North Carolina Medicaid Bulletin

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

Number 7 July 2004

In This Issue . . .

All Providers:
- ♦ About ACS 3
- ♦ Medicaid Denial of Medicare Part B Covered Services 4
- ♦ Medical Coverage Policies 5
- ♦ Medicare Crossovers 5
- ♦ Medicare Crossover Reference Request Form 6
- ♦ NCMMIS Update 2
- ♦ Resubmission of a Previously Denied Claim 7

Anesthesia Providers:
- ♦ Documentation Guidelines for Medical Direction 9

Dental Providers:
- ♦ Billing for Dental Procedure Codes D7270, D7280, and D7971 10
- ♦ Handwritten Service Review Numbers on Prior Approval Forms 10

Federally Qualified Health Centers:
- ♦ Maternal Outreach Worker Services - Revised Billing Guidelines 4

Hearing Aid Providers:
- ♦ Handwritten Service Review Numbers on Prior Approval Forms 10

Local Health Departments:
- ♦ Maternal Outreach Worker Services - Revised Billing Guidelines 4

Optical Services:
- ♦ Handwritten Service Review Numbers on Prior Approval Forms 10

Physicians:
- ♦ Coverage of New HCPCS “G” Codes for End-Stage Renal Disease Related Services 11
- ♦ Ocular Photodynamic Therapy with Verteporfin – Revised Billing Guidelines 13

Rural Health Clinics:
- ♦ Maternal Outreach Worker Services - Revised Billing Guidelines 4

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

CPT codes, descriptors, and other data only are copyright 2003 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.

Attention: All Providers

NCMMIS Update

The future NCMMIS Fiscal Agent, ACS State Healthcare, LLC (ACS) held the Executive Kickoff meeting with the State on May 11th. The first work sessions with the ACS staff were successfully completed the week of May 25th. Everything is on schedule for the new NCMMIS, called ***NCL**eads*, to be operational no later than **June 2006**.

Leading-edge Technology
Efficiency and Effectiveness
Application Knowledge
Delivery
Staffing Excellence

DHHS is committed to supplying comprehensive provider training by delivering thorough training at convenient locations. The State will work with provider representatives to ensure that training offerings that best meet providers' needs are delivered through various easily accessible mechanisms. *Watch for training details coming soon*. Statistics show that advance training lays the foundation that is necessary for effective use of system functionality. During the evaluation of the NCMMIS proposals, the Department solicited numerous references from states that had implemented systems similar to the base Medicaid systems proposed for North Carolina. Corrective actions to address lessons learned from other states were incorporated into the North Carolina request for proposal. Providers who attended training found the transition to the new system to be a more positive experience. Remember–***NCL*eads**–we know that North Carolina will ***lead*** other states in provider service and provider participation!

While you can continue to submit claims using any current method(s) with the new system, we hope you'll also learn about some new options to improve your business such as:

- More timely payments because you can enter and adjudicate claims online ("real time" processing instead of overnight processing);
- Web-based options to expedite the entry, adjustment and voiding of claims;
- Increased efficiencies through online prior approval requests processing; and
- Free software that allows you to enter, submit, and adjust claims electronically.

We will be soliciting your involvement during the implementation phase. If you think you may be interested in participating in the ***NCL*eads** implementation process, please e-mail ncmmis.provider@ncmail.net and indicate your provider type (e.g., physician, hospital, pharmacy, long-term care facility, etc.) in the Subject line. There will be more details about provider participation in the August 2004 general Medicaid bulletin. We look forward to working with you!

Portia Asbridge, Communications Manager, NCMMIS Initiative
DHHS, 919-855-3112

About ACS

ACS is a Fortune 500 company traded on the New York Stock Exchange (NYSE: ACS) with $3.8 billion in annual revenue. ACS provides services that enable business and government agencies to focus on core operations, respond to rapidly changing technologies, and reduce expenses associated with business processes and information processing. ACS provides data processing and/or business process outsourcing services to 15 Blue Cross Blue Shield Plans—including BC/BS of North Carolina—and to nine of the Top 10 commercial health insurers.

ACS implemented the first federally certified Medicaid Management Information System (MMIS) in 1972 and has gone on to successfully implement MMIS in 30 states over 32 years. Over the past 8 years, ACS has implemented more new Medicaid systems than any other vendor.

