Number 7 *July 2003*

North Carolina Medicaid Bulletin

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

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

Attention: All Providers

Proposed Medical Coverage Policies

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

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

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

Darlene Creech, Medical Policy Section
DMA, 919-857-4020

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

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Attention: All Providers

Medicaid Coverage for Pregnancy-Related Services

Pregnant women may receive Medicaid under the Medicaid for Pregnant Women (MPW) program or under other Medicaid programs, such as Medicaid for Families (MAF), Medicaid for the Disabled (MAD), Work First (AAF), etc. Under the MPW program, the pregnant woman receives a pink Medicaid identification card. Medicaid coverage under this category is limited to pregnancy-related services and other conditions that may complicate the pregnancy.

Under the other Medicaid programs, the pregnant woman receives a blue Medicaid identification card. These women may receive coverage for all Medicaid covered services including pregnancy-related services, prescriptions, dental, and vision care. Pregnancy-related services are exempt from the 24-visit limit, the six-prescription limit, and from copayment deductions.

Andy Wilson, Recipient and Provider Services
DMA, 919-857-4019

Attention: All Providers

CPT Code Update 2003

The Division of Medical Assistance has completed the coverage determination review of the new codes published in the *Current Procedural Terminology CPT 2003*. The table below indicates the new codes that will be covered by the N.C. Medicaid program. Unlisted procedure codes will be reviewed on a case-by-case basis following established billing guidelines. Notification will be made through a future general Medicaid bulletin when the system is ready to accept new claims and when denied claims may be resubmitted. Notification will be posted on DMA's website at http://www.dhhs.state.nc.us/dma/prov.htm if the system is ready prior to an upcoming bulletin publication.

20612	21046	21047	21048	21049	29827	29873	29899	33215	33224
33225	33226	33508	34833	34834	34900	35572	36511	36512	36513
35614	36515	36516	36536	36537	37182	37183	37500	38205	38206
38242	43201	43236	44206	44207	44208	44210	44211	44212	44238
44701	45335	45340	45381	45386	46706	49419	49904	50542	50543
50562	51701	51702	51703	55866	56820	56821	57420	57421	57455
57456	57461	58146	58290	58291	58292	58293	58294	58545	58546
58552	58553	58554	61316	61322	61323	61517	61623	62148	62160
62161	62162	62163	62164	62165	62264	64416	64446	64447	64448
66990	75901	75902	75954	76071	76801	76802	76811	76812	76817
83880	84302	85004	85032	85049	85380	87255	87267	87271	88174
88175	89055	92601	92602	92603	92604	92607	92608	92609	92610
92611	92612	92614	92616	92700	93580	93581	95990	96920	96921
96922	99293	99294	99299						

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

Attention: All Providers

CPT Codes Covered for Dates of Service on or After January 1, 2002

The table below indicates the additional new Current Procedure Terminology (CPT) codes that are covered by the N.C. Medicaid program effective with date of service January 1, 2002:

01967	01968	01969	10021	10022	11981	11982	11983	20526	20551
20552	20553	20979	24300	24332	24343	24344	24345	24346	25001
25024	25025	25259	25275	25394	25430	25431	25651	25652	25671
26340	29086	29805	29806	29807	29824	29900	29901	29902	33967
33979	33980	35647	35685	35686	36002	36820	36823	38220	38221
43313	43314	44126	44127	44128	44201	44203	44204	44205	45136
46020	47370	47371	47380	47381	47382	49491	49492	52001	53431
53444	53446	53448	53853	54162	54163	54164	54406	54415	57155
58346	58953	58954	59001	60650	64561	64581	64821	64822	64823
76085	76362	76394	76490	77301	77418	82274	83950	86141	86336
87198	87199	87802	87803	87804	87902	90740	92136	92973	92974
93025	93613	93701	95965	95966	95967	96000	96001	96002	96003
96004	96567								

Claim Filing Instructions

Claim Description	Filing Instructions
Claims not previously submitted for services performed after January 1, 2002, with a date of service less than 365 days prior to receipt of the claim.	Claims may be filed now.
Claims not previously submitted for services performed on or after January 1, 2002, with a date of service greater than 365 days prior to receipt of the claim.	Claims should not be filed at this time. Medicaid will notify providers through the general Medicaid bulletin when to submit these claims. **Note:** To accelerate payment, providers will be encouraged to bill these claims electronically whenever possible.
Claims previously submitted for services performed on or after January 1, 2002, that were denied with EOB 009, "Service not covered by the Medicaid program."	Claims will be systematically resubmitted by EDS. Providers do not need to resubmit these claims. **Note:** Denied claims that were resubmitted and paid using a different code may be subject to recoupment.

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

Attention: All Providers

General Medicaid Billing Seminars

Seminars on general Medicaid billing guidelines are scheduled for September 2003. Registration information and a list of dates and site locations for the seminars will be published in the August 2003 general Medicaid bulletin.

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

Attention: Adult Care Home Providers

Mental Health Needs Assessment Project

The Department of Health and Human Services has been charged with the development and implementation of a Mental Health Needs Assessment Project for Adult Care Homes. This comprehensive effort is designed to conduct assessments of all Medicaid-eligible recipients who reside in adult care homes to determine those who need mental health services and the level of services needed. The Division of Medical Assistance is the lead agency for this project.

Seminars focusing on how to complete the mental health assessment forms are scheduled for July 22, 23, and 24 at the locations listed below. **Preregistration for the seminars is required.** Providers may register for the Adult Care Homes Mental Health Needs Assessment seminars by completing and submitting the Adult Care Homes Mental Health Needs Assessment Seminar Registration Form or through Online Registration. **Registration forms must be submitted by 5:00 p.m. July 18, 2003.**

Due to limited seating, registration is limited to two staff members per office. Seminars begin at 9:00 a.m. and end at 12 noon. Providers are encouraged to arrive by 8:45 a.m. to complete registration. **Three Continuing Education Units (CEU) will be offered to those who attend the entire seminar.**

The registration form is located on page 6. Directions to the seminar locations are on page 6.

Tuesday, July 22, 2003
Martin Community College
Main Conference Room
1161 Kehukee Park Road
Williamston, NC

Wednesday, July 23, 2003
A-B Technical Community College
Simpson Lecture Room #109
Simpson Building
340 Victoria Road
Asheville, NC

Thursday, July 24, 2003
Wake County Commons Building
Room 100A
4011 Carya Drive
Raleigh, NC

Bill Hottel, Adult Care Home Unit
DMA, 919-857-4020

Directions to the Adult Care Home Mental Health Needs Assessment Seminar

A-B Technical College, Simpson Lecture Room #109, Simpson Building – Asheville, North Carolina

Directions to the College

Take I-40 to exit 50. Travel north on Hendersonville Road, which turns into Biltmore Avenue. Continue on Biltmore Avenue toward Memorial Mission Hospital. Turn left onto Victoria Road.

