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North Carolina Medicaid Bulletin

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

Attention: Rural Health Clinics and Federally Qualified Health Centers

Core Service Code Conversion – Correction to End-Dated Code

This article is being reprinted to correct the end-dated code listed for Federally Qualified Health Center (FQHC) core services published in the June 2002 Medicaid bulletin. The correct end-dated code is Y2089.

Effective with date of service June 30, 2002, state-created codes Y2058 and Y2089 will be end-dated to comply with the implementation of national procedure codes mandated by the Health Insurance Portability and Accountability Act (HIPAA).

Effective with date of service July 1, 2002, Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) providers must bill procedure code T1015 – Clinic visit/encounter, all inclusive –for all core services. An RHC/FQHC core service visit must be billed using the provider's six-digit provider number with alpha suffix "A."

End-dated Code	**New Code**
Y2058 – RHC Core Service	T1015 – Clinic visit/encounter, all inclusive
Y2089 – FQHC Core Service	T1015 – Clinic visit/encounter, all inclusive

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

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

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Attention: All Providers

Drug Coverage for Impotence Drugs

Effective, July 1, 2002, impotence drugs for males age 25 and over will no longer require prior approval. The limit of two units per month remains in effect. Physicians must continue to document the medical necessity for these impotence drugs by writing "erectile dysfunction" in their own handwriting on the face of the prescription.

For males under the age of 25, the physician (or designee) must call 919-857-4037 to obtain a prior approval form. The physician must complete the requested information for medical necessity and return the completed form to the following address:

N.C. Division of Medical Assistance
Attn: Sharman Leinwand, MPH, R.Ph.
2511 Mail Service Center
Raleigh, North Carolina 27699-2511
FAX: 919-733-2796

An authorization code will be assigned to all requests that are approved. This code must be included on the prescription to notify the pharmacist that the prescription has been approved for dispensing. Claims for prescriptions dispensed to recipients under the age of 25 must be submitted on paper and not through Point of Sale.

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

Attention: All Providers

Proposed Medical Coverage Policies

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

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

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

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

Attention: All Providers

Modifier 76 and 77 and Laboratory Codes

The following codes have the description of "each, every or per" in the CPT descriptor. Modifiers 76 and 77 have been removed from these codes to allow for billing of separate analytes.

82016	82017	82042	82127	82128	82131	82136	82139
82172	82190	82261	82379	82492	82657	82658	82784
82787	82926	82928	82952	83018	83080	82788	83789
83883	83896	83898	83901	83903	83904	83905	83906
83918	83919	84150	84182	84376	84377	84378	84379
86000	86001	86003	86146	86147	86160	86161	86171
86185	86235	86255	86256	86331	86403	86406	86586
86850	86870	86880	86885	86886	86903	86904	86911
86920	86921	86922	86927	86930	86931	86932	86940
86945	86970	86971	86972	86975	86976	86977	86978
86985	87046	87076	87077	87106	87118	87140	87147
87181	87184	87185	87186	87187	87188	87190	87253
87254	87274	87300	87449	87450	87451	87797	87798
87799	88240	88241	88271	88280	88285	88300	88302

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

Attention: All Providers

Health Insurance Portability and Accountability Act Update

The N.C. Medicaid program plans to implement the following HIPAA-related transactions in October 2002:

- 834 transaction (Benefit Enrollment and Maintenance-MCO Enrollment)
- 278 transaction (Health Care Services Review and Response-Prior Approval)
- 270 and 271 (Health Care Eligibility Benefit Inquiry and Response)

Trading partner testing is scheduled to begin in September 2002 for these three transactions. Please contact the Electronic Commerce Services (ECS) Unit at EDS for testing information after August 15, 2002, by calling 1-800-688-6696 or 919-851-8888. In lieu of testing directly with N.C. Medicaid, providers may test with a third party certification agency. Once certification information is on file with N.C. Medicaid, providers will have the capability to begin submitting and receiving HIPAA-compliant transactions, beginning in October 2002.

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

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

Attention: All Providers

Sodium Hyaluronate for Intra-Articular Injection - Billing Guidelines

The N.C. Medicaid program will end-date the current code for Sodium Hyaluronate to align with Medicare guidelines. Effective with date of service September 30, 2002, HCPCS code J7316 (Sodium hyaluronate 5 mg, for intra-articular injection) will be end-dated. Effective with date of service October 1, 2002, providers must bill Q3030 (Sodium hyaluronate, per 20 to 25 mg dose, for intra-articular injection). Providers must indicate the number of units given in block 24G on the CMS-1500 claim form and bill their usual and customary charge.

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

Attention: All Providers

Billing of Radiopharmaceuticals and Pharmaceutical Stress Agents for Myocardial Perfusion Testing

When billing for radiopharmaceutical and pharmacological stress agents used in myocardial perfusion diagnostic procedures use the following as a billing guideline.

Radioactive Imaging Agent	**Code**	**Pricing**
Technetium TC 99M Sestamibi (Cardiolite)	A9500	Invoice
Thallous Chloride TL201	A9505	Invoice
Supply of radiopharmaceutical diagnostic imaging agent, not otherwise classified such as Tetrofosim (Myoview)	78990	Invoice

The invoice must be attached and include the:

- name of the patient
- name of the agent
- dose administered
- cost per dose

Invoices submitted without this information will be denied.

Pharmacological Stress Agents	**Code**	**Pricing**
Dipyridamole (Persantine), per 10 mg.	J1245	Fee schedule
Dobutamine (Dobutrex), per 250 mg.	J1250	Fee schedule
Adenosine (Adenoscan), per 90 mg.	J0151	Fee schedule

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

Attention: All Providers

Electronic Data Interchange Update

Medicaid recipient eligibility verification is available to North Carolina Medicaid providers through Electronic Data Interchange (EDI) vendor networks. The provider staff can make inquiries for recipient Medicaid eligibility status from their office computer through the EDI vendor. Providers who wish to use this option must contract directly with an approved EDI vendor for software and network access. The following are North Carolina EDI vendors approved as of June 2002.

WebMD Corporation (formerly Envoy)
15 Century Blvd., Suite 600
Nashville, TN 37214
1-800-366-5716 (marketing)
www.webmd.com

MedifaxEDI
1283 Murfreesboro Rd
Nashville, TN 37217-2421
1-800-819-5003 (marketing)
marketing@medifax.com

Healthcare Data Exchange Corporation (HDX)
300 Lindenwood Dr., Suite 200
Malvern, PA 19355-1751
1-610-219-1859 (marketing, Brian Gill)
brian.gill@hdx.com

Passport Health Communications, Inc.
720 Cool Springs Blvd., Suite 450
Franklin, TN 37067
1-888-661-5657 (marketing, Lloyd Baker)
Lloyd.baker@passporthealth.com

Providers interested in subscribing for EDI services are encouraged to contact the above vendors. Updated lists will be published in the general Medicaid bulletin as new vendors are approved and enrolled.

Susan Ryan, Recipient and Provider Services
DMA, 919-857-4019

Attention: All Providers

Injectable Drugs in the Physician's Drug Program – Code Conversion Update

Effective with date of service July 1, 2002, state-created codes for drugs in the Physician's Drug Program were end-dated and replaced with national codes. Some temporary codes or CPT codes have also been replaced with HCPCS J, P or S codes. The chart below indicates the codes that have been replaced.

An invoice is required for those drugs that are billed with J3490. The invoice must include the name of the Medicaid recipient, the Medicaid identification (MID) number, the name of the medication, the dosage given, the National Drug Code (NDC) number from the vial(s) used, the number of vials used per NDC code, and the cost per dose. The NDC number is printed on each drug product.

Old Code	New Code	Description of Replacement Code
Q0156	P9041	Albumin (human), 5%, 50 ml**
Q0157	P9047	Albumin (human), 25%, 50 ml
J2996	J2997	Alteplase Recombinant, 1 mg**
W5181	S0016	Amikacin Sulfate, 500 mg
W5156	Q0144	Azithromycin, oral suspension 1 unit = 1 gm packet (Zithromax)
90586	J9031	BCG live (intravesical), per installation
W5170	J3490*	Baclofen Kit, 2 5 ml Ampules
W5169	J3490*	Baclofen Kit, 4 5 ml Ampules
X1270	S0009	Butorphanol Tartrate, 1 mg (Stadol)
W5185	J0692	Cefepime HCL, 500 mg
W5176	S0023	Cimetadine HCL, 300 mg
W5183	J0744	Ciprofloxacin for intravenous infusion, 200 mg
W5195	J9160	Denileukin Diftitox, 300 mcg (Ontak)
Q0160	J7193	Factor IX (antihemophilic factor, purified, non-recombinant), per I.U.
Q0161	J7195	Factor IX (antihemophilic factor, recombinant), per I.U.
W5127	J3490*	Lupron Depot Pediatric, 7.5 mg
W5128	J3490*	Lupron Depot Pediatric, 11.25 mg
W5129	J3490*	Lupron Depot Pediatric, 15 mg
W5198	S0079	Octreotide Acetate, 100 mcg (Sandostatin)**
J2352	J3490	Octreotide Acetate, 1mg (Sandostatin). Pricing based on 20 mg**
J2352	J3490	Octreotide Acetate, 1mg (Sandostatin). Pricing based on 10 mg**
W5192	S0080	Pentamidine Isethionate, 300 mg
J2994	J2993	Reteplase, 18.1 mg (Retavase)**
Y1856	J3490*	Sodium Bicarbonate 7.5% up to 50 ml
J7315	J7316	Sodium Hyaluronate, 5 mg for intra-articular injection**

* Indicates that an invoice is required with the claim.
****** Indicates a description change.

