North Carolina
Medicaid Special Bulletin

An Information Service of the Division of Medical Assistance

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Number IV **July 2004**

Attention:

Developmental Evaluation Centers (DEC)/Children's Developmental Service Agencies (CDSAs), and Early Intervention Service Providers

Early Intervention - Community Based Rehabilitative Services Provider Requirements and Seminar

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

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Early Intervention - Community Based Rehabilitative Service

Effective with dates of service July 1, 2004, Children's Developmental Service Agencies (formerly Developmental Evaluation Centers) will serve as local lead agencies for the North Carolina Infant-Toddler Program statewide. Medicaid-eligible children from birth through age 3 who are referred to and/or determined to be eligible for the N.C. Infant-Toddler Program are eligible to receive Early Intervention - Community Based Rehabilitative Services (CBRS) through the Children's Developmental Service Agency (CDSA).

Early Intervention - CBRS providers who meet provider requirements can enroll with the Division of Medical Assistance (DMA) as a Medicaid provider to provide services to eligible children birth through age 3. Enrollment information can be obtained from DMA's website at http://www.dhhs.state.nc.us/dma/provenroll.htm.

Eligible Providers

An eligible provider must receive endorsement from the N.C. Division of Public Health and enroll with DMA as a Medicaid individual provider or group provider that employs or contracts with individuals who hold a valid and active license in the healing arts in full force and effect to practice in the state of North Carolina, or a professional who meets the certification requirements for the Infant Toddler and Family Specialist (ITFS) as delineated in the *North Carolina Infant Toddler Program Procedures for Personnel Certification*. The Division of Public Health, through CDSAs, documents and verifies the qualifications, training, and certification of the ITFS, verifies the valid licensure status, and endorses the provider for Medicaid participation.

Provider Requirements

An eligible provider must be a licensed psychologist, licensed clinical social worker, licensed marriage and family counselor, or a qualified mental health professional (QMHP), or a qualified developmental disability professional (QDDP) with ITFS certification. Paraprofessionals may also enroll as providers if they meet the certification requirements for Infant Toddler and Family Associate as delineated in the *North Carolina Infant Toddler Program Procedures for Personnel Certification* and they are under the direct supervision of a professional certified according to these procedures. All providers of this service must possess the ITFS certification or be working toward certification at the required rate.

Service Authorization Process

All CBRS services require a referral by the CDSA. Referrals may be made by telephone, fax, or in writing to the mental health provider. The referring CDSA will give the provider a referral number that must be placed in block-19 of the CMS-1500 claim form in order for the claim to be paid. Failure to put the referral number on the claim when filing will result in denial of payment.

Covered Services

Medicaid payment for covered services is limited to those services performed by qualified providers who enroll in the Medicaid program in solo or group practice and are issued a provider number from the DMA Provider Services Unit.

Medicaid will reimburse as follows:

- Services are limited to children from birth through the age of 3 years.

  Note: For children who are transitioning from the N.C. Infant-Toddler Program to Preschool services, eligibility for this service may extend beyond the child's third birthday as long as there is a time-limited transition plan in place. Four year olds may be served only under the following condition:

  - the child is eligible for preschool special education services but community based rehabilitation services are needed to maintain skills during the transition period prior to the initiation of the preschool special education services through the IEP

- Procedures are limited to a total of 32 units per day.
- Providers are not subject to Carolina Access, Third Party Insurance, or Medicare requirements at this time.

Rehabilitative services include a range of coordinated services provided to a child from birth through age 3 in order to correct, reduce, or prevent further deterioration of identified deficits in the child's mental or physical health. They can also be targeted at restoring the developmental capacity of children who are felt to be at risk for such deficits because of specific medical, biological, or environmental risk factors. Children under three must meet all eligibility for early intervention services delineated in the *North Carolina Infant and Toddler Manual*.

Deficits are identified through comprehensive screening, assessments, and evaluations. Recommended services must be face-to-face encounters, medically necessary, within the scope of practice of the provider, and intended to maximize reduction of identified disability(ies) or deficit(s) and restoration of a recipient to his best possible functional level. Services include provision of direct hands-on treatment with the child and provision of collaboration with and instruction to parents and to caregivers in assisting in identifying, planning and maintaining a regimen related to regaining the child's functioning. Services may be provided in clinical settings, home, day care center, or other natural environment locations.

