Revision, 01/02, pg. 7
Termination of Inactive Medicaid Provider Numbers, 02/02, pg. 2; 05/02, pg. 5
Unlisted CPT Codes, 05/02, pg. 6
W-9 Form, 01/02, pg. 29; 02/02, pg. 5

Adult Care Home Providers

Reimbursement Rate Increase for Adult Care Home Providers, 01/02, pg. 2

Ambulance Services Providers

Reimbursement Rate Increase for Ambulance Services, 01/02, pg. 8

Area Mental Health Centers

Completion of the Residential Authorization Form, 04/02, pg. 12

Residential Authorization Form, 04/02, pg. 13

Carolina ACCESS Primary Care Providers

Carolina ACCESS Primary Care Provider Manual Available Online, 01/02, pg. 20
Carolina ACCESS Provider Surveys, 03/02, pg. 4

Community Alternatives Program Providers

Reimbursement Rate Increase for Community Alternatives Program Services, 02/02, pg. 3

Dialysis Treatment Facilities

Ferrlecit (Sodium Gluconate Complex, HCPCS Code J2915, 625 mg.) Coverage Criteria, 01/02, pg. 9

Durable Medical Equipment Providers

Discontinuation of HCPCS Codes K0008 and K0013, 02/02, pg. 2
HCPCS Code Changes, 04/02, pg. 2
Reimbursement Rate Correction for Code E1390, 05/02, pg. 3

Federally Qualified Health Centers

Core Service Code Conversion, 06/02, pg. 15
Mirena (Levonorgestrel-Releasing Intrauterine System, Code J7302) Coverage Criteria, 03/02, pg. 3

Health Check Providers

Health Check Seminar, 06/02, pg. 12

Health Departments

Diabetes Outpatient Self-Management Training: Supervision Clarification, 04/02, pg. 9
Mirena (Levonorgestrel-Releasing Intrauterine System, Code J7302) Coverage Criteria, 03/02, pg. 3
Provision of Psychological Services in Health Departments, 04/02, pg. 3

Home Health Agencies

Prior Approval Process, 04/02, pg. 3
Prior Approval Process for Outpatient Therapy Services, 05/02, pg. 1
Questions and Answers Regarding Personal Care Services (in Private Residences), 01/02, pg. 18
Written Confirmation of Verbal Orders, 01/02, pg. 31

Hospice Providers

Reimbursement Rate Increase for Hospice Services, 01/02, pg. 11
Reimbursement Rate Increase for Hospice Services – Correction to Article in January 2002 General Medicaid Bulletin, 02/02, pg. 7

Hospital Providers

Emergency Medical Screening Examinations, 05/02, pg. 2
ICD-9-CM Diagnosis Codes – Additions and Changes, 01/02, pg. 15
Reimbursement Rates for Lower Level of Care, Ventilator Dependent Care, and Swing Bed, 01/02, pg. 3
Revenue Code Changes, 04/02, pg. 7

Independent Practitioner Program Providers

Prior Approval Process, 04/02, pg. 3
Prior Approval Process for Outpatient Therapy Services, 05/02, pg. 1

Local Education Agencies

Prior Approval Process, 04/02, pg. 3
Prior Approval Process for Outpatient Therapy Services, 05/02, pg. 1

Long-Term Care Providers

Quality Control Eligibility Reviews of Medicaid Recipients in Long-Term Care, 03/02, pg. 2

Mecklenburg County Providers

Managed Care Update, 01/02, pg. 14; 06/02, pg. 2

Mental Health Services Providers

Prior Approval and Medicare, 03/02, pg. 4; 05/02, pg. 5

Nurse Midwives

Mirena (Levonorgestrel-Releasing Intrauterine System, Code J7302) Coverage Criteria, 03/02, pg. 3

Nurse Practitioners

Apligraf HCPCS Code Change, 04/02, pg. 12

Ferrlecit (Sodium Gluconate Complex, HCPCS Code J2915, 625 mg.) Coverage Criteria, 01/02, pg. 9