End-dated Codes for Injectable Drugs

The following codes will be end-dated from the Physician's Drug Program effective with date of service September 30, 2002. Vaccine codes are being end-dated in accordance with information obtained from the drug manufacturers and the Centers for Disease Control. These vaccines are no longer manufactured or available in the United States or are no longer recommended.

Injectable Drugs

Code	Description of End-Dated Codes
J0510	Benzquinamide HCl, up to 50 mg
J0190	Biperiden, 5 mg (Akineton)
J0695	Cefonicid Sodium, 1 gm
J0730	Chlorpheniramine Maleate, per 10 mg
J3080	Chlorprothixene, up to 50 mg
J0810	Cortisone, up to 50 mg
J2480	Hydrochlorides of Opium Alkaloids (Pantopan)
J1739	Hydroxyprogesterone Caproate, 125 mg/ml
J1741	Hydroxyprogesterone Caproate, 250 mg/ml
J3270	Imipramine HCl, up to 25 mg
W5128	Lupron Depot Pediatric, 11.25 mg
W5129	Lupron Depot Pediatric, 15 mg
J3450	Mephentermine, up to 30 mg
J2970	Methicillin Sodium, up to 1 gm (Staphcillin)
J1970	Methotrimeprazine, up to 20 mg
J3390	Methoxamine, up to 20 mg (Basoxyl)
J0340	Nandrolone Phenpropionate, up to 50 mg (Duradolin)
J2640	Prednisolone Sodium Phosphate, up to 20 mg
J1690	Prendisolone Terbutate, up to 20 mg
J2675	Progesterone, per 50 mg
J1930	Propiomazine HCl, up to 20 mg
J2330	Thiothixene, up to 4 mg (Navane)
J0400	Trimethapan Camsylate, up to 500 mg

Vaccines/Toxoids

Code	Description of End-Dated Codes
90646	***Hemophilus influenza b vaccine (Hib), PRP-D conjugate, for booster use only, for intramuscular use***
90659	***Influenza virus vaccine, whole virus, for intramuscular or jet injection use***
90676	***Rabies vaccine, for intradermal use***
90701	***Diptheria, tetanus toxoids, and whole cell pertussis vaccine (DTP), for intramuscular use***
90708	***Measles and rubella virus vaccine, live for subcutaneous or jet injection use***
90709	***Rubella and mumps virus vaccine, live, for subcutaneous use***
90712	***Poliovirus vaccine, (any type(s) (OPV), live, for oral use***
90719	***Diphtheria toxoid, for intramuscular use***
90720	***Diphtheria, tetanus toxoids, and whole cell pertussis vaccine and Hemophilus influenza B vaccine (DTP-Hib), for intramuscular use***
90725	***Cholera vaccine for injectable use***

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

Attention: All Providers

Injectable Drugs

The following FDA-approved drugs, immune globulins, and vaccines/toxoids should be added to the list published in the June 2002 general Medicaid bulletin. This completes the list of injectable drugs covered by the N.C. Medicaid program when provided in a physician's office for the FDA-approved indications. Fees are effective with date of service July 1, 2002.

Physicians will continue to bill on the CMS-1500 claim form using the appropriate drug code, indicating the number of units administered as specified in the listing. Free vaccines from the Vaccines for Children (VFC) program are not included in this list.

New Codes

Old Code	New Code	Description	Fee
Q0156	P9041	Albumin (human), 5%, 50 ml	$ 26.28
Q0157	P9047	Albumin (human), 25%, 50 ml	88.65
J2996	J2997	Alteplase recombinant, 1 mg**	24.82
J2994	J2993	Reteplase, 18.1 mg (Retavase)**	1,240.94

****** Indicates a description change.

Immune Globulins

Code	Description	Fee
90283	***Immune globulin (IgIV), human, for intravenous use, 500 mg***	$ 42.84
90291	***Cytomegalovirus immune globulin (CMV-IgIV), human, for intravenous use, 1 ml***	13.31
90371	***Hepatitis B immune globulin (HBIg), human, for intramuscular use, 0.5 ml***	68.04
90375	***Rabies immune globulin (RIg), human, for intramuscular and/or subcutaneous use, 2 ml***	151.20
90376	***Rabies immune globulin, heart-treated (RIg-HT), human, for intramuscular and/or subcutaneous use, 2 ml***	143.68
90379	***Respiratory syncytial virus immune globulin (RSV-IgIV), human, for intravenous use, 1 ml***	15.47
90384	***Rho(D) immune globulin (RhIg), human, full-dose, for intramuscular use, 1500 IU/300 mcg***	99.90
90385	***Rho(D) immune globulin (RhIg), human, mini-dose, for intramuscular use, 120 IU/50 mcg***	34.02
90386	***Rho(D) immune globulin (RhIglV), human, for intravenous use, 100 IU***	20.38
90389	***Tetanus immune globulin (TIg), human, for intramuscular use, 250 u/1 ml***	108.00
90396	***Varicella-zoster immune globulin, human, for intramuscular use, 125 u/1.25 ml***	112.50
J1460	Gamma Globulin, Intramuscular, 1 cc (Gammar)	3.24
J1470	Gamma Globulin, Intramuscular, 2 cc	6.48
J1480	Gamma Globulin, Intramuscular, 3 cc	9.72
J1490	Gamma Globulin, Intramuscular, 4 cc	12.96
J1500	Gamma Globulin, Intramuscular, 5 cc	16.20
J1510	Gamma Globulin, Intramuscular, 6 cc	19.44
J1520	Gamma Globulin, Intramuscular, 7 cc	22.68
J1530	Gamma Globulin, Intramuscular, 8 cc	25.92
J1540	Gamma Globulin, Intramuscular, 9 cc	29.16
J1550	Gamma Globulin, Intramuscular, 10 cc	32.40
J1560	Gamma Globulin, Intramuscular, over 10 cc (use correct combinations of services)	^^

^^ Designates special pricing.

Vaccines/Toxoids

Code	Description	Fee
90585	***Bacillus Calmette-Guerin vaccine (BCG), for tuberculosis, live, for percutaneous use, per vial***	$ 151.50
90632	***Hepatitis A vaccine, adult dosage, for intramuscular use, 1 ml***	57.83
90633	***Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule, for intramuscular use, 0.5 ml***	29.52
90645	***Hemophilus influenza b vaccine (Hib), Hb0C conjugate (4 dose schedule), for intramuscular use, 0.5 ml***	25.54
90647	***Hemophilus influenza b vaccine (Hib) PRP-OMP conjugate (3 Dose schedule), for intramuscular use, 0.5 ml***	21.86
90648	***Hemophilus influenza b vaccine (Hib) PRP-T conjugate (4 dose schedule), for intramuscular use, 0.5 ml***	22.58
90658	***Influenza virus vaccine, split virus, 3 years and above dosage, for intramuscular or jet injection use, 0.5 ml***	6.77
90675	***Rabies vaccine, for intramuscular use, 2 ml***	140.32
90680	***Rotavirus vaccine, tetravalent, live, for oral use***	17.37
90703	***Tetanus toxoid adsorbed, for intramuscular or jet injection use, 0.5 ml***	7.88
90704	***Mumps virus vaccine, live, for subcutaneous or jet injection use***	18.80 per dose
90705	***Measles virus vaccine, live, for subcutaneous or jet injection use, 0.5 ml***	14.94
90706	***Rubella virus vaccine, live, for subcutaneous or jet injection use, 0.5 ml***	15.65
90707	***Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous or jet injection use***	40.75 per dose
90713	***Poliovirus vaccine, inactivated, (IPV), for subcutaneous use***	26.05 per dose
90716	***Varicella virus vaccine, live, for subcutaneous use, 0.5 ml***	61.52
90704	***Mumps virus vaccine, live, for subcutaneous or jet injection use***	18.80 per dose
90718	***Tetanus and diphtheria toxoids (Td) adsorbed for use in individuals seven years or older, for intramuscular or jet injection, 0.5 ml***	10.35
90721	***Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DtaP-Hib), for intramuscular use***	42.30 per dose
90732	***Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use, 0.5 ml***	12.88

Vaccines/Toxoids, continued

Code	Description	Fee
90733	***Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous or jet injection use, 0.05 mg***	$ 72.31
90746	***Hepatitis B vaccine, adult dosage, for intramuscular use, 1 ml***	63.42
90747	***Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use, 40 mcg/2ml***	105.38

Corrections to the Injectable Drug List Update Published in the June 2002 Medicaid Bulletin

Old Code	New Code	Description	Fee
W5181	S0016	Amikacin Sulfate, 500 mg (Amikin) **	$ 30.83
W5156	Q0144	Azithromycin, oral suspension 1 unit = 1 gm packet (Zithromax), only oral drug on list	20.07
J1070	J1070	Testosterone Cypionate, up to 100 mg **	4.10

****** Indicates a description change.

Billing Guidelines When Billing by Invoice for J3490 (Miscellaneous Drug Code)

The following drugs are billed with the miscellaneous drug code, J3490. An invoice must be submitted with the claim when these drugs are billed. The invoice must include the name of the Medicaid recipient, the Medicaid identification (MID) number, the name of the medication, the dosage given, the National Drug Code (NDC) number from the vial(s) used, the number of vials used per NDC code, and the cost per dose. The NDC number is printed on each drug product.