Provision of services where the family or caregivers are involved must be directed to meeting the identified child's medical treatment needs. Services provided to non-Medicaid eligible family members independent of meeting the identified needs of the child are not covered by Medicaid. Services must be ordered by and under the direction of a physician or licensed practitioner of the healing arts.

Rehabilitative services include the following range of services, referred to as early intervention services, to be provided to all eligible children from birth through age 3 for who all services are medically necessary:

1) Screening Services: This is an interdisciplinary screen of standardized tests, the purpose of which is to identify those children who may require further evaluation and assessment. Planning for screening must occur under the medical direction of the CDSA and be carried out by the Medicaid provider. The component(s) of the screening performed must be within the scope of practice of the provider. Screenings are limited to three per recipient (covering the time between determining the child's eligibility through the end of the child's eligibility for the N.C. Infant-Toddler Program).

   Note: Screening services can only be provided by CDSAs.

2) Diagnostic/Evaluation Services: This is either an initial or follow-up evaluation to determine a child's level of functioning in each of the following developmental domains: (1) gross motor; (2) fine motor; (3) communication; (4) self-help and self-care; (5) social and emotional development; and (6) cognitive skills. The determination process includes the families' perspective on the capacity of the child in these developmental domains and their concerns, priorities and resources related to this capacity.

   The initial evaluation is limited to one per recipient. Follow-up evaluations are limited to three per year per recipient. Evaluations must be recommended by a licensed healing arts professional or certified ITFS.

   Note: Diagnostic/evaluation services can only be provided by CDSAs.

3) Group and Individual Treatment Sessions: These services are provided for the purpose of providing medical, nutritional, psychological, vision, audiological, behavioral, developmental, self help or nursing related services in order to reduce the child's physical or mental or developmental disability or deficit as it relates to the developmental delay(s) identified within a domain(s) or restore /sustain the capacity of the child in these domains.

   Note: Group and individual treatment sessions can only be provided by CDSAs.

4) Early Intervention – Community Based Rehabilitative Services:

   - Cognitive – This refers to the acquisition, organization and ability to process and use information.

     The ITFS, in consultation with the IFSP team, will work with caregivers on planning and developing individualized intervention strategies for the child to extend opportunities to practice thinking, problem solving and information processing skills into everyday activities in the home, daycare or other community setting. The ITFS will demonstrate and teach the intervention strategies to caregivers. Example goals could encompass; developing strategies for the child to understand cause and effect, object permanence, concepts of in and out, differentiating shapes and colors, associating movement with sound and establishing awareness of self and control of the environment, developing strategies to improve the child's visual tracking, eye contact, responding to reprimands and tone of voice, and following simple directions.

   - Communication – This includes expressive and receptive communication skills, both verbal and non-verbal.

     The ITFS, in consultation with the IFSP team, will work with caregivers on planning and developing individualized intervention strategies for the child to extend language stimulation into everyday activities in the home, daycare or other community setting. The ITFS will demonstrate and teach the intervention strategies to caregivers. Example goals could encompass increasing word comprehension, using suggested strategies to facilitate or enhance oral motor development for making sounds and words, or implement behavioral strategies to improve communication.

   - Social/Emotional Skills – This refers to interpersonal relationship abilities. This includes interactions and relationships with parent(s) and caregivers, other family members, adults and peers, as well as behavioral characteristics, e.g., passive, active, curious, calm, anxious and irritable.

The ITFS, in consultation with the IFSP team, will work with caregivers on planning and developing individualized intervention strategies for the child to extend appropriate behaviors and interactions into everyday activities in the home, daycare or other community setting. The ITFS will demonstrate and teach the intervention strategies to caregivers as well as provide emotional support in coping with a difficult child. Example goals could encompass helping caregivers understand the child's behaviors and how to respond, development of strategies to set limits and manage the child's problems, development of strategies to help organize behaviors before they become uncontrollable while providing opportunities for normal active exploration.

- Adaptive Development – This refers to the ability to function independently within the environment and the child's competency with daily living activities such as sucking, eating, dressing, playing, etc., as appropriate for the child's age.