Today, ACS administers Medicaid programs as the MMIS Fiscal Agent for 12 states (including Florida and Texas) and Washington, D.C., the nation's capital. ACS processes 400 million Medicaid claims worth $50 billion in payments each year to several hundred thousand doctors, hospitals, pharmacies, nursing homes, clinics, and other healthcare providers. ACS also administers six state Child Health Insurance Programs (S-CHIP), manages pharmacy benefits for 23 state programs (Medicaid and Seniors), and operates data warehouses and decision support systems for 12 Medicaid programs (including North Carolina, Texas, and Florida).

In North Carolina, ACS employs approximately 600 people in 10 locations around the State. For the N.C. Department of Health and Human Services, ACS manages pharmacy benefit prior authorizations and provides a large data warehouse with analytical tools to support program planning and evaluation and to detect waste, fraud, and abuse.

The new MMIS system for North Carolina, called ***NCL***eads, is operationally proven in four states and will be among the most technologically advanced in the nation. ***NCL***eads will support 24 x 7 accessibility, with appropriate security safeguards for program participants. Providers will be able to submit claims, check on claims and eligibility status, and receive claims payment electronically anytime—day or night. Provider questions and requests for information are handled by experienced help desk operators or can be addressed electronically.

Attention: All Providers

Medicaid Denial of Medicare Part B Covered Services

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

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

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

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

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

Claims Analysis Unit
DMA, 919-855-4045

Attention: Federally Qualified Health Centers, Local Health Departments, and Rural Health Clinics

Maternal Outreach Worker Services – Revised Billing Guidelines

Effective with date of service July 1, 2004, the billing guidelines for Maternal Outreach Worker Services have been revised. Providers may bill up to seven units per month using HCPCS code S9445, Patient education, not otherwise classified, non-physician provider, individual per session. For Medicaid billing, one unit equals 15 minutes. Services must be billed per date of service.

Medical Coverage Policy # 1M-7, *Baby Love Maternal Outreach Worker Program*, on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm has been revised to reflect this change.

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

Attention: All Providers

Medical Coverage Policies

The following new or amended medical coverage policies are now available on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm:

1A-13 – Occular Photodynamic Therapy
1M-7 – Baby Love Maternal Outreach Worker Program
3J – Personal Care Services-Plus
4A – Dental Services
8F – Outpatient Specialized Therapies
8H – Local Education Agencies

These policies supersede previously published policies and procedures. Providers may contact EDS at 1-800-688-6696 or 919-851-8888 with billing question.

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

Attention: All Providers

Medicare Crossovers

The N.C. Medicaid program will return to processing all crossover claims billed on a CMS-1500 form or as an 837 professional transaction as direct crossovers from Medicare. The expected date for this transition is September 6, 2004.

In anticipation of this change, providers should verify that their Medicare provider numbers are cross-referenced to their Medicaid provider numbers. Providers can verify this by contacting EDS Provider Services at 1-800-688-6696 or 919-851-8888.

If your Medicaid and Medicare provider numbers are not cross-referenced, please complete and submit the following form by fax or mail to EDS at the address indicated on the form. Additional information on crossover claims will be published in upcoming general Medicaid bulletins.

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

Medicare Crossover Reference Request

Provider Name: ____

Contact Person (required): ___________________________ Telephone (required): _______________

Select the appropriate *Medicare Carrier/Intermediary/DMERC* from the following listing, the *Action to be taken*, and your *Medicare* and *Medicaid* provider numbers. **If this section is not completed, the form will not be processed.** These are the only carriers for which EDS can currently cross-reference provider numbers.

Medicare Part A Intermediaries

- ☐ Riverbend GBA Medicare Part A (Tennessee) http://www.riverbendgba.com
- ☐ Palmetto GBA Medicare Part A. Effective November 1, 2001, Palmetto GBA assumed the role of North Carolina Part A intermediary from Blue Cross/Blue Shield of NC. (North Carolina) http://www.palmettogba.com
- ☐ Trailblazer Medicare Part A (Colorado, New Mexico and Texas) http://www.the-medicare.com
- ☐ United Government Services Medicare Part A (Wisconsin) http://www.ugsmedicare.com
- ☐ Palmetto Medicare Part A (South Carolina) http://www.palmettogba.com*
- ☐ AdminaStar Medicare Part A (Illinois, Indiana, Ohio, and Kentucky) http://www.adminastar.com*
- ☐ Carefirst of Maryland Medicare Part A (Maryland) http://www.marylandmedicare.com/pages/mdmedicare/mdmedicaremain1.htm*
- ☐ Veritus Medicare Part A (Pennsylvania) http://www.veritusmedicare.com*
- ☐ First Coast Service Options Medicare Part A, subsidiary of BCBS of Florida (Florida) http://www.floridamedicare.com *