Mirena (Levonorgestrel-Releasing Intrauterine System, Code J7302) Coverage Criteria, 03/02, pg. 3

Nursing Facility Providers

Requests for Retroactive Prior Approval, 04/02, pg. 5

Tracking Forms for the Preadmission Screening and Annual Resident Review Process, 04/02, pg. 4

Outpatient Therapy Services

Prior Approval Process, 04/02, pg. 3

Prior Approval Process for Outpatient Therapy Services, 05/02, pg. 1

Personal Care Services Providers

Cancellation of the Personal Care Services Seminars and Requests for Individual Visits, 03/02, pg. 5

Personal Care Services Seminar Schedule, 01/02, pg. 31; 02/02, pg. 10

Questions and Answers Regarding Personal Care Services (in Private Residences), 01/02, pg. 18

Reimbursement Rate Increase for Personal Care Services, 02/02, pg. 8

Travel Directions to the Personal Care Services Seminars, 02/02, pg. 11

Written Confirmation of Verbal Orders, 01/02, pg. 31

Pharmacists

Prior Authorization for Prescription Drugs, Special Bulletin II, 04/02

Physicians

Apligraf HCPCS Code Change, 04/02, pg. 12

Case Conference for Sexually Abused Children, 04/02, pg. 6

Emergency Medical Screening Examinations, 05/02, pg. 2

Ferrlecit (Sodium Gluconate Complex, HCPCS Code J2915, 625 mg.) Coverage Criteria, 01/02, pg. 9

Injectable Drug List Update, 06/02, pg. 3

Mirena (Levonorgestrel-Releasing Intrauterine System, Code J7302) Coverage Criteria, 03/02, pg. 3

Miscellaneous Supplies, 06/02, pg. 2

Neonatal Intensive Care Services, 05/02, pg. 4

Prior Approval Process, 04/02, pg. 3

Prescribers

Synagis Policy Revision, 01/02, pg. 7

Private Duty Nursing Providers

Written Confirmation of Verbal Orders, 01/02, pg. 31

Psychiatric Residential Treatment Facility Providers

Denials Relative to Patient Monthly Liability, 04/02, pg. 14

Residential Treatment Facility Providers for Levels II through IV

Accreditation Requirement and Provider Status Changes, 06/02, pg. 15

Completion of the Residential Authorization Form, 04/02, pg. 12

Residential Authorization Form, 04/02, pg. 13

Rural Health Clinics

Core Service Code Conversion, 06/02, pg. 15

Mirena (Levonorgestrel-Releasing Intrauterine System, Code J7302) Coverage Criteria, 03/02, pg. 3

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

Checkwrite Schedule

July 16, 2002

July 23, 2002

July 31, 2002

August 13, 2002

August 20, 2002

August 29, 2002

September 4, 2002

September 10, 2002

September 17, 2002

September 26, 2002

Electronic Cut-Off Schedule

July 12, 2002

July 19, 2002

July 26, 2002

August 9, 2002

August 16, 2002

August 23, 2002

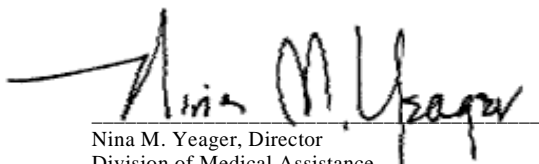
August 30, 2002

September 6, 2002

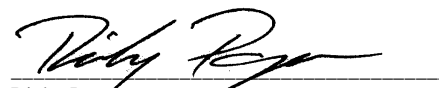
September 13, 2002

September 20, 2002

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



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



Ricky Pope
Executive Director
EDS

e

P.O. Box 300001
Raleigh, North Carolina 27622

Presorted Standard

U.S. POSTAGE

PAID

Raleigh, N.C.

Permit No. 1087