Campus

Stay on Victoria Road. Turn right between the Holly Building and the Simpson Building. The Simpson Building is located on the right.

Martin Community College, Main Conference Room – Williamston, North Carolina

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

Wake County Commons Building – Raleigh, North Carolina

Take the I-440 Beltline east to the exit 15, Poole Road. Turn right onto Poole Road. Travel approximately ½ mile. Turn left into the Wake County Office Park. Follow the winding road to the bottom of the hill; there are small directional signs along the way. The Commons Building is identified by the tall flag pole in front of the building. It is next to the last building in the office park. Parking is available across the street or to the left of the facility.

(cut and return registration form only)

Adult Care Home Mental Health Needs Assessment Seminars

(No Fee)

Provider Name _____ Provider Number _____

Address _____

City, Zip Code _____ County _____

Contact Person _____ E-mail Address _____

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

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

Return to: Division of Medical Assistance
Adult Care Home Services
2511 Mail Service Center
Raleigh, NC 27699-2511

Attention: Area Mental Health Centers, CAP-MR/DD Case Managers and Providers

Billing Changes for CAP-MR/DD Services

Effective with date of service September 30, 2003, the N.C. Medicaid program will end-date state-created procedure codes used to bill services provided through the Community Alternatives Program for Persons with Mental Retardation and Developmental Disabilities (CAP-MR/DD). Effective with date of service October 1, 2003, national codes for these services will be implemented to comply with the Health Insurance Portability and Accountability Act (HIPAA).

State-created code W8164, Augmentative Communication Device, Rental, will not be replaced.

The maximum reimbursement rate will not change for the following codes, except where noted.

Current Local Codes	Local Code Description	New National Codes	National Code Description
W8105	Adult Day Health Services, per day	S5102	Day Care Services - Adult, per diem
W8111	Personal Care Services, per 15 minutes	S5125	Attendant Care Services, per 15 minutes
W8118	Respite Care - Institutional, per day	H0045	Respite Care Services, Not in the Home, per diem
W8119 W8200	Respite Care - Community Based, per 15 minutes Respite Care - Facility Based, per 15 minutes	S5150(1)	Unskilled Respite Care, Not Hospice, per 15 minutes
W8144	In-Home Aide - Level 1, per 15 minutes	S5120	Chore Services, per 15 minutes
W8149	Environmental Accessibility Adaptations, per service	S5165	Home Modification, per service
W8151	Waiver Supplies and Equipment, per service	T1999	Miscellaneous Therapeutic Items and Supplies, Retail Purchases, Not Otherwise Classified(2)
W8157	Supported Employment - Individual, per 15 minutes	H2025	Ongoing Support to Maintain Employment, per 15 minutes
W8158	Supported Employment - Group, per 15 minutes	H2025HQ(3)	Ongoing Support to Maintain Employment - Group, per 15 minutes
W8161	Crisis Stabilization, per 15 minutes	H2011	Crisis Intervention Service, per 15 minutes

Current Local Codes	Local Code Description	New National Codes	National Code Description
W8162	Personal Emergency Response System, per month	S5161	Emergency Response System, Service Fee, per month
W8165	Augmentative Communication Device - Repairs/Service, per service	V5336	Repair/Modification of Augmentative Communication System or Device
W8178	Family Training, per 15 minutes	S5110	Home Care Training - Family, per 15 minutes
W8181	Respite Care - Nursing Bed, per 15 minutes	T1005TD(4) T1005TE(4)	Respite Care Services - RN, per 15 minutes Respite Care Services - LPN, per 15 minutes
W8182	Supported Living - Level 1, per day	H2016	Comprehensive Community Support Services - Level 1, per diem
W8185	Supported Living - Level 4, per day	H2016HI(5)	Comprehensive Community Support Services - Level 4, per diem
W8189	Interpreter Services, per 15 minutes	T1013	Sign Language or Oral Interpreter Services, per 15 minutes
W8192	Transportation, per service	T2001	Non-Emergency Transportation, Patient Attendant/Escort, per service
W8197	Supported Living Periodic - Group, per 15 minutes	H2015HQ(3)	Comprehensive Community Support Services - Group, per 15 minutes
W8198	Respite-Group (2 to 3 clients), per 15 minutes	S5150HQ(3)	Unskilled Respite Care, not Hospice - Group, per 15 minutes
W8199	Supported Living Periodic - Individual, per 15 minutes	H2015	Comprehensive Community Support Services - Individual, per 15 minutes
W8130	Developmental Day, per 15 minutes	T2027	Specialized Childcare, Waiver, per 15 minutes
W8163	Augmentative Communication Device Purchase	T2028	Specialized Supply, Not Otherwise Specified, Waiver
W8180	Vehicle Adaptations, per service	T2039	Vehicle Modifications, per service
W8183	Supported Living - Level 2, per day	T2014	Habilitation, Prevocational, Waiver, per diem
W8184	Supported Living - Level 3, per day	T2020	Day Habilitation, Waiver, per diem

Current Local Codes	Local Code Description	New National Codes	National Code Description
W8188	Case Management, per month	T2022	Case Management, per month
W8190	Therapeutic Case Consultation, per 15 minutes	T2025	Waiver Services, Not Otherwise Specified
W8194 W8195	Day Habilitation, Periodic - Group (over 2 clients), per 15 minutes Day Habilitation, Periodic - Group (2 clients), per 15 minutes	T2021HQ(6)	Day Habilitation, Waiver, per 15 minutes
W8196	Day Habilitation, Periodic – Individual, per 15 minutes	T2021	Day Habilitation, Waiver, per 15 minutes

(1) State-created codes W8119 and W8200 will be replaced with national code S5150. There will not be a differentiation between community-based (W8119) and facility-based (W8200).

(2) Identify the product in "Remarks."

(3) National modifier "HQ" identifies a group setting.

(4) National modifier "TD" identifies that an RN provides the service and "TE" identifies that an LPN provides the service.

(5) National modifier "HI" identifies an integrated mental health and mental retardation/developmental disabilities program.

(6) National modifier "HQ" identifies a group setting. A rate adjustment is required for this code. The new rate will be published in a future general Medicaid bulletin.