Medicare Part B Carrier

- ☐ CIGNA Medicare Part B (Tennessee, North Carolina, and Idaho) http://www.cignamedicare.com
- ☐ AdminaStar Medicare Part B (Indiana and Kentucky) http://www.adminastar.com*
- ☐ Palmetto Medicare Part B (South Carolina) http://www.palmettogba.com*

Medicare Regional DMERC

- ☐ Palmetto Region C DMERC (Alabama, Arkansas, Colorado, Florida, Georgia, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas and the Virgin Islands); http://www.palmettogba.com

*Trading Partners currently in testing phase.

Action to be taken:

☐ ***Addition*** **-** *This is used to add a new provider number (Medicare or Medicaid) to the crossover file.*

Medicare Provider number: ______________________ Medicaid Provider number: ______________

☐ ***Change*** - *This is used to change an existing provider number (Medicare or Medicaid) on the crossover file.*

Medicare Provider number: ______________________ Medicaid Provider number: ______________

Mail completed form to:
P.O. Box 300009
Raleigh, NC 27622
FAX: 1-919-851-4014
1-800-688-6696

PVS002 Revised 07/04

Attention: All Providers

Resubmission of a Previously Denied Claim

If one of the following EOBs is received and the validity is questionable, do not appeal by submitting an adjustment request. Please contact EDS Provider Services at 1-800-688-6696 or 919-851-8888. Adjustments submitted for these EOB denials will be denied with EOB 998 which states "Claim does not require adjustment processing, resubmit claim with corrections as a new day claim" or EOB 9600, which states "Adjustment denied; if claim was with adjustment it has been resubmitted. The EOB this claim previously denied for does not require adjusting. Correct/resubmit in lieu adjustment request."
(Revised 05/27/04)

0002	0069	0128	0181	0237	0327	0572	0670	0860	0942
0003	0074	0129	0182	0240	0356	0576	0671	0863	0943
0004	0075	0131	0183	0241	0363	0577	0672	0864	0944
0005	0076	0132	0185	0242	0364	0579	0673	0865	0945
0007	0077	0133	0186	0244	0394	0578	0674	0866	0946
0009	0078	0134	0187	0245	0398	0580	0675	0867	0947
0011	0079	0135	0188	0246	0424	0581	0676	0868	0948
0013	0080	0138	0189	0247	0425	0584	0677	0869	0949
0014	0082	0139	0191	0249	0426	0585	0679	0875	0950
0017	0084	0141	0194	0250	0427	0586	0680	0888	0952
0019	0085	0143	0195	0251	0428	0587	0681	0889	0953
0023	0089	0144	0196	0253	0430	0588	0682	0898	0960
0024	0090	0145	0197	0255	0435	0589	0683	0900	0967
0025	0093	0149	0198	0256	0438	0590	0685	0905	0968
0026	0094	0151	0199	0257	0439	0593	0688	0908	0969
0027	0095	0153	0200	0258	0452	0604	0689	0909	0970
0029	0100	0154	0201	0270	0462	0607	0690	0910	0972
0033	0101	0155	0202	0279	0465	0609	0691	0911	0974
0034	0102	0156	0203	0282	0505	0610	0698	0912	0986
0035	0103	0157	0204	0283	0511	0611	0732	0913	0987
0036	0104	0158	0205	0284	0513	0612	0734	0916	0988
0038	0105	0159	0206	0286	0516	0616	0735	0917	0989
0039	0106	0160	0207	0289	0523	0620	0749	0918	0990
0040	0108	0162	0208	0290	0525	0621	0755	0919	0991
0042	0110	0163	0210	0291	0529	0622	0760	0920	0992
0041	0111	0164	0213	0292	0536	0626	0777	0922	0995
0046	0112	0165	0215	0293	0537	0635	0797	0925	0997
0047	0113	0166	0217	0294	0548	0636	0804	0926	0998
0049	0114	0167	0219	0295	0553	0641	0805	0927	1001
0050	0115	0170	0220	0296	0556	0642	0814	0929	1003
0051	0118	0171	0221	0297	0557	0661	0817	0931	1008
0058	0120	0172	0222	0298	0558	0662	0819	0932	1022
0062	0121	0174	0223	0299	0559	0663	0820	0933	1023
0063	0122	0175	0226	0316	0560	0665	0822	0934	1035
0065	0123	0176	0227	0319	0574	0666	0823	0936	1036
0067	0126	0177	0235	0325	0575	0668	0824	0940	1037
0068	0127	0179	0236	0326	0569	0669	0825	0941	1038