  The ITFS, in consultation with the IFSP team, will work with caregivers on planning and developing individualized intervention strategies for the child to extend self help skills into everyday activities in the home, daycare or other community setting. The ITFS will demonstrate and teach the intervention strategies to caregiver and child in collaboration with healing arts professionals, when appropriate. Example goals could encompass increasing acceptance of different food textures, acceptance of and handling utensils for self feeding, using suggested strategies to develop or enhance oral motor development for proper sucking or chewing, develop strategies to stimulate independent play, introduce concepts and develop strategies for self care in play such as dressing, bathing, brushing teeth, and brushing hair.

Billing Guidelines for Early Intervention - Community Based Rehabilitative Services

Claim Type: CMS-1500
Procedure Code: H0036
Modifiers:
HI – Integrated mental health/mental retardation/developmental disabilities program
HM – Less than bachelor's degree level (will use for paraprofessional)
TL – Early Intervention
HQ – Group setting
U1 – Group service by a paraprofessional

Procedure Code	Code Description	Bill with Modifier	Billing Units
Early Intervention			
H0036	Community psychiatric supportive treatment, face-to-face, per 15 minutes	HI – denotes an integrated mental health/mental retardation/developmental disability program provided by individual early intervention (EI) professional	1 unit = 15 min (not to exceed 8 hours per day)
H0036	Community psychiatric supportive treatment, face-to-face, per 15 minutes	TL – denotes an early intervention service	1 unit = 15 min (not to exceed 2 hours:45 minutes per day)
Paraprofessional			
H0036	Community psychiatric supportive treatment, face-to-face, per 15 minutes	HM – denotes service provided by a paraprofessional	1 unit = 15 min (not to exceed 8 hours per day)
H0036	Community psychiatric supportive treatment, face-to-face, per 15 minutes	U1 – denotes service provided by a paraprofessional to a group	1 unit = 15 min (not to exceed 2 hours:45 minutes per day)
Professional			
H0036	Community psychiatric supportive treatment, face-to-face, per 15 minutes	No modifier is required when the service is provided by an individual professional	1 unit = 15 min (not to exceed 8 hours per day)
H0036	Community psychiatric supportive treatment, face-to-face, per 15 minutes	HQ – denotes service provided by an individual professional in a group setting	1 unit = 15 min (not to exceed 2 hours:45 minutes per day)

CMS-1500 Claim Form Instructions

Instructions for completing the standard CMS-1500 claim form are listed below.

Block	Block Name	Explanation
1.	**Type of Coverage**	Place an (X) in the Medicaid block**.**
1a.	**Insured's ID Number**	Enter the recipient's ten-character identification number found on the MID card.
2.	**Patient's Name**	Enter the recipient's full name (last name, first name, middle initial) exactly as it appears on the MID card.
3.	**Patient's Birth Date** **Sex**	Enter the recipient's date of birth using eight digits (e.g., July 19, 1960 would be entered as 07191960). **Note:** A two-digit year is acceptable on paper claims. A four-digit year is **required** for electronic claims. Place an (X) in the appropriate block to indicate the recipient's sex (M = male; F = female).
5.	**Patient's Address** **Telephone**	Enter the recipient's street address including city, state, and zip code. Entering the recipient's telephone number is optional.
9.	**Other Insured's Name**	If applicable, enter private insurance information. For programs that use Medicare override statements, enter applicable statement.
10.	**Is Patient's Condition Related To:** **a. Employment?** **b. Auto Accident?** **c. Other Accident?**	If applicable, check the appropriate block.
16.	**Dates Patient Unable to Work in Current Occupation** **"From" and "To"**	If billing for postoperative management only (designated by modifier 55 in block 24D), enter the "From" and "To" dates the provider was responsible for recipient's care. If the provider was responsible for care for nonconsecutive periods of time per follow-up period, multiple claims must be filed. Date spans cannot overlap with dates on another claim. Refer to the April 1999 Special Bulletin II, Modifiers, for billing guidelines.
19.	**Reserved for Local Use**	Enter the referral number from CDSA.
21.	**Diagnosis or Nature of Illness or Injury**	The written description of the primary diagnosis is not required. However, the claim must be ICD-9-CM coded to describe the primary diagnosis.
23.	**Prior Authorization Number**	Any provider billing for laboratory services must enter the CLIA number in this field. It is not necessary to enter the authorization code in this block.