The code conversion requires the use of some national codes with descriptions that may imply a change in coverage. However, there are no changes to the current CAP-MR/DD coverage policy, service definitions or requirements, except as noted. Providers must be alert to the use of the national code as it applies to CAP-MR/DD. (Refer to the Division of Mental Health, Developmental Disability, and Substance Abuse Services at http://www.dhhs.state.nc.us/mhddsas/manuals/index.htm for service information.)

Because there are several new national codes that are used for multiple CAP programs as well as regular Medicaid services, the Division of Medical Assistance will identify CAP recipients as members of a "population group" for their specific CAP program. This is required to control and monitor billing for services. Please refer to upcoming general Medicaid bulletins for information on the implementation of CAP population group designations.

Diane Holder, R.N., Behavioral Health Care, Medical Policy Services
DMA, 919-857-4020

Attention: Area Mental Health Programs and Residential Treatment Providers

Seminars for HIPAA Code Conversions for Services Provided to Children under the Age of 21

Seminars for area mental health programs and residential treatment providers are scheduled for September 2003. The seminars will provide information on the conversion to CPT codes for services provided to children under the age of 21. Registration information and a list of dates and site locations for the seminars will be published in the August 2003 general Medicaid bulletin.

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

Attention: Area Mental Health Centers, Developmental Evaluation Centers, Independent Practitioners, Local Health Departments, and Physician Services

Correction to V Code Diagnosis for Outpatient Occupational Therapy Services

The May 2003 bulletin article titled *Addition of V Code Diagnosis for Outpatient Specialized Therapies* stated that all occupational therapy claims, including claim adjustments and resubmitted claims, submitted for billing June 1, 2003 or after, must include the discipline-specific ICD-9-CM diagnosis code V57.2. In order to meet HIPAA requirements, **the code has been corrected to V57.21**. Effective July 1, 2003, use diagnosis code V57.21. Claims previously submitted for processing using diagnosis code V57.2 do not need to be corrected and resubmitted.

This does not change the requirement to bill the primary diagnosis that justifies the need for the specialized therapy. **Remember: The primary treatment ICD–9-CM diagnosis code must be entered first on the claim form. The discipline-specific V code should follow the primary treatment code.**

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

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

Respiratory Therapy Criteria

Medical Coverage Policy 8F, Outpatient Specialized Therapies, and 8G, Independent Practitioners, have been updated to include medical necessity criteria and prior approval criteria for continued treatment for respiratory therapy. These policies are available on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm.

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

Attention: Carolina ACCESS Primary Care Providers

Carolina ACCESS Enrollment, Referral, Emergency Room, and Utilization Reports

The Division of Medical Assistance's Managed Care Section is beginning the process of replacing paper copies of the Carolina ACCESS Enrollment, Referral, Emergency Room, and Quarterly Utilization reports with web-based versions of the reports. The target implementation date is December 2003. This article is the first in a series of articles to prepare primary care providers (PCPs) for this change and to provide instructions for accessing the web-based reports.

Internet access and minimum system requirements are necessary to access web-based reports. Providers who do not have Internet access or have systems that do not meet the minimum hardware and software requirements listed below, should begin immediately to upgrade their systems in preparation for the change.

In addition to system requirements, security access is required. Providers will be notified in upcoming Medicaid bulletins about how to obtain necessary security and how to contact customer support.

Access Points and Requirements
Internet ACCESS Required:

- PC must be connected to or capable of connecting to the Internet.
- If PC is behind a Firewall, Ports 80 and 443 must be open.

System Requirements
Minimum Hardware Specification for the PC Workstation:

- 200 MHz
- 2.1GB Hard Drive
- 3 ½" Floppy Drive
- CD Rom Drive
- 64MB Ram
- MS Mouse
- Monitor
- MS Keyboard
- Network Surge Protector

Minimum Software Requirements:

Windows NT/Windows 2000 Operating System: NT 4.0 sp5 and above.
Windows 9x Operating System: Windows 95 and above.
Windows XP Operating System.
Microsoft Internet Explorer (IE) version: Vs 5.5 sp2 and above with 128bit encryption.
Netscape Navigator 6.0 or higher.
Settings for Microsoft IE (Tools…Internet Options) Maximum of Medium Security. Allow per session cookies. Check for newer versions of stored pages set to: every time you visit the page.

The workstation must also have an appropriate viewer for a commonly published file format. Examples include:

- ASCII text reports
- Mainframe spool files
- Microsoft Office 97, 2000, or XP products: Word, Excel, and PowerPoint
- Adobe Portable Document Format (PDF), PostScript
- Crystal Decisions' Crystal Reports
- HTML documents
- PCL reports

Managed Care Section
DMA, 919-857-4022

Attention: Carolina ACCESS Primary Care Providers, Anesthesiologists, Pathologists, and Radiologists

Change in Carolina ACCESS Editing for Anesthesiology, Pathology or Radiology Services

Effective September 1, 2003, Carolina ACCESS editing will be modified to allow payment for anesthesiology, pathology or radiology services that have not been authorized by the primary care provider if **either** the **group provider number** or the **attending provider number** billing the service identifies the provider as an anesthesiologist, pathologist or radiologist. Prior to September 1, 2003, unauthorized services billed by these disciplines will pay only if the billing provider number is identified as an anesthesiologist, pathologist or radiologist.

Managed Care Section
DMA, 919-857-4022

Attention: Carolina ACCESS Primary Care Providers

Referral Policy for Specialty Care

The Carolina ACCESS (CA) contract requires primary care providers (PCPs) to coordinate care for their enrollees by arranging referrals for medically necessary health care services that they do not directly provide. Although referrals are at the discretion of the PCP, requests for Medicaid covered specialty care must be based on the PCP's assessment of the patient's medical need. Medicaid covered services include medically necessary care by neurologists, cardiologists, infectious disease specialists, etc., as well as services rendered by chiropractors and podiatrists.

Referrals can be made by phone or in writing. When referring CA enrollees for specialty care, the PCP must define the scope of the referral. This includes the number of visits being authorized and the diagnostic evaluation needed to effectively evaluate the patient. To facilitate continuity of care for CA enrollees, any further diagnosis, evaluation or treatment of the patient not identified in the original referral is the responsibility of the PCP.

It is the responsibility of the specialty provider to obtain the PCP's authorization (Carolina ACCESS provider number) prior to treatment. The PCP may refuse to authorize services if authorization is requested after the services have been rendered. This will result in denied claims.