List of EOBs that Do Not Require Adjustment, continued

1043	1233	2238	5224	7906	7943	7980	9103	9230	9291
1045	1275	2270	5225	7907	7944	7981	9104	9231	9295
1046	1278	2335	5226	7908	7945	7982	9105	9232	9600
1047	1307	2911	5227	7909	7946	7983	9106	9233	9611
1048	1324	2912	5228	7910	7947	7984	9174	9234	9614
1049	1350	2913	5229	7911	7948	7985	9175	9235	9615
1050	1351	2914	5230	7912	7949	7989	9180	9236	9625
1057	1355	2915	6703	7913	7950	7990	9200	9237	9630
1058	1380	2916	6704	7914	7951	7991	9201	9238	9631
1059	1381	2917	6705	7915	7952	7992	9202	9239	9633
1060	1382	2918	6707	7916	7953	7993	9203	9240	9642
1061	1396	2919	6708	7917	7954	7994	9204	9241	9684
1062	1399	2920	7700	7918	7955	7995	9205	9242	9801
1063	1400	2921	7701	7919	7956	7996	9206	9243	9804
1064	1404	2922	7702	7920	7957	7997	9207	9244	9806
1078	1422	2923	7703	7921	7958	7998	9208	9245	9807
1079	1442	2924	7705	7922	7959	7999	9209	9246	9919
1084	1443	2925	7706	7923	7960	8174	9210	9247	9947
1086	1502	2926	7707	7924	7961	8175	9211	9248	9993
1087	1506	2927	7708	7925	7962	8326	9212	9249	
1091	1513	2928	7709	7926	7963	8328	9213	9250	
1092	1605	2929	7712	7927	7964	8327	9214	9251	
1152	1866	2930	7717	7928	7965	8400	9215	9252	
1154	1868	2931	7733	7929	7966	8401	9216	9253	
1156	1873	2944	7734	7930	7967	8901	9217	9254	
1170	1944	2988	7735	7931	7968	8902	9218	9256	
1175	1949	3001	7736	7932	7969	8903	9219	9257	
1177	1956	3002	7737	7933	7970	8904	9220	9258	
1178	1999	3003	7738	7934	7971	8905	9221	9259	
1181	2024	5001	7740	7935	7972	8906	9222	9260	
1183	2027	5002	7741	7936	7973	8907	9223	9261	
1184	2147	5201	7788	7937	7974	8908	9224	9268	
1186	2148	5206	7794	7938	7975	8909	9225	9269	
1197	2149	5216	7900	7939	7976	9036	9226	9272	
1198	2235	5221	7905	7940	7977	9054	9227	9273	
1204	2236	5222	7901	7941	7978	9101	9228	9274	
1232	2237	5223	7904	7942	7979	9102	9229	9275	

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

Attention: Anesthesia Providers

Documentation Guidelines for Medical Direction

The final rule on the Tax Equity and Financial Responsibility Act (TEFRA, 1998) requires physicians to meet seven requirements for medical direction of anesthesia services. In addition to these seven requirements, the Division of Medical Assistance (DMA) also implemented medical direction modifiers, effective with date of processing May 15, 2004. (Refer to the April 2004 general Medicaid bulletin for additional information on medical direction modifiers for anesthesia services.)

The Centers for Medicare and Medicaid Services (CMS) seven requirements are:

1. **"Perform a pre-anesthetic examination and evaluation."**
   The physician should evaluate the patient, performing an appropriate history and physical examination to adequately plan the anesthetic. This must be specifically documented in the medical record.

2. **"Prescribe the anesthesia plan."**
   The physician should personally prescribe and document the anesthesia plan.

3. **"Personally participate in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence."**
   During anesthetics that are not considered to be general, (i.e., regional and/or MAC anesthetic), there is no period of induction or emergence. During general anesthetics, the physician should document his or her presence and availability by appropriate signing of the anesthetic record, to indicate in a chronological fashion, participation in induction and emergence. Monitoring of the patient during emergence can occur at any time in the process of emergence.

4. **"Ensure that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual."**
   Although no specific documentation in each patient's record is required, records of current licensure and training certification should be maintained. Knowledge of the individual's skill set and training is recommended.