CMS-1500 Claim Form Instructions, continued

Block	Block Name	Explanation
24A.	**Date(s) of Service "From" and "To"**	Enter the eight-digit date of service in the "From" block. **Example:** Record the date of service January 31, 2003 as 01312003. If the service consecutively spans a period of time, enter the beginning service date in the "From" block and the ending service date in the "To" block. **Note:** A two-digit year is acceptable on paper claims. A four-digit year is **required** for electronic claims.
24B.	**Place of Service**	Enter the appropriate code from the **Place of Service Code Index**.
24C.	**Type of Service**	Enter the appropriate code from the **Type of Treatment/Type of Service Code Index**. **Note:** Effective date of processing October 16, 2003, Type of Service will no longer be required.
24D.	**Procedures, Services, or Supplies**	Enter the appropriate five-digit CPT or HCPCS code. **Note:** Providers mandated to bill modifiers can bill up to three modifiers per procedure code, if applicable.
24F.	**Charges**	Enter the usual and customary charge for each service rendered.
24G.	**Days or Units**	Enter the number of visits or units.
24H.	**EPSDT Family Plan**	If the service is the result of an EPSDT (Health Check) screening referral, enter "E." If the service is related to family planning, enter "F."
26.	**Patient's Account No.**	A provider has the option of entering either the recipient control number or medical record number in this block. This number will be keyed by EDS and reported back to the provider in the medical record field of the RA. This block will accommodate up to 20 characters (alpha or numeric) but only the first nine characters of this number will appear on the RA.
28.	**Total Charge**	Enter the total charges. (Medicaid is not responsible for any amount that the recipient is not responsible for if the recipient is private pay or has Third Party coverage.)

CMS-1500 Claim Form Instructions, continued

Block	Block Name	Explanation
29.	**Amount Paid**	**For dates of services before October 1, 2002**, enter the total amount received from third party payment source(s). No TPL voucher is needed when payment is entered. **Do not enter Medicare payments, copayment amounts or previous Medicaid payments.** These are automatically deducted at the time the claim is processed for payment. **For dates of service after October 1, 2002**, enter the total amount received from Medicare, including penalties and outpatient psychiatric reductions, and other third party payment source(s). When the recipient has both Medicare and Medicaid coverage, and another insurance primary to Medicaid, the provider must total both the Medicare payment and the commercial insurance payment in block 29 and submit a paper claim with both the Medicare voucher and the commercial insurance voucher attached. **Do not enter copayment amounts or previous Medicaid payments.** Refer to the **September 2002 Draft Special Bulletin IV (Revised November 14, 2002)** ***Medicare Part B Billing Guidelines*** (http://www.dhhs.state.nc.us/dma/bulletin.htm) for detailed instructions on billing for Medicare Part B.
31.	**Signature of Physician or Supplier Including Degrees or Credentials**	The physician, supplier or an authorized representative must either: 1. sign and date all claims, or 2. use a signature stamp and date stamp (only script style stamps and black ink stamp pads are acceptable), or 3. if a **Provider Certification for Signature on File form** has been completed and submitted to EDS, leave the signature block blank and enter the date only. Printed initials and printed signatures are not acceptable and will result in a denied claim.
33.	**Physician's or Supplier's Billing Name, Address, Zip Code & Phone #.**	Enter the billing provider's name, street address including zip code, and phone number. **PIN #:** Enter the attending physician's eight character Medicaid provider number. **GRP #:** Enter the seven-character group provider number used for Medicaid billing purposes. The provider number must correspond to the provider name above (i.e., if billing with a group number, use the group name entered in block 33).

Place of Service Code Index

POS Code	Description	Explanation
11	**Office**	Location, other than a hospital or nursing facility, where the health professional routinely provides health exams, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	**Home**	Home is considered the recipient's private residence, which also includes an adult care home facility.
21	**Inpatient Hospital**	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by or under the supervision of physicians to recipients admitted for a variety of medical conditions.
22	**Outpatient Hospital**	A section of a hospital that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	**Emergency Department - Hospital**	A section of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	**Ambulatory Surgical Center**	A free-standing facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	**Free-Standing Birthing Center**	A facility, other than a hospital's maternity facilities or a physician's office, that provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborns.
26	**Military Treatment Facility**	A medical facility operated by one or more of the Uniformed Services Military Treatment Facilities (MTF). Also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
32	**Nursing Facility**	A facility that primarily provides skilled and intermediate nursing care to residents and provides related services for the rehabilitation of injured, disabled or sick persons or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	**Custodial Care Facility**	A facility that provides room, board, and other personal assistance services, generally on a long-term basis, which does not include a medical component.
34	**Hospice**	A facility, other than a recipient's home, in which palliative and supportive care for terminally ill recipients and families are provided.