The PCP may make referrals or authorize payment for services for their CA enrollees who have not contacted them for the purpose of establishing a patient/provider relationship.

PCPs must document all referrals in the patient's medical record. The Division of Medical Assistance (DMA) provides a monthly referral report to each PCP for verification of the validity and accuracy of the referrals. Any inappropriate referrals should be reported to the PCP's Managed Care Consultant for investigation.

Note: In addition to PCP referral authorization, prior approval (PA) may be required to verify medical necessity before rendering some services. Obtaining PA does not guarantee payment or ensure that the enrollee is eligible on the date of service.

Managed Care Section
DMA, 919-857-4022

Attention: Durable Medical Equipment Providers

Use of Modifiers for Durable Medical Equipment Claims

Effective with claims received August 1, 2003, durable medical equipment (DME) providers must use the following modifiers with HCPCS codes in block 24D when submitting DME claims:

NU for new purchase
UE for used purchase
RR for rental

These modifiers are used on the CMS-1500 claim form to replace type of service codes: N for new purchase, U for used purchase, and E for rental.

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

Attention: Durable Medical Equipment Providers

HCPCS Code Changes

The following HCPCS codes are end-dated and replaced with new codes effective with date of service July 1, 2003. These changes are being made to comply with the implementation of national standard codes mandated by the Health Insurance Portability and Accountability Act (HIPAA).

Old Code	New Code	Description	Quantity Limitation or Lifetime Expectation	Maximum Reimbursement Rate
K0021	E0971	Anti-tipping device, wheelchair	2 years	Rental: $ 3.03 New Purchase: 30.27 Used Purchase: 22.70
K0034	E0951	Loop heel, each	2 years	Rental: $ 1.67 New Purchase: 16.50 Used Purchase: 12.37
K0101	E0958	Wheelchair attachment to convert any wheelchair to one arm drive	3 years	Rental: $ 40.84 New Purchase: 408.42 Used Purchase: 306.31
W4154	S8181	Tracheostomy tube holder	12 per month	New purchase: $ 4.07
W4644	A4246	Betadine or pHisohex solution, per pint	10 per month	New purchase: $ 3.79
W4650	A4213	Syringe, sterile, 20 cc or greater, each	50 per month	New purchase: $ 1.08

These new codes do not require prior approval. However, as with all durable medical equipment, a Certificate of Medical Necessity and Prior Approval form must be completed.

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

Attention: Durable Medical Equipment Providers

Length of Need Documentation

The prescribing physician, physician assistant or nurse practitioner must document on the Certificate of Medical Necessity and Prior Approval form the length of need for all items listed in the Capped Rental category of the Durable Medical Equipment Fee Schedule. Refer to Medical Coverage Policy 5, Durable Medical Equipment, on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm for additional information.

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

Attention: Durable Medical Equipment Providers

Removal of Codes E1405 and E1406 from DME Fee Schedule

Effective July 1, 2003, HCPCS code E1405, oxygen and water vapor enriching system with heated delivery, and HCPCS code E1406, oxygen and water vapor enriching system without heated delivery, have been end-dated and removed from the Durable Medical Equipment Fee Schedule.

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

Attention: All Dental Providers and Health Department Dental Clinics

ADA Code Updates for the Year 2003 and the New Dental Claim Form

In January 2003, the American Dental Association (ADA) revised the ADA claim form and the Current Dental Terminology (CDT-4) Users manual. The Division of Medical Assistance (DMA) and EDS are currently implementing system changes to comply with the new codes and claim form. The anticipated implementation date for the new form and procedure codes is October 1, 2003. However, providers should continue to use the 2000 ADA claim form and CDT-3 procedure codes until the final implementation date is confirmed.

Specific updates to CDT-4, including procedure code deletions, additions, and revised code descriptions, were published in the May 2003 general Medicaid bulletin (available on DMA's website at http://www.dhhs.state.nc.us/dma/bulletin.htm). Upcoming Medicaid bulletins will specify the exact implementation date for the 2002 ADA claim form and procedure codes.

Once the system has been updated to accept the 2002 ADA claim form, providers will be given a three-month transition period to begin using the new form. During the transition period, both the 2000 and 2002 ADA claim form will be accepted.

Claim forms can be ordered from the ADA at the address listed below:

American Dental Association
Attn: Salable Materials Office
211 E. Chicago Avenue
Chicago, IL 60611
Telephone: 1-800-947-4746

ADA Procedure Codes Must be Billed with the "D" Prefix
Effective with dates of service beginning October 1, 2003, all dental procedures codes must be billed with the "D" prefix (such as D0120, D0150, etc.) for both electronic and paper claims. Services billed using the numeric zero prefix procedure codes will deny with the explanation of benefit (EOB) message 0024, which states: "Procedure code, procedure/modifier combination or revenue code is missing, invalid, or invalid for this bill type. Correct and rebill denied detail as a new claim."

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

Attention: Hearing Aid Providers

HIPAA Code Conversion for the Hearing Aid Program

To comply with the implementation of national code sets mandated by the Health Insurance Portability and Accountability Act (HIPAA), it is necessary to end-date all N.C. Medicaid state-created (local) codes and convert them to national codes. Effective with date of service July 31, 2003, all local hearing aid codes will be end-dated. Effective with date of service August 1, 2003, providers must submit national codes when billing for hearing aid services. These changes apply to paper and electronic claim formats. Please continue to use the CMS-1500 claim form (formerly HCFA-1500).

Hearing Aid/Device

Local Code	National Code	Maximum Reimbursement Rate
V5050 Hearing aid, monaural	**V5050** Hearing aid, monaural, in the ear (Bill for all newly fit monaural hearing aids)	Attach invoice
V5130 Hearing aids, binaural	**V5130** Binaural, in the ear (Bill for all newly fit binaural hearing aids)	Attach invoice
V5050 Replacement aid	**V5060** Hearing aid, monaural, behind the ear (Bill for all replacement aids)	Attach invoice
Y2170 Custom earmold	**V5264** Earmold, insert, not disposable	Attach invoice
Y2171 Accessories	**V5267** Accessories (To include one care kit per recipient, per lifetime)	Attach invoice
Y2169 Hearing aid repair	**V5014** Repair/modification of hearing aid	Attach invoice
Y2173 Initial care kit (Stethoscope and forced air blower)	**V5267** Accessories (Bill initial care kit as an accessory)	Attach invoice
No Code 30-day trial rental	No longer applicable	No charge
No Code Hearing aid loaner	No longer applicable	No charge
Y2172 Hearing aid batteries	**V5266** Battery for use in hearing device (Maximum: $35 per claim and allow six claims per 365 days)	Retail
New Code	**V5274** Assistive listening device/FM	Attach invoice