5. **"Monitor the course of anesthesia administration at frequent intervals."**
   For a general anesthetic lasting one hour or less, the documentation of presence during induction and at some point during emergence will be sufficient. If the anesthetic lasts longer than an hour, at least one visit to the operating room should be documented.

6. **"Remain physically present and available for immediate diagnosis and treatment of emergencies."**
   No specific documentation is required.

7. **"Provide indicated post-anesthesia care."**
   Standing orders in the post-anesthesia care unit (PACU) are sufficient but should be dated and signed appropriately.

A legible identification of the directing anesthesiologist is required on each page of the patient’s record. Change of medical direction must be documented. Should review of medical records fail to document medical direction, recoupment of paid claims will be initiated and further investigation of the practice will be pursued by DMA.

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

Attention: Dental Providers (Including Health Department Clinics)

Billing for Dental Procedure Codes D7270, D7280, and D7971

The following dental procedures must be billed with valid tooth numbers entered in field 59 on the 1999 (version 2000) ADA dental claim form. Valid tooth numbers are listed for each of these specific procedure codes.

Procedure Code	Description	Tooth Numbers
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	A-T, 1-32, AS-TS, 51-82
D7280	Surgical access of an unerupted tooth	A-T, 1-32, AS-TS, 51-82
D7971	Excision of pericoronal gingiva	A-T, 1-32, AS-TS, 51-82

If claims for these procedure codes were denied as duplicates for multiple teeth on the same date of service, refile the denied procedure with a valid tooth number.

Note: D7280 and D7971 are not allowed on the same date of service as an extraction for the same tooth number.

Medical Coverage Policy #4A, *Dental Services*, has been updated to incorporate this information and is available on the Division of Medical Assistance website at http://www.dhhs.state.nc.us/dma/dental/1dental.pdf.

Ronald Venezie, DDS, MS, Dental Director
DMA, 919-857-4020

Attention: Dental Providers, Hearing Aid Providers, and Optical Services

Handwritten Service Review Numbers on Prior Approval Forms

Effective August 1, 2004, the EDS prior approval staff will no longer hand write the Service Review Number (SRN) on the provider's copy of approved prior request forms because entering the SRN on ADA claim forms submitted by dental providers and the CMS-1500 claim forms submitted by optical services and hearing aid providers is not a requirement for reimbursement. The provider's copy of the approved prior approval request form will continue to be stamped with the word "approved" and will be dated, and initialed by the prior approval staff.

Approval criteria for services and the requirements for completing the approval request form have not changed.

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

Attention: Physicians

Coverage of New HCPCS "G" Codes for End-Stage Renal Disease Related Services

N.C. Medicaid is in the process of implementing system changes to allow new HCPCS "G" codes implemented by Medicare to be billed for end-stage renal disease (ESRD) related services for recipients receiving dialysis. The HCPCS code descriptions include the applicable number of visits provided within each month for ESRD related services and the age of the recipient. HCPCS codes G0308 through G0327 will be used in place of CPT codes 90918 through 90925. The CPT codes will be end-dated. The table below includes the HCPCS codes and descriptions.

Code	Description
G0308	End Stage Renal Disease (ESRD) related services during the course of treatment, for patients under 2 years of age to include monitoring the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month.
G0309	End Stage Renal Disease (ESRD) related services during the course of treatment, for patients under 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2 or 3 face-to-face physician visits per month.
G0310	End Stage Renal Disease (ESRD) related services during the course of treatment, for patients under 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month.
G0311	End Stage Renal Disease (ESRD) related services during the course of treatment, for patients between 2 and 11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month.
G0312	End Stage Renal Disease (ESRD) related services during the course of treatment, for patients between 2 and 11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2 or 3 face-to-face physician visits per month.
G0313	End Stage Renal Disease (ESRD) related services during the course of treatment, for patients between 2 and 11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month.
G0314	End Stage Renal Disease (ESRD) related services during the course of treatment, for patients between 12 and 19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month.