Old Code	Old Description	New Code	New Description
W5170	Baclofen kit, 2 5 ml ampules	J3490	Baclofen kit, 2 5 ml ampules
W5169	Baclofen kit, 4 5 ml ampules	J3490	Baclofen kit, 4 5 ml ampules
W5127	Lupron depot pediatric, 7.5 mg	J3490	Lupron depot pediatric 7.5 mg, pricing based on 7.5 mg package
W5128	Lupron depot pediatric, 11.25 mg	J3490	Lupron depot pediatric 11.25 mg, pricing based on 11.25 mg package
W5129	Lupron depot pediatric, 15 mg	J3490	Lupron depot pediatric 15 mg, pricing based on 15 mg package
W5198	Octreotide acetate LAR depot, 1 mg	J3490	Octreotide acetate, 1 mg, pricing based on 20 mg (Sandostatin)
W5198	Octreotide acetate LAR depot, 1 mg	J3490	Octreotide acetate, 1 mg, pricing based on 10 mg (Sandostatin)
Y1856	Sodium bicarbonate	J3490	Sodium bicarbonate, 7.5%, up to 50 ml

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

Attention: All Providers

CPT Code Update for 2002 - Coverage of Additional Codes

Effective with date of service January 1, 2002, N.C. Medicaid providers may bill the four new CPT codes listed in the following table, which replace codes deleted or revised by the American Medical Association (AMA) for 2002. Claims submitted with the deleted code for dates of service on or before March 31, 2002 will continue to be accepted for processing. Claims for dates of service on or after April 1, 2002 must be filed using the 2002 CPT code listed below.

The 2001 CPT description of code 20550 ***Injection, tendon sheath, ligament, trigger points or ganglion cyst*** was changed to ***Injection; tendon sheath, ligament, ganglion cyst*** in CPT 2002. Three codes were added to 2002 CPT to differentiate the techniques associated with multiple muscle group injections for trigger points and injection of a tendon at the site of origin or insertion.

Deleted Code	Revised Code	New Code	Description
	20550	20551	***Injection; tendon origin/insertion***
	20550	20552	***Injection; single or multiple trigger point(s), one or two muscle group(s)***
	20550	20553	***Injection; single or multiple trigger point(s), three or more muscle group(s)***
86683		82274	***Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations***

Denied claims related to billing these new codes may be corrected and resubmitted.

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

Attention: Health Departments

Conversion of Refugee Health Assessment Code, STD Control Treatment Code, and TB Control Treatment Code

Effective with date of service September 30, 2002, procedure codes Y2034, Y2013, and Y2012 will be end-dated. Health departments will follow new billing guidelines beginning with date of service October 1, 2002. Please refer to the August 2002 Special Bulletin IV, *HIPAA Code Conversion*, for policy and billing details.

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

Attention: Physicians

New Codes for the Oral Screening Preventive Package for Use in Primary Care Physician Offices

Effective with date of service October 1, 2002, procedure codes W8002 and W8003 (Oral Screening Preventive Package) will be end-dated and replaced by American Dental Association (ADA) dental codes to comply with the implementation of national procedure codes mandated by the Health Insurance Portability and Accountability Act (HIPAA).

Procedure code W8002 (Initial Oral Screening) will be replaced with the following procedure codes:

Procedure Code	Description
D0150	Comprehensive oral evaluation
D1203	Topical application of fluoride (prophylaxis not included) - child
D1330	Oral hygiene instructions

The following criteria apply for the Initial Oral Screening:

- Includes early caries screening and detection of other notable findings in the oral cavity.
- Includes prevention and dietary counseling.
- Includes prescribing a fluoride supplement, if indicated.
- Includes application of fluoride varnish.
- Medicaid will only allow reimbursement for this oral screening when teeth are present and fluoride varnish is applied to the teeth.
- Limited to recipients under 3-years-old.
- Allowed once per provider for each recipient.
- Periodic oral screening is recommended 4 to 6 months after the initial oral screening.
- Exempt from third party liability.

Procedure code W8003 (Periodic Oral Screening) will be replaced with the following procedure codes:

Procedure Code	Description
D0120	Periodic oral evaluation
D1203	Topical application of fluoride (prophylaxis not included) - child
D1330	Oral hygiene instructions

The following criteria still apply for the Periodic Oral Screening:

- Includes early caries screening and detection of other notable findings in the oral cavity.
- Includes prevention and dietary counseling.
- Includes application of fluoride varnish.
- Medicaid will only allow reimbursement for this oral screening when teeth are present and fluoride varnish is applied to the teeth.
- Limited to recipients under 3-years-old.
- Periodic oral screening is recommended four 4 to 6 months after the initial oral screening.
- Periodic oral screening and fluoride varnish application are recommended two times per year at 4 to 6 month intervals for the same or different provider.
- Exempt from third party liability.

Claims Filing Process

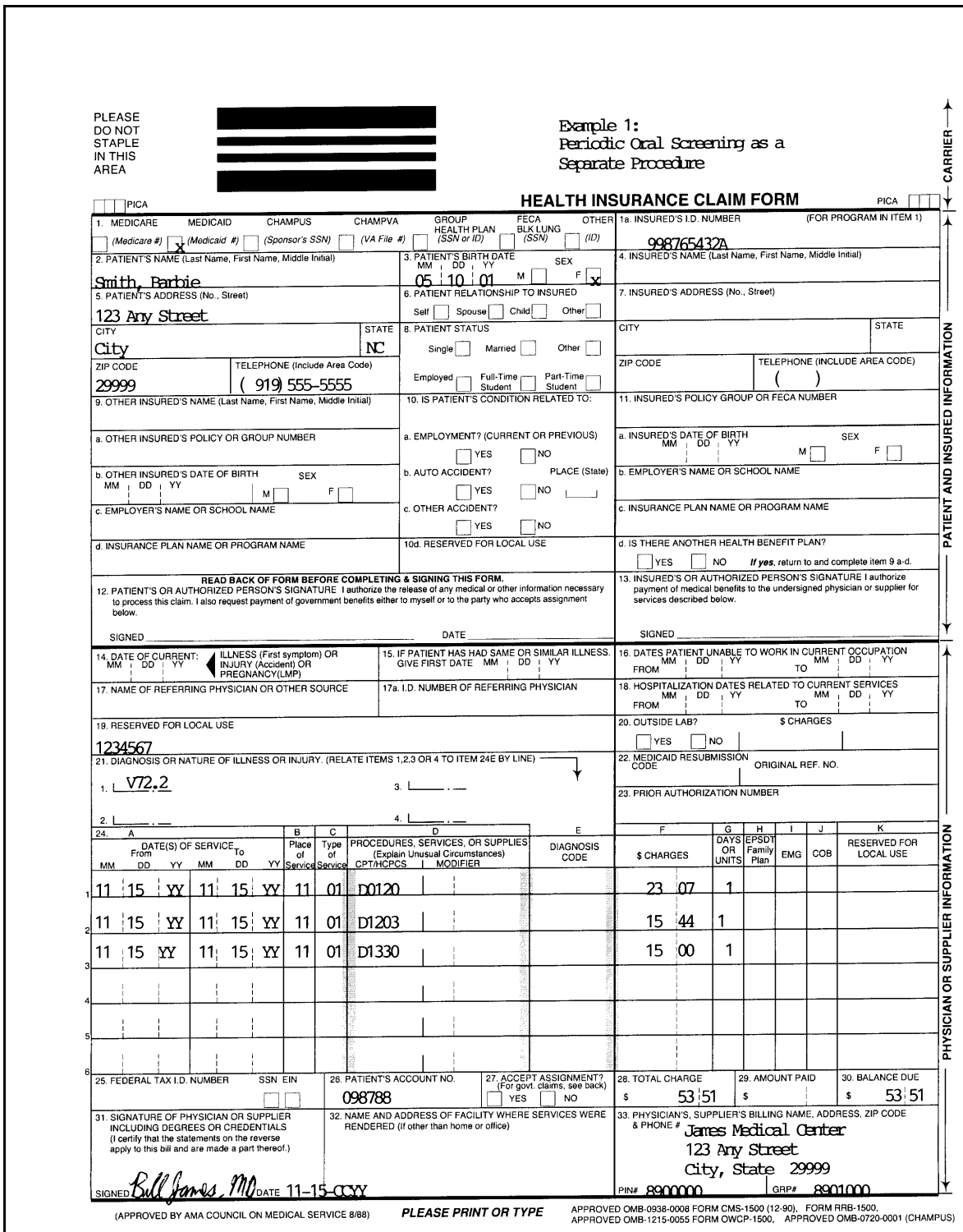
Prior approval is not required for these services. These services are billed on the CMS-1500 claim form or electronically through ECS. Refer to the claim examples on pages 16, 17, and 18. Refer to the Basic Medicaid handout for additional billing instructions.

For health departments, these services are billed through HSIS. Refer to the HSIS screen entry examples on page 19.

Note: Medicaid will only allow reimbursement of these ADA codes if all three procedures are billed on the same claim for the same date of service.

Note: These procedure codes all begin with an alpha "D" character followed by four numeric characters.

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



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

Example 1:
Periodic Oral Screening as a Separate Procedure

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) x 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) 998765432A
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Smith, Barbie	3. PATIENT'S BIRTH DATE MM 05 DD 10 YY 01 SEX M F x
5. PATIENT'S ADDRESS (No., Street) 123 Any Street	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other
CITY City STATE NC	8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student
ZIP CODE 29999 TELEPHONE (Include Area Code) (919) 555-5555	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F	b. AUTO ACCIDENT? YES NO PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
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 _____
CITY STATE	
ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )	
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F	
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.	