Dispensing Fees

Local Code	National Code	Maximum Reimbursement Rate
V5090 Dispensing fee for V5050 (Hearing aid, monaural)	**V5090** Dispensing fee, unspecified hearing aid (For dispensing hearing aid, monaural)	$ 230.57
V5110 Dispensing fee for V5130 (Hearing aid, binaural)	**V5110** Dispensing fee, bilateral (For dispensing hearing aid, binaural)	371.93
V5160 Dispensing fee for V5060 (Replacement hearing aid)	**V5241** Dispensing fee, monaural, any type (For dispensing replacement aid)	90.69
Y2167 Dispensing fee for V5264 (Earmolds)	**V5299** Hearing services, miscellaneous (For dispensing earmolds)	14.06
Y2168 Dispensing fee for V5267 (Accessories)	**V5299** Hearing services, miscellaneous (For dispensing accessories)	14.06
Y2164 Dispensing fee for V5014 (Hearing aid repairs)	**V5240** Dispensing fee, BICROS (For dispensing hearing aid repairs)	34.76
Y2165 Dispensing fee for 30-day trial	End-dated with effective date of service, July 31, 2003	
Y2166 Dispensing fee for loaner aid	End-dated with effective date of service, July 31, 2003	
New Code	**V5160** Dispensing fee, binaural (For dispensing assistive listening/FM)	$ 185.96

Note: V5241 cannot be billed if a dispensing fee is paid to the provider by the manufacturer. Bill V5299 for dispensing earmolds (V5264) and/or accessories (V5267).

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

Attention: Home Health Agencies

Deletion of Skilled Nursing HCPCS Codes W9952 through W9959

Effective with date of service October 1, 2003, home health providers will no longer use HCPCS codes to bill for home health skilled nursing visits. Providers must continue to follow the MEDICARE-Medicaid Skilled Services Billing Guide in Section 5, Home Health Services of the *N.C. Medicaid Community Care Manual* and use revenue codes 550 and/or 559 to bill for skilled nursing visits. The following HCPCS codes will be end-dated with date of service September 30, 2003.

HCPCS Code	Description
W9952	Home Health skilled nursing visit for observation of a stable patient
W9953	Home Health skilled nursing visit for prefilling insulin syringes
W9954	Home Health skilled nursing visit for prefilling medicine planners
W9955	Home Health skilled nursing visit for venipuncture
W9956	"One-time" Home Health skilled nursing visit
W9957	Home health skilled nursing visit meeting Medicare criteria
W9958	Home Health skilled nursing visit not otherwise classified
W9959	Home Health skilled nursing visit denied by Medicare for dually-eligible patient

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

Attention: Home Health Agencies and Hospital Providers

Denials Due to Incorrect Billing Procedure

Claims for home health services and outpatient services that are filed with the same revenue code on the same date of service on multiple details are being denied as duplicates. Providers must enter a separate detail line for each date of service, combining all units provided on that date in the detail. For example, if two billable home health skilled nursing visits are provided on the same day, the number of service units entered for that detail line is 2.

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

Attention: Home Infusion Therapy Providers

Billing Changes for Home Infusion Drug Therapies

Effective with date of service October 1, 2003, Home Infusion Therapy (HIT) providers must use national codes to bill for each drug therapy. The Division of Medical Assistance (DMA) must make these changes to comply with the implementation of the national code sets mandated by the Health Insurance Portability and Accountability Act (HIPAA). Providers should carefully note all of the changes involved in this conversion to the new codes. Please note that concurrent therapy codes now have **modifiers** that describe when a therapy is a second concurrently administered infusion therapy (SH) and when a therapy is a third or more concurrently administered infusion therapy (SJ). The key points include:

- The code conversion requires the use of some national codes with descriptions that may imply a change in coverage. However, there are no changes to the HIT coverage policy in Section 7, Home Infusion Therapy of the *N.C. Medicaid Community Care Manual.* Providers must be alert to the use of the national code as it applies to N.C. Medicaid.
- The new codes separate the nursing services from the HIT drug therapy package. There is a separate per diem code for nursing services that must be entered on the claim after the HIT drug therapy code.
- When billing for a combination of therapies, providers must enter the code for each of the therapies, plus the code for the nursing services. DMA has designated which therapy is billed as the second and as the third therapy in a combination therapy. The designations are for billing purposes only. They are not intended to have any clinical implications. The second and third therapies are identified with a modifier that must be included on the claim.
- Codes must be entered in a specific order on the claim form as outlined under **Billing Instructions** on page 21.
- All of the HIT drug therapies will continue to be paid as a per diem. The combined fees for the separate new codes for therapies and for the nursing services equal the current fees.

End-Dated Codes
Effective with dates of service September 30, 2003, the following codes are end-dated:

Code	Description
W8221	Antibiotic Infusion Therapy
W8222	Chemotherapy
W8223	Pain Management Infusion Therapy
W8224	Two Simultaneous Antibiotic Infusion Therapies
W8225	Antibiotic Infusion Therapy and Chemotherapy
W8226	Antibiotic and Pain Management Infusion Therapies
W8227	Chemotherapy and Pain Management Infusion Therapies
W8228	Chemotherapy, Antibiotic and Pain Management Infusion Therapies
W8229	Termination Allowance
W8230	RN Monitoring (Over 2 Hours) for Amphotericin B Infusion Therapy

New Codes
Effective with date of service October 1, 2003, HIT providers must use the following codes to bill for drug therapies. The national code description is listed with any requirements specific to N.C. Medicaid shown in brackets at the end of the description. Please see **Billing Instructions** on page 21 for the required code combinations.