HCPCS G Codes for End-Stage Renal Disease Related Services, continued

Code	Description
G0315	End Stage Renal Disease (ESRD) related services during the course of treatment, for patients between 12 and 19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2 or 3 face-to-face physician visits per month.
G0316	End Stage Renal Disease (ESRD) related services during the course of treatment, for patients between 12 and 19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month.
G0317	End Stage Renal Disease (ESRD) related services during the course of treatment, for patients 20 years of age and over; with 4 or more face-to-face physician visits per month.
G0318	End Stage Renal Disease (ESRD) related services during the course of treatment, for patients 20 years of age and over; with 2 or 3 face-to-face physician visits per month.
G0319	End Stage Renal Disease (ESRD) related services during the course of treatment, for patients 20 years of age and over; with 1 face-to-face physician visit per month.
G0320	End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients under two years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents
G0321	End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients two to eleven years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents.
G0322	End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients 12 to 19 years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents.
G0323	End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients twenty years of age and older.
G0324	End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients under two years of age.
G0325	End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients between two and 11 years of age.
G0326	End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients between 12 and 19 years of age.
G0327	End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients 20 years of age and over.

Providers will be notified through a general Medicaid bulletin or by an announcement on the Division of Medical Assistance's website at http://www.dhhs.state.nc.us/dma/prov.htm if the system is ready prior to the next bulletin publication. Additional coverage criteria and the effective date of coverage will be included in this notification.

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

Attention: Physicians

Ocular Photodynamic Therapy with Verteporfin – Revised Billing Guidelines

The N.C. Medicaid program covers ocular photodynamic therapy (OPT) with verteporfin (Visudyne) effective with date of service January 1, 2001. Claims that were previously denied may be refiled as a new claim. The requirement to request a time limit override for claims billed for dates of service between January 1, 2001 and June 30, 2003 has been waived. These claims must be received for processing by 12:00 a.m. on October 1, 2004.

For dates of service **January 1, 2002 and after**, bill:

- **CPT code 67221**, photodynamic therapy (includes intravenous infusion) for destruction of localized lesion of choroid – for the procedure
- **CPT code 67225**, photodynamic therapy, second eye, at single session
- **HCPCS code J3395**, injection, verteporfin, 15 mg. – for the injection
- **ICD-9-CM diagnosis code 362.52**

For dates of service **January 1, 2001 through December 31, 2001**, bill:

- **CPT code 67221**, photodynamic therapy (includes intravenous infusion) for destruction of localized lesion of choroid – for the procedure
- **HCPCS code G0184** – for the second eye at a concurrent session
- **HCPCS code J3490**, unclassified drug – for the injection
- **ICD-9-CM diagnosis code 362.52**

Note: When billing for verteporfin with **HCPCS code J3490**, the unclassified drug code, providers must attach an invoice to the claim form. **An invoice must be submitted with each claim**. The paper invoice must indicate the name of the recipient, the recipient's Medicaid identification (MID) number, the name of the medication, the dosage given, the National Drug Code (NDC) number(s) from the vial(s) used, the number of vials used, and the cost per dose. Providers must indicate the number of units given in block 24G on the claim form.

The Medicaid unit of coverage for verteporfin is one 15 mg. vial.

- For dates of service January 1, 2001 through December 31, 2003, the maximum reimbursement rate is $1,381.50.
- For dates of service January 1, 2004 through March 31, 2004, the maximum reimbursement rate per unit is $1,304.75.
- For dates of service April 1, 2004 and after, the maximum reimbursement rate per unit is $1,404.26.

Refer to Medical Coverage Policy #1A-13, *Ocular Photodynamic Therapy*, on the Division of Medical Assistance's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm for complete coverage criteria.

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

Proposed Medical Coverage Policies

In accordance with Session Law 2003-284, proposed new or amended Medicaid medical coverage policies are available for review and comment on DMA's website at http://www.dhhs.state.nc.us/dma/prov.htm. To submit a comment related to a policy, refer to the instructions on the website. Providers without Internet access can submit written comments to the address listed below.

Gina Rutherford
Division of Medical Assistance
Medical Policy Section
2501 Mail Service Center
Raleigh, NC 27699-2501

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

Holiday Observance

The Division of Medical Assistance and EDS will be closed on Monday, July 5, 2004 in observance of Independence Day.

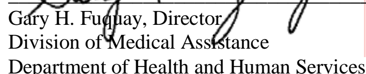
Checkwrite Schedule

July 12, 2004	August 10, 2004	September 8, 2004
July 20, 2004	August 17, 2004	September 14, 2004
July 29, 2004	August 26, 2004	September 23, 2004

Electronic Cut-Off Schedule

July 9, 2004	August 6, 2004	September 3, 2004
July 16, 2004	August 13, 2004	September 10, 2004
July 23, 2004	August 20, 2004	September 17, 2004

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



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

Cheryll Collier
Executive Director
EDS