PHYSICIAN OR SUPPLIER 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 MM DD YY FROM 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 MM DD YY FROM 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. V72.2 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
1 11 15 YY	11 15 YY	11	01	D0120			23 07	1				
2 11 15 YY	11 15 YY	11	01	D1203			15 44	1				
3 11 15 YY	11 15 YY	11	01	D1330			15 00	1				
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO. 098788	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $ 53 51
29. AMOUNT PAID $	30. BALANCE DUE $ 53 51		
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.) SIGNED Bill James, MD DATE 11-15-CCYY	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 # James Medical Center 123 Any Street City, State 29999 PIN# 8900000 GRP# 8901000

(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)

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

Example 2:
Initial Oral Screening in Conjunction with an office visit

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) X 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): 987654321A
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Patty, Peppermint	3. PATIENT'S BIRTH DATE MM DD YY: 05 10 01 SEX M F X
5. PATIENT'S ADDRESS (No., Street): 123 Any Street	6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other
CITY: City STATE: NC	8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student
ZIP CODE: 29999 TELEPHONE (Include Area Code): (919) 555-5555	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F	b. AUTO ACCIDENT? YES NO PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

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 _____

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
7. INSURED'S ADDRESS (No., Street)	
CITY / STATE	
ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )	
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F	
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.	

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 _____

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
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN
19. RESERVED FOR LOCAL USE: 1234567	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE): 1. L 382.9 2. 3. 4.	

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY	
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY	
20. OUTSIDE LAB? YES NO $ CHARGES	
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
1. 11 15 YY 11 15 YY	11	01	99212		80 00	1				
2. 11 15 YY 11 15 YY	11	01	D0150		31 46	1				
3. 11 15 YY 11 15 YY	11	01	D1203		15 44	1				
4. 11 15 YY 11 15 YY	11	01	D1330		15 00	1				
5.										
6.										

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.: 09878B	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $ 141 90
29. AMOUNT PAID $	30. BALANCE DUE $ 141 90		

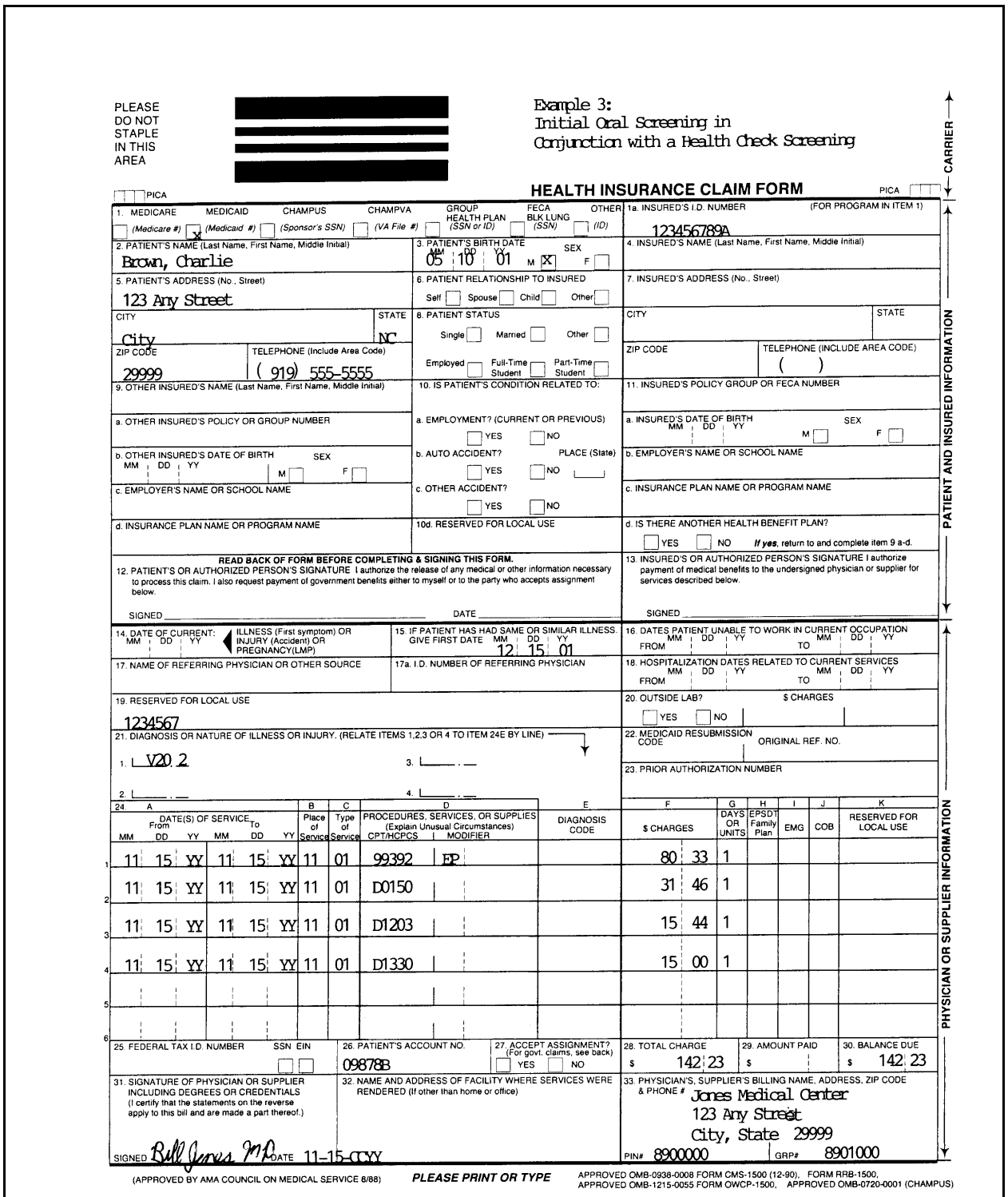
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Bill Jones, MD DATE 11-15-CCYY	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Jones Medical Center 123 Any Street City, State 29999 PIN# 8900000 GRP# 8901000	

CARRIER

PATIENT AND INSURED INFORMATION

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)



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

Example 3:
Initial Oral Screening in
Conjunction with a Health Check Screening

HEALTH INSURANCE CLAIM FORM

PICA

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): 123456789A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Brown, Charlie

3. PATIENT'S BIRTH DATE: 05 10 01 — SEX: M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

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

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

CITY: City — STATE: NC

6. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY — STATE

ZIP CODE: 29999 — TELEPHONE (Include Area Code): (919) 555-5555

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? 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 _____

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: 12 15 01

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

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. V20.2 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
1 11 15 YY	11 15 YY	11	01	99392	EP		80 33	1				
2 11 15 YY	11 15 YY	11	01	D0150			31 46	1				
3 11 15 YY	11 15 YY	11	01	D1203			15 44	1				
4 11 15 YY	11 15 YY	11	01	D1330			15 00	1				
5												
6												

25. FEDERAL TAX I.D. NUMBER — SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 09878B

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

28. TOTAL CHARGE: $ 142 23

29. AMOUNT PAID: $

30. BALANCE DUE: $ 142 23

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.)

SIGNED Bill Jones MD DATE 11-15-CCYY

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 #
Jones Medical Center
123 Any Street
City, State 29999

PIN# 8900000 GRP# 8901000

(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)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Screen Entry Examples of the Services Screen (Option 65) for Local Health Department's that Use the N.C. Health Services Information System (HSIS)

Example #1 – Periodic Oral Screening as a Separate Procedure

```
NEXT RECORD:  COUNTY 999    SCREEN 65    ID 444444444    DATE 120902  ACTION A
MESSAGE:

NAME: Smith, Barbie                                    POST-OP FROM DT: _______
SERVICE GROUP:                                                 THRU DT: _______
DIAG CODES A: V72.2_ B:        C:        D:        E:        F:        G:
           H:        I:        J:        K:        HLTH CHK/EPSDT REFERRAL:_

 B/
 R/            MODIFIERS DIAG     SVC             ATN   TYP  REF  POST
 D  PGM  CPT   M1 M2 M3  1 2 3 4  PROV  UNITS POS  PHY   SVC  PHY   OP   SITE
 B  CH  D0120  __ __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
 R  CH  D1203  __ __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
 R  CH  D1330  __ __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
```

Example #2 – Initial Oral Screening in Conjunction with an Office Visit

```
NEXT RECORD:  COUNTY 999    SCREEN 65    ID 333333333   DATE 120902  ACTION A
MESSAGE:

NAME: Patty, Peppermint                                POST-OP FROM DT: _______
SERVICE GROUP:                                                 THRU DT: _______
DIAG CODES A: 382.9_ B:        C:        D:        E:        F:        G:
           H:        I:        J:        K:        HLTH CHK/EPSDT REFERRAL: R

 B/
 R/            MODIFIERS DIAG     SVC             ATN   TYP  REF  POST
 D  PGM  CPT   M1 M2 M3  1 2 3 4  PROV  UNITS POS  PHY   SVC  PHY   OP   SITE
 B  CH  99212  __ __ __  A _ _ _  RN___  01   71  _____  __  _____  _   99999
 B  CH  D0150  __ __ __  A _ _ _  RN___  01   71  _____  __  _____  _   99999
 B  CH  D1203  __ __ __  A _ _ _  RN___  01   71  _____  __  _____  _   99999
 B  CH  D1330  __ __ __  A _ _ _  RN___  01   71  _____  __  _____  _   99999
```