Code	Description	Maximum Reimbursement Rate
S9494	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drug and nursing visits coded separately), per diem [For N.C. Medicaid, this code may be used for only antibiotic therapy.]	$ 58.33
S9329	Home infusion therapy, chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drug and nursing visits coded separately), per diem	53.15
S9325	Home infusion therapy, pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment, (drug and nursing visits coded separately), per diem	44.47
T1030	Nursing care, in the home, by registered nurse, per diem	40.18
S9494SH	Antibiotic therapy, per diem [National modifier SH denotes the second concurrently administered infusion therapy.]	40.90
S9329SH	Chemotherapy, per diem [National modifier SH denotes the second concurrently administered infusion therapy.]	52.96
S9325SH	Pain management therapy, per diem [National modifier SH denotes the second concurrently administered infusion therapy.]	47.73
S9325SJ	Pain management therapy, per diem [National modifier SJ denotes the third concurrently administered infusion therapy.]	48.38
S9379	Home infusion therapy, infusion therapy, not otherwise classified; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drug and nursing visits coded separately), per diem [For N.C. Medicaid, this code may be used for only the termination allowance for HIT drug therapies.]	38.26

Code	Description	Maximum Reimbursement Rate
T1002SD	RN Services, up to 15 minutes [National modifier SD denotes that the service was provided by a registered nurse with specialized, highly technical home infusion training.] [For N.C. Medicaid, this code may be used for only RN Monitoring (over 2 hours) for Amphotericin B infusion therapy.]	$ 6.70

Billing Instructions
The following instructions amend the instructions in subsection 7.10.4, Filing a Claim in the *N.C. Medicaid Community Care Manual* in regard to the completion of block 24 on the CMS-1500 for drug therapies.

The new codes require a provider to enter multiple detail lines when billing for a course of treatment. The code combinations are listed below:

When billing for…	Use these codes…
Antibiotic Therapy	**S9494** - Home infusion therapy, antibiotic ***and*** **T1030** - Nursing care, in the home, by registered nurse, per diem
Chemotherapy	**S9329** - Home infusion therapy, chemotherapy infusion ***and*** **T1030** - Nursing care, in the home, by registered nurse, per diem
Pain Management Therapy	**S9325** - Home infusion therapy, pain management infusion ***and*** **T1030** - Nursing care, in the home, by registered nurse, per diem
Two Simultaneous Antibiotic Therapies	**S9494** - Home infusion therapy, antibiotic ***and*** **S9494SH** - Antibiotic therapy as the second billed therapy ***and*** **T1030** - Nursing care, in the home, by registered nurse, per diem
Antibiotic and Chemotherapy	**S9494** - Home infusion therapy, antibiotic ***and*** **S9329SH** - Chemotherapy as the second billed therapy ***and*** **T1030** - Nursing care, in the home, by registered nurse, per diem
Antibiotic and Pain Management	**S9494** - Home infusion therapy, antibiotic ***and*** **S9325SH** - Pain management infusion as the second billed therapy ***and*** **T1030** - Nursing care, in the home, by registered nurse, per diem
Chemotherapy and Pain Management	**S9329** - Home infusion therapy, chemotherapy ***and*** **S9325SH** - Pain management infusion as the second billed therapy ***and*** **T1030** - Nursing care, in the home, by registered nurse, per diem
Antibiotic, Chemotherapy, and Pain Management	**S9494** - Home infusion therapy, antibiotic ***and*** **S9329SH** - Chemotherapy as the second billed therapy ***and*** **S9325SJ** - Pain management infusion as the third billed therapy ***and*** **T1030** - Nursing care, in the home, by registered nurse, per diem

In addition, certain codes must be billed in a specific order.

1. Always bill the primary therapy code (S9494, S9329 or S9325) first.
2. Bill nursing services (T1030) after the related primary therapy code. Nursing services will not be paid unless the related primary therapy code has been paid for the same date of service.
3. If billing a combination of two therapies, bill the second concurrent therapy after the related primary therapy code. The second therapy will not be paid unless the appropriate primary therapy code has been paid for the same date of service.
4. If billing the combination of antibiotic, chemotherapy, and pain management, bill pain management as the third concurrent therapy (S9325SJ) after billing for chemotherapy as the second concurrent therapy (S9329SH). Pain management as a third therapy will not be paid unless S9329SH has been paid for the same date of service.
5. When billing the termination allowance (S9379), bill the allowance after the related primary therapy code. The termination allowance will not be paid unless one of the therapy codes has been paid for a corresponding date of service.
6. When billing the RN monitoring for Amphotericin B (TD1002SD), bill for the monitoring after the antibiotic therapy (S9494).

Example: *A provider wishes to bill for a concurrent course of treatment that includes antibiotic therapy and pain management therapy that was ordered for 10/15 through 10/21. The physician terminates the treatment on 10/19. The provider intends to bill for the combination therapy for 10/15 through 10/19. Because the treatment was terminated on 10/19 with two days remaining in the original prescribed course of treatment, the provider also wishes to bill for two days of the termination allowance. The provider will enter a detail line for S9494 antibiotic therapy on the claim. After entering the detail line for S9494, the provider will enter the detail lines for the following services (they may be entered in any sequence):*

- *S9325SH for pain management therapy as the second therapy;*
- *T1030 for nursing care, in the home, by registered nurse, per diem; and*
- *S9379 for the termination allowance.*

The provider must complete each detail line in block 24 on the CMS-1500 as follows:

24A. DATE(S) OF SERVICE, From/To:

Drug Therapy Codes: Enter the date for the month that the course of treatment begins in the **From** block. If the treatment is continued from the prior month, enter the first day of the month in the **From** block. Enter the last day of the course of treatment for the month in the **To** block. If the treatment extends into the following month, enter the last day of the month in the **To** block. Do NOT span calendar months. Do NOT include dates of service prior to October 1, 2003.

Example: *The patient's course of treatment is from 10/25/03 through 11/15/03. On the claim submitted for October, enter 102503 in the* **From** *block and 103103 in the* **To** *block. On the claim submitted for November, enter 110103 in the* **From** *block and 111503 in the* **To** *block.*

When billing for a **second** therapy, the dates of service must be the same as the primary therapy. When billing for a **third** therapy, the dates of service must be the same as the primary and second therapy.

Nursing Services: Enter the same dates of service as listed for the related drug therapy.

RN Monitoring for Amphotericin B: Use a separate line for each day the monitoring is done. Enter the date of the monitoring in the **From** block. Enter the same date in the **To** block.

Termination Allowance for an Interrupted Course of Treatment: Enter the date of the last day of treatment in the **From** block. Enter the same date in the **To** block.

24B. PLACE OF SERVICE: Enter **12** to show that the items/services were provided at the patient's home.

24C. TYPE OF SERVICE: Enter **15**.

24D. PROCEDURES, SERVICES OR SUPPLIES: Enter the appropriate HCPCS code. For a second or third concurrent therapy, enter the appropriate modifier under **MODIFIER**.

24E. DIAGNOSIS CODE: Leave blank.
Note: The diagnosis code must be entered in block 21. Enter the ICD-9-CM code for the principle diagnosis that corresponds to the service rendered. "V" codes are not acceptable.