Place of Service Codes, continued

POS Code	Description	Explanation
51	**Inpatient Psychiatric Facility**	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
53	**Community Mental Health Center**	A facility that provides comprehensive mental health services on an ambulatory basis primarily to individuals residing or employed in a defined area.
54	**Intermediate Care Facility/Mentally Retarded**	A facility that primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or nursing facility.
61	**Comprehensive Inpatient Rehabilitation Facility**	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include rehabilitative nursing, physical therapy, speech pathology, social or psychological services, and orthotic and prosthetic services.
62	**Comprehensive Outpatient Rehabilitation Facility**	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
65	**End Stage Renal Disease Treatment Facility**	A facility other than a hospital, that provides dialysis treatment, maintenance or training to recipients or caregivers on an ambulatory or home-care basis.
71	**State or Local Public Health Clinic**	A facility maintained by either state or local health departments that provides ambulatory primary medical care under the general direction of a physician.
72	**Rural Health Clinic**	A certified facility that is located in a medically underserved rural area that provides ambulatory primary medical care under the general direction of a physician.
81	**Independent Laboratory**	A laboratory certified to perform diagnostic or clinical tests independent of an institution or a physician's office.
99	**Other Unlisted Facility**	Other unlisted facilities not identified above, such as a school.

Examples of CMS-1500 Claim Form for Early Intervention - Community Based Rehabilitative Services

PLEASE DO NOT STAPLE IN THIS AREA

PICA **HEALTH INSURANCE CLAIM FORM** PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
111111111P

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Recipient, Jane

3. PATIENT'S BIRTH DATE MM DD YY SEX M F
07 01 03 F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)
111 Recipient Street

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child X Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE
Recipient Town NC

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)
12345 (999) 999-9999

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (INCLUDE AREA CODE)
( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes, return to and complete item 9 a-d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ________ DATE ________

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ________

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE
1234567

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 318.0
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
07 10 04	07 10 04	22		H0036	HI		103 45	5				

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ 103 45

29. AMOUNT PAID $

30. BALANCE DUE $ 103 45

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Signature on file
SIGNED DATE July 1, 2004

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Dr. Jane Provider
111 Provider Street
Provider Town, NC 12345
PIN# 8300000K GRP# 8300000

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Examples of CMS-1500 Claim Form for Early Intervention - Community Based Rehabilitative Services, continued

PLEASE DO NOT STAPLE IN THIS AREA

PICA **HEALTH INSURANCE CLAIM FORM** PICA

CARRIER

1\. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 222222222S

2\. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Joe

3\. PATIENT'S BIRTH DATE MM DD YY: 07 01 03 SEX M [X] F [ ]

4\. INSURED'S NAME (Last Name, First Name, Middle Initial)

5\. PATIENT'S ADDRESS (No., Street): 111 Recipient Street

6\. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [X] Other [ ]

7\. INSURED'S ADDRESS (No., Street)

CITY: Recipient Town STATE: NC

8\. PATIENT STATUS: Single [ ] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (999) 999-9999

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9\. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10\. IS PATIENT'S CONDITION RELATED TO:

11\. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [ ] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? [ ] YES [ ] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12\. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ____ DATE ____

13\. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ____

PATIENT AND INSURED INFORMATION

14\. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15\. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16\. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17\. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18\. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19\. RESERVED FOR LOCAL USE: 1234567

20\. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

21\. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1\. 295.30 3. ____ 2. ____ 4. ____

22\. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23\. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
04 12 04	04 12 04	22		H0036	HM		44 82	6				

PHYSICIAN OR SUPPLIER INFORMATION

25\. FEDERAL TAX I.D. NUMBER SSN EIN

26\. PATIENT'S ACCOUNT NO.