Example #3 – Initial Oral Screening in Conjunction with a Health Check Periodic Screening

```
NEXT RECORD:  COUNTY 999   SCREEN 65    ID 222222222    DATE 103102   ACTION A
MESSAGE:

NAME: Brown, Charlie                                   POST-OP FROM DT: _______
SERVICE GROUP:                                                 THRU DT: _______
DIAG CODES A: V20.2_ C:        D:        E:        F:        G:
           H:        I:        J:        K:        HLTH CHK/EPSDT REFERRAL:_
 B/
 R/            MODIFIERS DIAG     SVC             ATN   TYP  REF  POST
 D  PGM  CPT   M1 M2 M3  1 2 3 4  PROV  UNITS POS  PHY   SVC  PHY   OP   SITE
 B  CH  99392  EP __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
 B  CH  D0150  __ __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
 B  CH  D1203  __ __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
 B  CH  D1330  __ __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
```

Attention: Prescribers

Valid DEA Numbers Required on Pharmacy Prescriptions

The Division of Medical Assistance (DMA) requires DEA numbers on all recipient pharmacy claims. Providers must have their DEA registration number on file. Failure to do so may result in denied claims. If a prescriber does not have a DEA number and needs to issue prescriptions to Medicaid recipients, the prescriber should contact Brenda Scott in the DUR Section at 919-733-3590.

A prescriber Medicaid identification number (ID) will be issued in lieu of the DEA number. The ID number follows the same format as the DEA number and will always begin with a Z (for example, ZF1234567).

Prescribers must enter this number on their Medicaid prescriptions. This number is referred to as a PRESCRIBER MEDICAID IDENTIFICATION NUMBER only, and should not be referred to as a DEA number.

If updated information has not been submitted to EDS Provider Enrollment, please copy, complete, and return the following form for each prescriber in your practice. Please send the information to the following address:

EDS Provider Enrollment Unit
P.O. Box 300009
Raleigh, North Carolina 27622

FAX: 919-851-4014

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

DEA NUMBER

Provider Name _____

Medicaid Provider Number _____

Street Address _____

City _____ State _____ Zip Code _____

Telephone Number ___(___)_____

DEA Number _____

OR

Prescriber Medicaid Identification Number _____

Attention: Rural Health Clinics and Federally Qualified Health Centers

Billing for Laboratory Services

The Centers for Medicare and Medicaid Services (CMS) Program Memorandum A-00-30 clarified that diagnostic laboratory tests furnished by personnel in a Rural Health Clinic (RHC)/Federally Qualified Health Center (FQHC) are not covered services reimbursed under the core visit because laboratory tests are beyond the scope of RHC/FQHC services. While the law requires that these providers provide routine diagnostic services, according to CMS, laboratory tests are not within the scope of services covered and reimbursed under this provision. Therefore, effective January 1, 2002, laboratory services (including the six required lab tests for RHC certification) furnished by the clinic must be reimbursed based on the fee schedule allowable under the provider's "C" suffix provider number.

Billing Guidelines

- RHC/FQHC providers must bill laboratory services that are performed at the RHC/FQHC using their "C" suffix provider number. Laboratory services not rendered in the RHC/FQHC that are sent to a referring laboratory must be billed by the referring laboratory. The laboratory that performs the service must meet CLIA certification requirements and bill for the service rendered.
- Nominal reimbursement is available for collecting samples for lab testing in addition to the amounts paid under the laboratory fee schedule. Only one collection fee is allowed for each venipuncture for each recipient encounter, regardless of the number of specimens drawn. When a series of specimens is required to complete a single test (e.g., glucose tolerance test), the series is treated as a single encounter. Only the provider who has extracted the specimen from the recipient may bill the collection code. Bill G0001 on the CMS-1500 claim under the RHC/FQHC's "C" suffix provider number.
- Because there is a national cap on payment for laboratory services, the maximum allowable rate for laboratory services is established through the laboratory fee schedule. No additional reimbursement for laboratory services is provided through cost adjustments at the end of the year.

RHC/FQHC fee schedules listing the laboratory rates can be obtained by contacting the Division of Medical Assistance (DMA) using the Fee Schedule Request form, which can be obtained from DMA's website at http://www.dhhs.state.nc.us/dma. Completed forms can be submitted by fax to 919-715-0896.

Adjusting the Cost Report

The cost of the technical aspects of the test must be adjusted from the cost report. These costs include associated space, equipment, supplies, facility overhead, and personnel.

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

Attention: Maternity Care Coordination, Maternity Support, and Child Service Coordination Services

Termination of Coverage

Effective with date of service September 30, 2002, the following state-created codes will be end-dated: Refresher Childbirth (Y2045), Enhanced Maternity Care Coordination (Y2352), and Enhanced Child Service Coordination (Y2353). The N.C. Medicaid program will no longer cover these services.

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

Attention: Maternity Care Coordination, Maternity Support, Child Service Coordination, and Maternal Outreach Worker Services

New Codes for Maternal and Child Services

Effective with date of service October 1, 2002, Maternity Care Coordination, Maternity Support, Child Service Coordination, and Maternal Outreach Worker services must bill the following CPT or HCPCS codes. The new codes replace the state-created codes listed below, in compliance with the implementation of national codes mandated by the Health Insurance Portability and Accountability Act (HIPAA).

Old Code	Old Description	New Code	New Description
W8201	Maternity Care Coordination Initial	T1017	Maternity care coordination
W8202	Maternity Care Coordination Subsequent		
Y2044	Maternity Care Coordination Home Visit		
W8203	Childbirth Education	S9442	Childbirth education
W8204	Maternal Care Skilled Nurse Home Visit	T1001	Maternal care skilled nurse home visit
Y2046	Postpartum Home Visit	99501	***Home visit for postnatal assessment and follow-up care***
Y2047	Newborn Home Visit	99502	***Home visit for newborn care and assessment***
Y2049	Intensive Psychosocial Counseling	96152	***Health and behavior intervention***
Y2155	Child Service Coordination	T1016	Child service coordination
Y2525	Maternal Outreach Worker Brief	S9445	Maternal outreach worker services
Y2526	Maternal Outreach Worker Standard		
Y2527	Maternal Outreach Worker Extended		

For a description of the policies relative to these new codes, please refer to August 2002 Special Bulletin IV, *HIPAA Code Conversion*. This information supersedes previously published policies and guidelines.

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

Attention: Home Health Agencies, Private Duty Nursing Providers, and Community Alternatives Program Case Managers

Conversion of Home Health Supply Codes to National Codes

Congress has mandated that all payer sources comply with guidelines of the Health Insurance Portability and Accountability Act (HIPAA). This includes using standardized national codes for services that are common to all carriers. As codes are end-dated and new codes are added, providers will be notified in the general Medicaid bulletin at http://www.dhhs.state.nc.us/dma.

Some of the codes currently used will be replaced by multiple codes, and some will be deleted and replaced with existing codes. Read each description carefully to ensure that the correct size, quantity or preparation is billed. For example, the current code for gauze elastic bandages (Kling, Kerlix, roller gauze) is W4602 and is priced per roll; the replacement codes will be A6263, A6264, A6405, and A6406. The new codes are priced per linear yard.

Current codes shown below will be end-dated effective with date of service September 30, 2002. The new codes will be effective with date of service October 1, 2002.

Home Health Supplies			
Current Code	**New Code**	**Description**	**Maximum Rate/Unit**
		Dressing Supplies	
W4601 W4653	A6216	Gauze, non-impregnated, non-sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	$ 4.07
W4601 W4653	A6217	Gauze, non-impregnated, non-sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	.05
W4601 W4653	A6218	Gauze, non-impregnated, non-sterile, pad size more than 48 sq. in. without adhesive border, each dressing	.05
W4602	A6263	Gauze, elastic, non-sterile, all types, per linear yard	.29
W4602	A6264	Gauze, non-elastic, non-sterile, per linear yard	.48
W4602	A6405	Gauze, elastic, sterile, all types, per linear yard	.33
W4602	A6406	Gauze, non-elastic, sterile, all types, per linear yard	.79
W4668	K0573	Tape, waterproof, per 18 sq. in.	6.73
		Intravenous Therapy and Parenteral Supplies	
W4649	A4209	Syringe with needle, sterile 5 cc or greater, each	.31
W4650	A4213	Syringe, sterile, 20 cc or greater, each	1.08
W4654	A4259	Lancets, per box of 100	12.68
		Miscellaneous Supplies	
W4618	A4554	Disposable underpads, all sizes (e.g., Chux's)	$ 5.71

Home Health Supplies, continued

Current Code	New Code	Description	Maximum Rate/Unit
		Skin Care (Decubitus) Supplies	
W4620 W4621	E0191	Heel or elbow protector, each	8.45
		Solutions	
W4644	A4246	Betadine or pHisoHex solution, per pint	5.59
		Tracheostomy Supplies	
W4154	S8181	Tracheostomy tube holder	4.07
W4624	A4625*	Tracheostomy care kit for new tracheostomy	6.01
W4624	A4629*	Tracheostomy care kit for established tracheostomy	4.73

* Denotes existing codes. Please note that these are existing codes replacing W4624.

Providers must bill their usual and customary charges.