24F. CHARGES: Enter the total charge for the items on the detail line.

24G. DAYS OR UNITS: Enter the number of units billed on the detail line as follows:
Drug Therapy Codes: Enter the number of consecutive days shown in **24A**.

Nursing Services: Enter the number of consecutive days shown in **24A**.

RN Monitoring of Amphotericin B: Enter the number of 15-minute units of monitoring in excess of two hours on the date of service. Calculate the number of units as follows:

Step 1 Total the amount of time that the RN is with the patient to monitor the administration of the drug on the date of service. (Remember, do not include travel time or other time not with the patient.)

Step 2 Subtract the two hours included in the per diem.

Step 3 Divide the remaining number of minutes by 15 to get the number of whole units.

Step 4 Add an additional unit if the remainder is 8 minutes or more.

Example: *The RN is with the patient for 3 hours, 47 minutes on 11/15/03 to monitor the administration of Amphotericin B. The first two hours are included in the per diem rate - they may not be billed. Divide the remaining one hour, forty-seven minutes (a total of 107 minutes) by 15. 107 minutes divided by 15 equals 7 units with a remainder of 2. Because the remainder is less than 8, do not add an additional unit. You may bill for 7 units for 11/15/03 under HCPCS code T1002SD.*

Termination Allowance: Enter the number of days that the allowance applies, not to exceed seven days.

24H. EPSDT/FAMILY PLANNING: Leave blank.

24I. EMG: Leave blank.

24J. COB: Optional.

24K. RESERVED FOR LOCAL USE: Optional.

Denied Details
Because many of the new codes are dependent on the payment of other codes – for example, nursing services will not be paid if payment has not been made for the related primary therapy – providers must determine what causes a denial before attempting corrective action. The problem with the detail that failed to process must be resolved before any services dependent on payment of that detail will process for payment.

Example: *A provider files a claim for a concurrent course of treatment that includes antibiotic therap, pain management therapy, and the nursing services. Antibiotic therapy is the primary therapy for billing purposes with this combination therapy; therefore, if the detail for the antibiotic therapy fails to process for payment, the detail for pain management as the second therapy and detail for the nursing services will deny. The provider must resolve the problem with the billing of the antibiotic therapy before resubmitting a claim for the other services.*

Providers should consult the *N.C. Medicaid Community Care Manual* for additional information about Medicaid HIT coverage. The manual is available on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm.

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

Attention: Optical Providers

HIPAA Code Conversion for the Visual Services Program

To comply with the implementation of national code sets mandated by the Health Insurance Portability and Accountability Act (HIPAA), it is necessary to end-date all N.C. Medicaid state-created (local) codes and convert them to national codes. Effective with date of service July 31, 2003, all state-created optical codes will be end-dated. Effective with date of service August 1, 2003, providers must submit national codes when billing for optical services. These changes apply to paper and electronic claim formats. Please continue to use the CMS-1500 claim form (formerly HCFA-1500).

Billing Procedures for Visual Aids and Dispensing Fees
Materials are to be billed at invoice cost and the invoice must be submitted with CMS-1500 form. Dispensing fees are to be billed at the established fee.

Visual Aids

Provider's Supply of Medicaid Frames/Lenses (Requires Justification and Prior Approval)		
Local Code	**National Code**	**Maximum Reimbursement Rate**
V0730 Not otherwise classified (Frames, lenses, special services)	**V2799** Vision services, miscellaneous	Attach invoice
Y5534 Supply uncut lens/lenses	End-dated effective with date of service July 31, 2003	
Y5535 Edge and mount single vision lens	End-dated effective with date of service July 31, 2003	
Y5536 Edge and mount multifocal lens	End-dated effective with date of service July 31, 2003	

Note: Bill V2799 as one unit only.

Contact Lenses		
Local Code	**National Code**	**Maximum Reimbursement Rate**
V0310 Standard hard contact lens, monocular	**V2510** Contact lens, gas permeable, sph, per lens	Attach invoice
V0300 Standard soft contact lens, monocular	**V2520** Contact lens, hydrophilic, sph, per lens	Attach invoice
V2599 Care kit for contact lenses	**V2599** Contact lens, other type	Attach invoice

Note: Bill one contact lens as one unit.
Bill a pair of contact lenses as two units.

Subnormal Visual Aids		
Local Code	**National Code**	**Maximum Reimbursement Rate**
V2600 Magnifiers/readers	**V2600** Handheld, low vision aids	Attach invoice
Y5516 Telescopic glasses	**V2615** Telescopic and other compound lens systems	Attach invoice
Y5517 Microscopic glasses	End-dated effective with date of service July 31, 2003	
Y5518 Loupes	**V2610** Single lens spectacle mounted low vision aids	Attach invoice
V1035 Temporary/loaner cataract glasses	End-dated effective with date of service July 31, 2003	

Dispensing Fees

Spectacle Lenses		
Local Code	**National Code**	**Maximum Reimbursement Rate**
V0500 Single vision lens (one)	**92340** Fitting of spectacles, except for aphakia; monofocal	$ 7.72
V0290 Bifocal or balance lens (one)	**92341** Fitting of spectacles, except for aphakia; bifocal	11.59
V0640 Trifocal lens (one)	**92342** Fitting of spectacles, except for aphakia; multifocal other than bifocal	15.46
V1110 Cataract lens (one)	**92353** Fitting of spectacle prosthesis for aphakia; multifocal	21.28

Note: Bill one lens as one unit.
Bill a pair of lenses as two units.

Frames and Repairs (to include adjustments)		
Local Code	**National Code**	**Maximum Reimbursement Rate**
V0140 Dispense frame	**92370** Repair and refitting spectacles, except for aphakia	$ 7.72
V0131 Dispense frame front	End-dated effective with date of service July 31, 2003	
V2030 Dispense temple (one)	End-dated effective with date of service July 31, 2003	

Contact Lenses		
Local Code	**National Code**	**Maximum Reimbursement Rate**
V0320 Dispense contact lens (one)	Continue to bill state-created (local code) **V0320**	$ 92.73
V0330 Dispense contact lenses (two)	Continue to bill state-created (local code) **V0330**	160.73

Replacement Contact Lenses		
Local Code	**National Code**	**Maximum Reimbursement Rate**
Y5513 Dispense new Rx lens for previous contact lens wearer (one)	**92326** Replacement of contact lens	$ 39.05
Y5514 Dispense replacement (previous) contact lens to previous contact lens wearer.	End-dated effective with date of service July 31, 2003	

Dispensing Fees for Contact Lenses Include K-Readings, Measurements, Fitting, Training, etc.