27\. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [ ] NO

28\. TOTAL CHARGE $ 44 82

29\. AMOUNT PAID $

30\. BALANCE DUE $ 44 82

31\. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on file

SIGNED DATE July 1, 04

32\. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33\. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Dr. Joe Provider
123 Provider Street
Provider Town, NC 12345

PIN# 8300000K GRP# 8300000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Examples of CMS-1500 Claim Form for Early Intervention - Community Based Rehabilitative Services, continued

PLEASE DO NOT STAPLE IN THIS AREA

HEALTH INSURANCE CLAIM FORM

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER
1a. INSURED'S I.D. NUMBER: 123456789T
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Joe
3. PATIENT'S BIRTH DATE: 03 05 02 — SEX: M x
5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street
6. PATIENT RELATIONSHIP TO INSURED: Child X
CITY: Recipient Town — STATE: NC
ZIP CODE: 12345 — TELEPHONE (Include Area Code): (999)999-9999
8. PATIENT STATUS
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? b. AUTO ACCIDENT? c. OTHER ACCIDENT?
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE — SIGNED / DATE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE — SIGNED
19. RESERVED FOR LOCAL USE: 1234567
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY:
1. 318.0
2. 780.39

24. A From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D CPT/HCPCS	Modifier	E Diagnosis Code	F $ Charges	G Days or Units	H EPSDT Family Plan	I EMG	J COB	K Reserved for Local Use
04 15 04	04 15 04	22		H0036	U1		60 50	11				

25. FEDERAL TAX I.D. NUMBER — SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? YES / NO
28. TOTAL CHARGE: $ 60 50
29. AMOUNT PAID: $
30. BALANCE DUE: $ 60 50
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS: Signature on file — DATE July 1, 2004
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #: Dr. Joe Provider, 123 Provider Street, Provider Town, NC 12345 — PIN# 8300000K — GRP# 8300000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE
APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Billing for Early Intervention - Community Based Rehabilitative Services Using the NCECS-Web Claims Entry Tool

With the implementation of standard electronic transactions mandated by HIPAA, N.C. Medicaid launched a web-based claim entry tool called NCECS-Web. The new NCECS-Web claim entry tool requires certain elements for all providers who submit electronic claims. The following guide has been created to assist providers using the NCECS-Web claims entry tool. The guide follows the CMS-1500 claim format.

Specific values are listed, if applicable.

https://webclaims.ncmedicaid.com/ncecs

Recipient Information		
Field Title	**Required**	**Definition**
Recipient First Name	Yes	Enter the recipient's first name exactly as it appears on the Medicaid ID card. NCECS-Web users may utilize the List Management Feature to populate this field, or free key the information.
Recipient Last Name	Yes	Last name of individual for whom claim is filed. Enter recipient last name exactly as it appears on the Medicaid ID card. NCECS-Web users may utilize the List Management Feature to populate this field, or free key the information.
Medicaid ID	Yes	Enter the recipient's ten character Medicaid ID number as it appears on the Medicaid ID card. There are nine numbers followed by one letter in a Medicaid ID number. NCECS-Web users may utilize the List Management Feature to populate this field, or free key the information.
Date Field	No	Leave blank.
Patient's Weight (lbs)	No	Leave blank.
Patient Account Number	Yes	The recipient's unique alphanumeric number assigned by the provider to facilitate retrieval of individual financial records and posting of the payment. Users of NCECS-Web may utilize the List Management Feature to populate this field, or free key the information.
Prior Authorization Number	No	Leave blank.
Post OP From Date	No	Leave blank.
Post OP Through Date	No	Leave blank.
Medical Record Number	Optional	The recipient's medical record number as assigned by the provider. Users of NCECS-Web may utilize the List Management Feature to populate this field, or free key the information.

Provider Information		
Field Title	**Required**	**Definition**
Provider Last Name or Organization Name	Yes	Name of provider agency filing claim for payment. Users of NCECS-Web may utilize the List Management Feature to populate this field, or free key the information.
Provider First Name	No	Leave blank.
Medicaid Provider Number	Yes	Billing Provider Number as assigned by Medicaid. Users of NCECS-Web may utilize the List Management Feature to populate this field, or free key the information.
National Provider ID	No	Reserved for future use
Referring Physician Provider No (Carolina Access):	Yes	Referral by the Children's Developmental Services Agency, CDSA.
CLIA Number	No	Leave blank

Miscellaneous Claim Information		
Field Title	**Required**	**Definition**
EPSDT: Follow-up/No	No	Leave blank.
Release of Information, Yes/No	Yes	Does the provider have a signed release from the patient/recipient allowing the release of information for claims processing? Select "Yes".
EPSDT referral given to patient? Yes/No	No	Leave blank.
EPSDT Referral Type	No	Leave blank.
Paperwork on file at provider site for Medicare override?	No	Leave blank.
Original ICN	Required only when the Claims Submission Reason Code is a 7 or 9	Original Internal Control (claim) Number as assigned to claims by Medicaid.
Place of Service Facility Type Code	Yes	Enter the appropriate code from the Place of Service Code Index.