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

Attention: Durable Medical Equipment Providers

Addition of HCPCS Code K0195

Effective with date of service August 1, 2002, code K0195, elevating legrest, pair (for use with capped rental wheelchair base), has been added to the Capped Rental category of the Durable Medical Equipment Fee Schedule. The maximum reimbursement rates for code K0195 have been established as follows:

Monthly rental rate	$ 20.97
New purchase rate	209.70
Used purchase rate	157.27

Prior approval is required. The lifetime expectancy of these legrests is three years. Providers must bill their usual and customary charges.

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

Attention: Psychiatric Residential Treatment Facility Providers

Billing Guidelines for Psychiatric Residential Treatment Facility Services

Prior to April 1, 2002, claims submitted by a Psychiatric Residential Treatment Facility (PRTF) processed as Inpatient Nursing Home claims. Effective April 1, 2002, claims are now processed and are reflected on the Remittance and Status Report (RA) as Inpatient Hospital claims. Providers using North Carolina Electronic Claim Submission (NCECS) software will continue to use the UB-92 Nursing Home claims option to enter and submit the claim information. However, additional information is required on the claim.

Required changes and additional fields are:

1. **Form Locator 4 – TYPE OF BILL**

   The type of bill remains the same as 891.

2. **Form Locator 7 – COVERED DAYS**

   Enter the number of covered days that correspond with the dates of service that are being billed. Claims must always be billed for more than one day of service and can span different months on the same claim. For example, if a recipient is admitted on April 30, the last day of the month, the "from" date of service is 04302002. The "through" date of service must be any date greater than 04302002.

3. **Form Locator 17 – ADMISSION DATE**

   The admission date must always be entered on the claim <MMDDYYYY>.

4. **Form Locator 18 – ADMISSION HOUR**

   A valid admission hour, 00 through 23, is required.

00 = 12:00-12:59 Midnight	12 = 12:00-12:59 Noon
01 = 01:00-01:59	13 = 01:00-01:59
02 = 02:00-02:59	14 = 02:00-02:59
03 = 03:00-03:59	15 = 03:00-03:59
04 = 04:00-04:59	16 = 04:00-04:59
05 = 05:00-05:59	17 = 05:00-05:59
06 = 06:00-06:59	18 = 06:00-06:59
07 = 07:00-07:59	19 = 07:00-07:59
08 = 08:00-08:59	20 = 08:00-08:59
09 = 09:00-09:59	21 = 09:00-09:59
10 = 10:00-10:59	22 = 10:00-10:59
11 = 11:00-11:59	23 = 11:00-11:59

5. **Form Locator 21 – DISCHARGE HOUR**

   When the recipient has been discharged, a valid discharge hour, 00 through 23, is also required (see chart above).

6. Form Locator 22 – PATIENT STATUS

A valid patient status is now required.

01 = Discharged to home or self care (routine discharge).

02 = Discharged/transferred to another short-term general hospital.

05 = Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution.

07 = Left against medical advice.

20 = Expired.

30 = Still a patient or expected to return for outpatient services.

7. Form Locator 39 – VALUE CODES

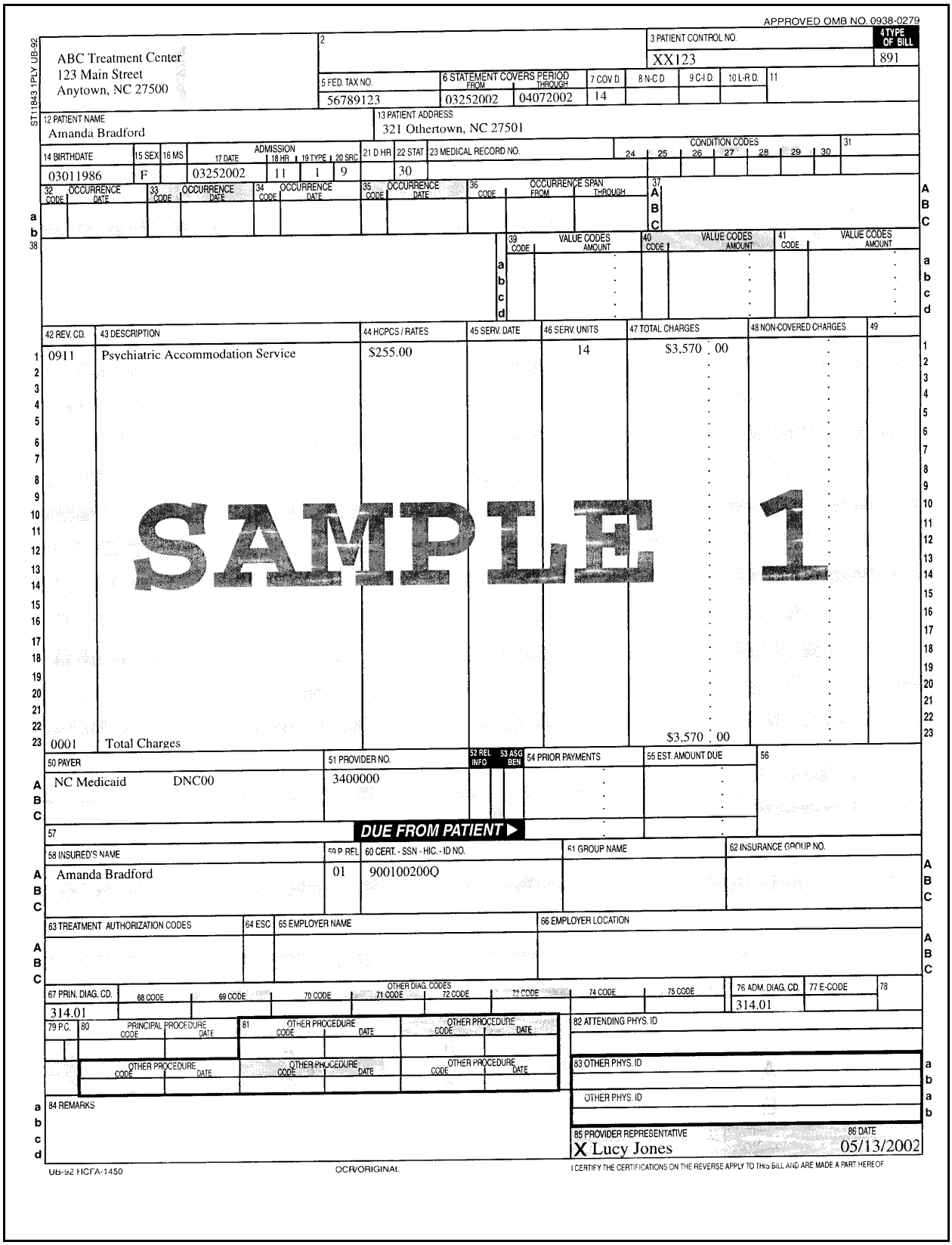
Use value code 23 to indicate the Patient Monthly Liability (PML) amount. The PML amount is required on all claims beginning the first of the month following the thirtieth day from the date of admission. Failure to enter the code and PML amount (even if the amount is $0.00) will result in denial of the claim.

8. Form Locator 76 – ADMITTING DIAGNOSIS CODE

The admitting diagnosis code is now required in form locator 76, as well as in the principal diagnosis section of the claim. These diagnoses are also required to be further subdivided. For example, 296 (Affective Psychoses) is now required to be further subdivided to 296.2. Please refer to the ICD-9-CM code book for accurate codes.

Refer to pages 27 and 28 for claim samples. Sample 1 shows the required fields for claims submitted within the first thirty (30) days when the PML is not required. Sample 2 shows the correct way to bill when the PML is required.

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



APPROVED OMB NO. 0938-0279

ST: 1843 1PLY UB-92

ABC Treatment Center
123 Main Street
Anytown, NC 27500

2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
	XX123	891

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
56789123	03252002	04072002	14				

12 PATIENT NAME	13 PATIENT ADDRESS
Amanda Bradford	321 Othertown, NC 27501

14 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24 25 26 27 28 29 30	31
03011986	F		03252002	11	1	9		30			

32 OCCURRENCE CODE / DATE	33 OCCURRENCE CODE / DATE	34 OCCURRENCE CODE / DATE	35 OCCURRENCE CODE / DATE	36 OCCURRENCE SPAN CODE / FROM / THROUGH	37 A B C

38

39 VALUE CODES CODE / AMOUNT	40 VALUE CODES CODE / AMOUNT	41 VALUE CODES CODE / AMOUNT
a		
b		
c		
d		

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0911	Psychiatric Accommodation Service	$255.00		14	$3,570 . 00		
0001	Total Charges				$3,570 . 00		

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
NC Medicaid DNC00	3400000					

57 DUE FROM PATIENT ▶

58 INSURED'S NAME	59 P REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
Amanda Bradford	01	900100200Q		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