Telescopic and Microscopic Aids		
Local Code	**National Code**	**Maximum Reimbursement Rate**
Y5511 Monocular	End-dated effective with date of service July 31, 2003	
Y5512 Binocular	**92392** Supply of low vision aids	$ 61.82

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

Attention: Personal Care Services (In Private Residences) Providers

Billing and Claim Form Changes for Personal Care Services in Private Residences

Effective with date of service October 1, 2003, providers of Personal Care Services (PCS) must bill on the CMS-1500 claim form using HCPCS code S5125 "Attendant care services; per 15 minutes" for services provided in private residences. Dates of service through September 30, 2003 must be billed on the UB-92 claim form using revenue code 599. The Division of Medical Assistance (DMA) must make these changes to comply with the implementation of the national code sets mandated by the Health Insurance Portability and Accountability Act (HIPAA). This article revises the applicable billing instructions listed in the *N.C. Medicaid Community Care Manual*.

Providers must complete each block in line 24 on the CMS-1500 as follows:

24A. DATE(S) OF SERVICE, From/To:
Use a separate detail line for each day that the service is provided. Enter the date of service in the **From** block. Enter the same date in the **To** block.

24B. PLACE OF SERVICE: Enter **12** to show that the items/services were provided in the patient's home.

24C. TYPE OF SERVICE: Enter **01**.

24D. PROCEDURES, SERVICES OR SUPPLIES: Enter **S5125**.

24E. DIAGNOSIS CODE: Leave blank.
Note: The diagnosis code must be entered in block 21. Enter the ICD-9-CM code for the principle diagnosis that corresponds to the service rendered. "V" codes are not acceptable.

24F. CHARGES: Enter the total charge for the units for each date of service on the detail line. (The charges are calculated by multiplying the provider agency's unit rate by the number of units.)

24G. DAYS OR UNITS: Enter the number of 15-minute units billed on the detail line. Refer to Section 6.12.2, Units of Services in the *N.C. Medicaid Community Care Manual* for instructions on calculating the number of units.

24H. EPSDT/FAMILY PLANNING: Leave blank.

24I. EMG: Leave blank.

24J. COB: Optional.

24K. RESERVED FOR LOCAL USE: Optional.

These changes do not affect coverage policy, related procedures and requirements or the reimbursement rate. Providers should consult the *N.C. Medicaid Community Care Manual* for additional information about Medicaid PCS coverage in private residences. The manual is available on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm.

CMS-1500 claim form instructions are available in the *General Medicaid Billing/Carolina ACCESS Policies and Procedures Guide* on DMA's website at http://www.dhhs.state.nc.us/dma/medbillcaguide.htm.

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

Attention: Private Duty Nursing Providers

Billing Changes for Private Duty Nursing

Effective with date of service October 1, 2003, the following changes will be made when requesting approval of and billing for Private Duty Nursing (PDN):

1. The unit of service to use for prior approval and billing will be 15 minutes instead of an hour. The Division of Medical Assistance (DMA) will automatically convert the unit of service to 15-minute units for prior approvals that are in effect as of October 1, 2003. Providers will not have to submit a new prior approval request to convert the units for those patients.
2. The 15-minute maximum allowable reimbursement is $8.84. Providers are reminded to bill their usual and customary charge for the service.
3. Providers will use the CMS-1500 claim form instead of the UB-92 to file claims.
4. Providers will use HCPCS code T1000 "Private duty, independent nursing services – licensed, up to 15 minutes" instead of RC590 to bill for PDN.

Revenue code 590, one-hour unit, and the UB-92 claim form are used for dates of service through September 30, 2003. DMA must make these changes to comply with the implementation of the national code sets mandated by the Health Insurance Portability and Accountability Act (HIPAA). This article revises the instructions in the *N.C. Medicaid Community Care Manual*.

Providers must complete each detail line in block 24 on the CMS-1500 as follows:

24A. DATE(S) OF SERVICE, From/To:
Use a separate detail line for each day that the service is provided. Place the date of service in the **From** block. Enter the same date in the **To** block.

24B. PLACE OF SERVICE: Enter **12**.

24C. TYPE OF SERVICE: Enter **01**.

24D. PROCEDURES, SERVICES OR SUPPLIES: Enter **T1000**.

24E. DIAGNOSIS CODE: Leave blank.
Note: The diagnosis code must be entered in block 21. Enter the ICD-9-CM code for the principle diagnosis that corresponds to the service rendered. "V" codes are not acceptable.

24F. CHARGES: Enter the total charge for the units on the detail line. The charges are the provider agency's unit rate times the number of units billed on the line.

24G. DAYS OR UNITS: Enter the number of 15-minute units billed on the detail line. Do not enter an amount in excess of the prior approved amount. If less than 15 minutes but more than 8 minutes of care have been provided, a whole unit of service may be billed.

Example: *The patient is approved for 34 units (eight hours, 30 minutes) of PDN per day. On 11/2/03, **t**he primary caregiver asks the PDN nurse to leave early so that the caregiver can take the patient for a physician visit. The PDN nurse completes six hours, 35 minutes of care. The provider agency may bill for 26 units (six hours, 30 minutes) of PDN for 11/2/03. The provider may not bill for the additional five minutes.*

24H. EPSDT/FAMILY PLANNING: Leave blank.

24I. EMG: Leave blank.

24J. COB: Optional.

24K. RESERVED FOR LOCAL USE: Optional.

These changes do not affect coverage policy, or the related procedures and requirements. Providers should consult the *N.C. Medicaid Community Care Manual* for additional information about Medicaid PDN coverage. The manual is available on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm.

CMS-1500 claim form instructions are available in the *General Medicaid Billing/Carolina ACCESS Policies and Procedures Guide* on DMA's website at http://www.dhhs.state.nc.us/dma/medbillcaguide.htm.

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

Holiday Closing

The Division of Medical Assistance (DMA) and EDS will be closed on Friday, July 4, 2003, in observance of Independence Day.

Checkwrite Schedule

July 15, 2003	August 12, 2003	September 3, 2003
July 22, 2003	August 19, 2003	September 9, 2003
July 31, 2003	August 28, 2003	September 16, 2003

Electronic Cut-Off Schedule

July 11, 2003	August 8, 2003	September 5, 2003
July 18, 2003	August 15, 2003	September 12, 2003
July 25, 2003	August 22, 2003	
	August 29, 2003	

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

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

Patricia MacTaggart
Executive Director
EDS

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