Miscellaneous Claim Information, continued		
Field Title	**Required**	**Definition**
Claim Submission Reason Code	Yes, defaults to 1-Original. Drop down box allows user to change to void or replacement	A code that indicates the reason claim has been submitted. It is used to differentiate whether a claim is an original, voided or replacement claim.
Rendering/Attending Provider First Name	Yes	Enter the provider's first name.
Rendering/Attending Provider Last Name	Yes	Enter the provider's last name.
Rendering/Attending Medicaid Provider Number	Yes	PIN # - Enter the attending provider's eight digit Medicaid provider billing number.
Principal Diagnosis	Yes	Enter the ICD-9-CM code for the principle diagnosis that is responsible for the services rendered. "V" codes are not acceptable.
Additional		Fields for up to 11 additional diagnoses.

Insurance Detail Screen		
Field Title	**Required**	**Definition**
Other Insurance Responsibility Sequence	When applicable	Indicates hierarchy of responsibility.
Recipient Relationship to the Insured	When applicable	Indicates relationship between the Medicaid recipient for whom claim is being filed and person Insured by other health plan. Relationship may be self if the person is the same.
Other Insurance Claim Filing Indicator	When applicable	Drop down selection used to describe the type of policy entered.
Other Insurance Paid Amount	When applicable	Total amount received from third party sources. Do not enter Medicaid copayment amount; it will be automatically deducted during claims processing.
Other Insured Last Name	When applicable	Last name of insured on other insurance health plan. May match Medicaid recipient for whom claim is filed.
Other Insured First Name	When applicable	First name of insured on other insurance health plan. May match Medicaid recipient for whom claim is filed.
Other Insured Member ID	When applicable	Enter the individual identification number for patient, as issued by insurance plan.
Other Insurer Name	When applicable	Name of other insurance company.
Other Insurer Identification Number	When applicable	Identification number from other insurance health plan. Used to indicate group policy numbers.
Other Insurer Claim Paid Date	When applicable	Use only if other insurance is involved in the payment of claim.

Service Detail Screen		
Field Title	**Required**	**Definition**
From Date of Service	Yes	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.
Through Date of Service	Yes	
Place of Service	Yes	Indicates location where service was rendered. Drop down box offers all valid place of service codes under HIPAA.
HCPCS	Yes	Enter the appropriate five digit CPT code.
Mod 1 through Mod 4	No	Leave blank.
Charge	Yes	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.)
Units	Yes	Enter the number of 15-minute units billed on the detail line. Do not enter an amount in excess of the per day limit.
E/F	No	Leave blank.
DME Days	No	Leave blank.
Claim Note	No	Leave blank.
Line Item Control Number	Optional	Used by provider to enter internal tracking number for service.

NCECS-Web Claims Entry Screen Examples

North Carolina
Electronic Claims Submission
Main Menu
Claims Entry
Dental
CMS-1500
UB-92
List Management
Reports
Dental Submitted Batches
CMS-1500 Submitted Batches
UB-92 Submitted Batches
Claim Submission
Claim Submission
Reference Materials

CMS-1500

Selection Criteria

Claim Type: CMS-1500 Claim ID: 111620041683882824 Save Cancel Delete

Recipient Information

Recipient Last Name: Recipient Recipient First Name: Jane Medicaid ID: 123456789P
Date Field: Patient weight(lbs):
Patient Account Number: 1234P Medical Record Number: Post OP from Date:
Prior Authorization Number: Post OP Through Date:

Provider Information

Provider Last Name or Organization Name: Mental Health Family Care Provider First Name: Jane
National Provider ID:
Medicaid Provider Number: 8300000
Referring Physician Provider No:(Carolina Access Physician Number) 1234567 CLIA Number:

Miscellaneous Claim Information

EPSDT: Follow-up No Release of Information: Yes No
EPSDT referral given to Patient?: Yes No EPSDT Referral Type:
Work on file at Provider Site for Medicare Override?: Yes No
Related To: Auto Accident State of Auto Accident:
Employment Accident Date of Accident:
Other Accidental Injury
Original ICN:

Local intranet

1. Complete the Recipient Last Name, Recipient First Name, Medicaid ID and Patient Account Number fields. Other fields in this section are completed when applicable.