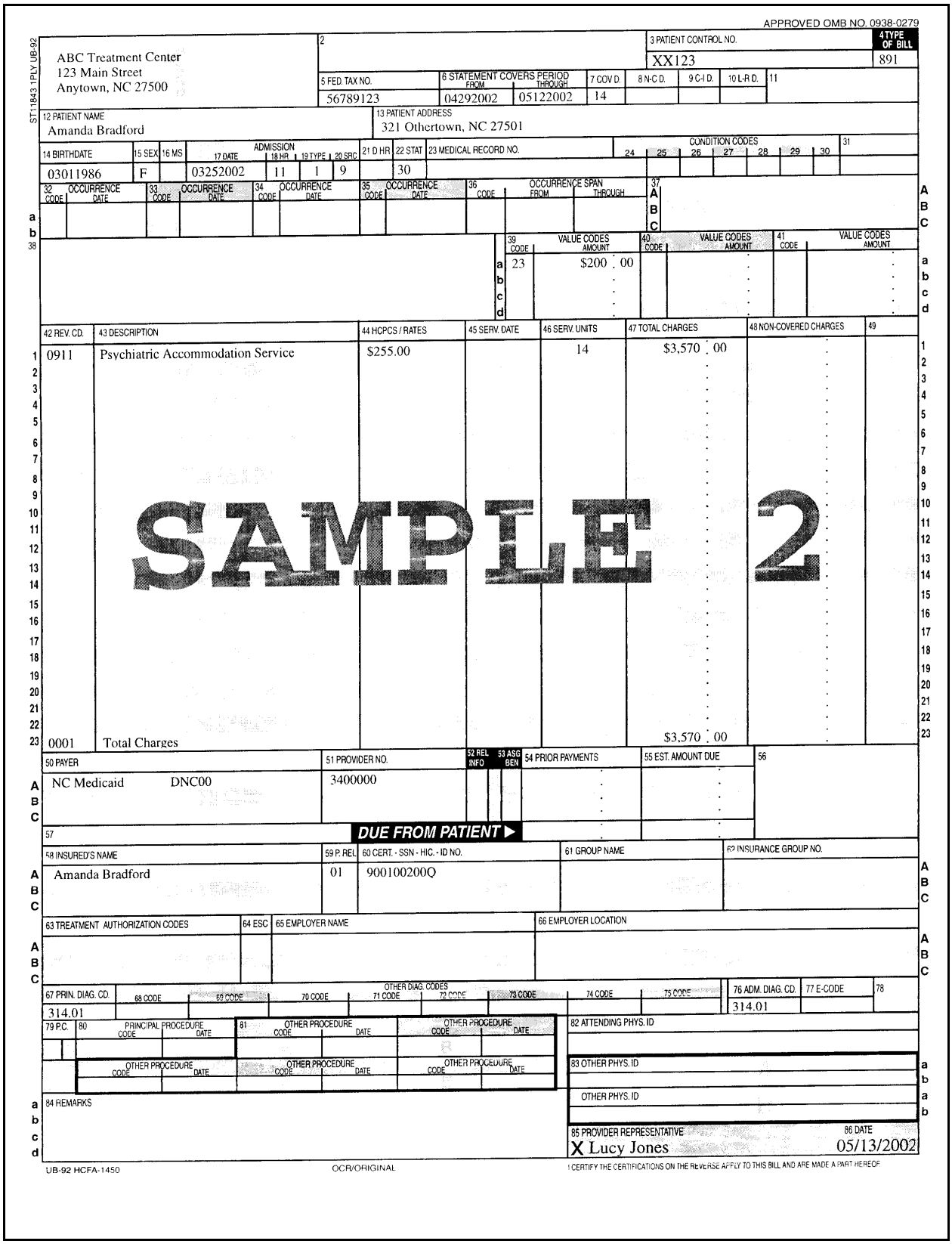
67 PRIN. DIAG. CD.	68 CODE	69 CODE	70 CODE	OTHER DIAG. CODES 71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
314.01									314.01		

79 P.C.	80 PRINCIPAL PROCEDURE CODE / DATE	81 OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	82 ATTENDING PHYS. ID

OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	83 OTHER PHYS. ID
			OTHER PHYS. ID

84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE
	X Lucy Jones	05/13/2002

UB-92 HCFA-1450 OCR/ORIGINAL I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF



APPROVED OMB NO. 0938-0279

ST-1843-1PLY UB-92

ABC Treatment Center
123 Main Street
Anytown, NC 27500

2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
	XX123	891

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
56789123	04292002	05122002	14				

12 PATIENT NAME	13 PATIENT ADDRESS
Amanda Bradford	321 Othertown, NC 27501

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24 25 26 27 28 29 30	31
03011986	F		03252002	11	1	9		30			

32 OCCURRENCE CODE / DATE	33 OCCURRENCE CODE / DATE	34 OCCURRENCE CODE / DATE	35 OCCURRENCE CODE / DATE	36 OCCURRENCE SPAN CODE / FROM / THROUGH	37
a					A
b					B
					C

38

39 VALUE CODES CODE / AMOUNT	40 VALUE CODES CODE / AMOUNT	41 VALUE CODES CODE / AMOUNT
a 23 $200.00		
b		
c		
d		

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0911	Psychiatric Accommodation Service	$255.00		14	$3,570.00		
23	0001	Total Charges				$3,570.00		

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A NC Medicaid DNC00	3400000					
B						
C						
57	DUE FROM PATIENT ▶					

58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A Amanda Bradford	01	900100200Q		
B				
C				

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A			
B			
C			

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
314.01									314.01		

79 P.C.	80 PRINCIPAL PROCEDURE CODE / DATE	81 OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	82 ATTENDING PHYS. ID
	OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	83 OTHER PHYS. ID
				a b
				OTHER PHYS. ID
				a b

84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE
a b c d	X Lucy Jones	05/13/2002

UB-92 HCFA-1450 OCR/ORIGINAL I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

Attention: Durable Medical Equipment Providers

Completion of Certificate of Medical Necessity and Prior Approval Forms

Current statistics show that almost 50 percent of all Certificate of Medical Necessity and Prior Approval (CMN/PA) forms sent to EDS for processing are returned to the provider as unresolved due to incomplete documentation. Of this percentage, nearly 30 percent are returned again for the same problem. Efforts to resolve problems with incomplete CMN/PA forms are delaying the review and disposition of durable medical equipment (DME) requests. EDS will not process incomplete forms. Incomplete forms returned to providers must be corrected and resubmitted to EDS within 60 days of the initial review or the request will be voided.

Please ensure that each request corresponds to the instructions for completion of the CMN/PA form given in step 2 of subsection 6.4 of the *N.C. Medicaid Durable Medical Equipment* manual. It is not necessary to complete fields 3, 6, and 10. Entering ICD-9-CM codes in fields 11 and 12 and a CPT code in field 13 is optional. All of the remaining fields must be completed. Field 24 is required for the following HCPCS codes: E0202, E0607, E0608, E0609, E0480, E0650, E0651, E0652, E0784, E0935, W4006, and W4007.

N/A must only be used in the following fields under the following circumstances:

- field 4 – if the patient does not have a Medicare number
- field 16 – if the patient is an infant or child or the request is not for a bed
- field 18 – if the patient is an infant or a child, check "Other: specify" and write "infant" in the space provided
- field 24 – if the request is not for one of the HCPCS codes listed above

When completing field 25, be sure to refer to Appendix F of the *N.C. Medicaid Durable Medical Equipment* manual for requirements for selected items, including apnea monitors, bi-level therapy, CPAP, external insulin pumps, oxygen and oxygen equipment, portable pulse oximeters, pressure reducing support surfaces, TENS units, therapeutic ventilators, and wheelchairs.

When completing field 26, be sure to fully identify the equipment that is being requested. The provider's return address must be entered in field 29. Failure to do so will delay the return of the form. A stamped address may be used. All of the information provided must be accurate and thorough.

Note: Each page of documentation with the CMN/PA must contain the recipient's name and Medicaid identification (MID) number. Effective immediately, EDS will retain all documentation attached to the CMN/PA and the white (original) copy of the form. The yellow and pink copies will be returned to the provider. It is the provider's responsibility to maintain copies for their records.

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

Attention: Dental Providers and Ambulatory Surgical Center Providers

Billing When Dental Services are Rendered in an Ambulatory Surgical Center

Dental Providers

If a Medicaid recipient is physically unmanageable, medically compromised or severely mentally retarded and will not cooperate for treatment in the dental office, treatment can be completed in an Ambulatory Surgical Center (ASC). The ADA claim form is used by dentists for billing dental services. The dentist's billing instructions do not change, except for the place of service. Since the service is rendered in the ASC, the place of service code "F" must be entered in block 49 on the ADA claim form. Services that normally require prior approval are handled in the usual manner.

Ambulatory Surgical Center Providers

ASC bills for facility use. The ASC claims are filed on the CMS-1500 claim form. The facility rates for ambulatory dental services are priced based on total time, utilizing ASC Groups 1 through 4, as outlined below:

ASC Group	Total Time
1	up to 30 minutes
2	31 - 60 minutes
3	61 - 90 minutes
4	over 90 minutes

For ASC dental treatment, specific changes in ASC billing procedures are listed below:

- For a dental service in the ASC, the place of service code "22" must be entered in block 24B on the CMS-1500 claim form.
- The ADA and/or CPT dental procedures codes for the services that the dentist performed are the procedure codes that must be entered in block 24D of the CMS-1500 claim form.
- Modifier SG must be entered in block 24D on the CMS-1500 claim form.
- The number of units for each ADA and/or CPT dental procedure code must be entered in block 24G of the CMS-1500 claim form.
- When dental services are rendered in an ASC, the operating room time must be indicated on the CMS-1500 claim form (e.g., "total surgical time - 11:14 - 11:55"). This must be entered in any available space in block 24 on the CMS-1500 claim form.