2. Complete Provider Organization Name, Referring Physician (CDSA referral), and Medicaid Provider Number fields. Other fields in this section, are completed when applicable.

NCECS-Web Claims Entry Screen Examples, continued

Address https://webclaims.ncxix.hcg.eds.com/ncecs/ Go Links

North Carolina
Electronic Claims Submission
Main Menu
Claims Entry
Dental
CMS-1500
UB-92
List Management
Reports
Dental Submitted Batches
CMS-1500 Submitted Batches
UB-92 Submitted Batches
Claim Submission
Claim Submission
Reference Materials

Related Causes: Auto Accident
Employment Accident
Other Accidental Injury
State of Auto Accident:
Date of Accident:
Original ICN:
Place of Service Facility Type Code: 11-Office
Claim Submission Reason Code: 1-Original
Rendering/Attending Information
R/A Provider First Name: Jane
R/A Provider Last Name: Provider
R/A Medicaid Provider Number: 8300000K
CMS Insurance Detail
Add/Edit Other Insurance
Other Insurance Total Insurance: 0.00
Diagnosis Cod
Principal: 318
Additional 1 2 3 4 5 6 7 8 9 10 11
CMS-1500 Detail
Add/Edit Details
Dtl Num | Date of Ser | Through Date Of | DME | Line Itm Ctrl
1 | 07/10/2004
Claim Note

3. Enter the place of service the service was rendered.

4. Use only when a payment has been made from a Third Party source.

5. Enter the ICD-9-CM code with no decimal points.

6. Click here to enter the details of the service provided. See the next page for more information.

NCECS-Web Claims Entry Screen Examples, continued
CMS-1500 Add/Edit Details

Address https://webclaims.ncxix.hcg.eds.com/ncecs/
North Carolina
Electronic Claims Submission
Main Menu
Claims Entry
Dental
CMS-1500
UB-92
List Management
Reports
Dental Submitted Batches
CMS-1500 Submitted Batches
UB-92 Submitted Batches
Claim Submission
Claim Submission
Reference Materials

CMS 1500 Add/Edit Details
Please complete the following form to create/edit CM
Claim Type: CMS 1500
Recipient Information
Last Name: Recipient
CMS 1500 Detail

	#	From Date of Service	Through Date Of Service	Place of Service	HCPCS/CPT	Mod1	Mod2	Mo
Edit Copy Del	1	07/10/2004	07/10/2004	11	H0036	HI		
Add Clear								

7. Input the From and To Date of Service, Place of Service, and Procedure Code – then scroll to the right to complete the other fields listed below on the next screen print.

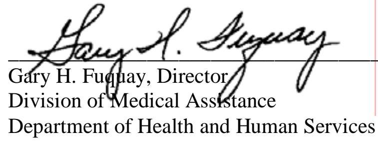
CMS-1500 Add/Edit Details, continued

Address https://webclaims.ncxix.hcg.eds.com/ncecs/
North Carolina
Electronic Claims Submission
Main Menu
Claims Entry
Dental
CMS-1500
UB-92
List Management
Reports
Dental Submitted Batches
CMS-1500 Submitted Batches
UB-92 Submitted Batches
Claim Submission
Claim Submission
Reference Materials

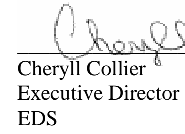
d return to the mai
Save Cance

HCPCS/CPT	Mod1	Mod2	Mod3	Mod4	Charge	Units	E/F	DME Days	Line Itm Ctrl Num
H0036	HI				103.45	5		0	0

8. Input the total charge for the day and the total units. (1 unit= 15 minutes). After completing each detail, either hit "enter" or scroll back to the left and click on "Add" to record the detail line.



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



Cheryll Collier
Executive Director
EDS