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

Attention: Carolina ACCESS Providers

Change in Carolina ACCESS Override Policy

Effective September 1, 2002, Carolina ACCESS (CA) overrides will no longer be approved when an enrollee has failed to establish a medical record with the primary care provider (PCP) designated on the enrollee's Medicaid identification (MID) card. The CA contract requires PCPs to coordinate care for their enrollees. This means that PCPs must either schedule an appointment for enrollees based on the standards of appointment availability **or** authorize another provider to treat the enrollee. The contract defines the standards of appointment availability as:

- Emergency immediately upon presentation or notification
- Urgent within 24 hours
- Routine sick care within 3 days
- Routine well care within 90 days (15 days if pregnant)

It is the responsibility of the treating provider to obtain authorization for treatment from the PCP listed on the recipient's MID card **prior** to treatment. If authorization is requested **after** services have been rendered, claims may deny. No override will be considered unless the PCP has been contacted and refused to authorize treatment.

Override requests must be submitted using the Override Request form and sent to EDS within six months of the date of service. EDS has 30 days to evaluate the request.

The Division of Medical Assistance (DMA) sends a monthly enrollment report to each PCP to assist in identification of their enrollees. DMA also sends a monthly referral report to each PCP so they can verify the validity and accuracy of the referrals. PCPs must document all referrals in the patient record. It is the responsibility of the PCP to review the reports and report discrepancies to their regional Managed Care Consultant for investigation.

Managed Care Section
DMA, 919-857-4022

Attention: Hospital Providers

Revision of Utilization Review Plans

The Code of Federal Regulations (CFR) requires that hospitals (general, psychiatric, critical access, rehabilitation) providing inpatient services for Medicaid recipients must have a written Utilization Review (UR) plan approved by their state Medicaid program. The plan requirements are found at 42 CFR 456.50 through 456.145. This citation has been reprinted in its entirety as Appendix E of the *N.C. Medicaid Hospital Services* manual. **Annual revision of UR plans is not necessary.**

Revision of a hospital UR plan is necessary only when one of the following occurs:

1. The hospital name changes.
2. The hospital has a change in ownership.
3. The physical location of the facility changes.
4. There is a change in the number or type of specialty beds.

New or revised UR plans should be mailed to:

Division of Medical Assistance
Medical Policy Section
Hospital Utilization Review
2511 Mail Service Center
Raleigh, NC 27699-2511

Ann H. Kimbrell, R.N., Institutional Services
DMA, 919-857-4020

Attention: Physicians, Nurse Practitioners, Nurse Midwives, and Health Departments

Varicella-Zoster Immune Globulin, Human, for Intramuscular Use (CPT 90396), Billing Guidelines

The N.C. Medicaid program covers ***Varicella-zoster immune globulin, human, for intramuscular use*** (CPT 90396). For Medicaid billing, one unit represents 125 units of the Varicella-zoster immune globulin. Providers must indicate the number of Medicaid units given in block 24G on the CMS-1500 claim form. For example, 625 units given in 6.25 ml = 5 Medicaid units. Providers must bill their usual and customary charge.

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

Attention: Independent Practitioner Providers, Developmental Evaluation Centers, Public Health Agencies, Area Mental Health Centers, Home Health Providers, Hospital Outpatient Clinics, and Physician Services

Prior Approval of Outpatient Specialized Therapy Services

Beginning October 1, 2002, Medical Review of North Carolina (MRNC) under a contract with the Division of Medical Assistance (DMA) will process the requests for prior approval of outpatient specialized therapy services provided to Medicaid recipients. Therapy services encompass all outpatient treatment for occupational (OT), physical (PT), speech (ST), respiratory (RT), and audiological therapy regardless of where the services are provided. MRNC will review these services and authorize care at designated trigger points. Services provided in an inpatient setting such as nursing homes, acute rehabilitation facilities, and hospitals are not included.

After the trigger points have been reached, claims will not process without prior approval authorization.

Note: HMO and Medicare recipients are exempt from this policy.

Note: For Local Educational Agencies (LEAs), the prior approval process is deemed met by the IEP process.

Workshops for Outpatient Specialized Therapy Prior Approval Process

Detailed instructions about the prior approval process will be provided in workshops scheduled for September 2002. There is no charge for the workshops. However, to ensure adequate seating, please complete and submit the registration form below or register online beginning September 1, 2002, at http://www.mrnc.org under the News and Upcoming Events section. Workshops will begin at 10:00 a.m. and end at 1:00 p.m.

Please access and print the PDF version of the September 2002 Special Bulletin V, *Outpatient Specialized Therapies*, from the DMA website and bring it with you. This Special Bulletin will be available September 1, 2002 at http://www.dhhs.state.nc.us/dma.

Directions to the sites are available on page 34 of this bulletin.

The registration form for the Outpatient Specialized Therapy Prior Approval Process Workshops is on page 34 of this bulletin.

September 10, 2002
Park Inn Gateway Conference Center
909 US Highway 70 SW
Hickory, NC

September 11, 2002
Hilton Greenville
207 Greenville Blvd SW
Greenville, NC

September 12, 2002
McKimmon Center
Raleigh, NC

Directions to the Outpatient Specialized Therapy Prior Approval Process Workshops

Park Inn Gateway Conference Center – Hickory, North Carolina
Take I-40 to exit 123. Follow signs to Highway 321 North. Take the first exit (Hickory exit) and follow the ramp to the stoplight. Turn right at the light onto Highway 70. The Gateway Conference Center is on the right.

Hilton – Greenville, North Carolina
Take Highway 264 East to Greenville. Turn right onto Allen Road in Greenville. Travel approximately 2 miles. Allen Road becomes Greenville Boulevard/Alternate 264. Follow Greenville Boulevard for 2½ miles to the Hilton Greenville, which is located on the right.

McKimmon Center – Raleigh, North Carolina
Traveling East on I-40
Take exit 295 and turn left onto Gorman Street. Travel approximately one mile. The McKimmon Center is located on the right between Avent Ferry Road and Western Boulevard.

Traveling West on I-40
Take exit 295 and turn right onto Gorman Street. Travel approximately one mile. The McKimmon Center is located on the right between Avent Ferry Road and Western Boulevard.

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

(cut and return registration form only)

Outpatient Specialized Therapy Prior Approval Workshop Registration Form

(No Fee)

Provider Name _____ Provider Number _____
Address _____ Contact Person _____
City, Zip Code _____ County _____
Telephone Number (___) _____ Date _____
E-Mail address _____ Fax Number _____
_____ Persons will be attending the seminar at _____ on _____
(Location) (Date)

Return to: Medical Review of North Carolina, Inc.
5625 Dillard Drive, Suite 203
Cary, NC 27511-9227
ATTN: Medicaid - PAT
FAX: 919-851-0236

Attention: All Providers

Medicare Part B Seminar Schedule

Seminars for billing Medicare Part B services are scheduled for September 2002. Because the process for billing these services will change for claims submitted with dates of service October 1, 2002 and after, these seminars will be used to instruct providers on "how to bill" Medicaid for Medicare Part B services provided to Medicare/Medicaid recipients after the change is implemented.

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

Due to limited seating, preregistration is required and limited to two staff members per office. Unregistered providers are welcome to attend when reserved space is adequate to accommodate. Providers may register for the Medicare Part B seminar by completing and submitting the Medicare Part B registration form on page 37, or providers can register online at http://www.dhhs.state.nc.us/dma under the heading Provider Links. Please select the most convenient site and return the completed registration form to EDS as soon as possible. Seminars begin at 10:00 a.m. and end at 1:00 p.m. Providers are encouraged to arrive by 9:45 a.m. to complete registration.

Directions to the sites are available on page 36 of this bulletin.

The registration form for the Medicare Part B Seminars is on page 37 of this bulletin.

Wednesday, September 4, 2002
Holiday Inn Conference Center
530 Jake Alexander Blvd., S.
Salisbury, NC

Thursday, September 5, 2002
Ramada Inn Plaza
3050 University Parkway
Winston-Salem, NC

Tuesday, September 10, 2002
WakeMed
Andrews Conference Center
3000 New Bern Avenue
Raleigh, NC

Thursday, September 12, 2002
Blue Ridge Community College
Bo Thomas Auditorium
College Drive
Flat Rock, NC

Tuesday, September 17, 2002
Coast Line Convention Center
501 Nutt Street
Wilmington, NC

Wednesday, September 18, 2002
Hilton Greenville
207 Greenville Blvd SW
Greenville, NC

Directions to the Medicare Part B Seminars

The registration form for the Medicare Part B Seminars is on page 37 of this bulletin.

Holiday Inn Conference Center – Salisbury, North Carolina
Traveling South on I-85
Take exit 75. Turn right onto Jake Alexander Boulevard. Travel approximately ½ mile. The Holiday Inn is located on the right.

Traveling North on I-85
Take exit 75. Turn left onto Jake Alexander Boulevard. Travel approximately ½ mile. The Holiday Inn is located on the right.

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

Wake Med Andrews Conference Center – Raleigh, North Carolina
Driving and Parking Directions
Take the I-440 Raleigh Beltline to exit 13A, New Bern Avenue.

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

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

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

Blue Ridge Community College – Flat Rock, North Carolina
Take I-40 to Asheville. Travel east on I-26 to exit 22. Turn right and then take the next right. Follow the signs to Blue Ridge Community College. Turn left at the large Blue Ridge Community College sign. The college is located on the right. Pass the college's main entrance and turn right into the college entrance past the pond. The parking lot is on the left.

Coast Line Convention Center – Wilmington, North Carolina
Take I-40 east to Wilmington. Take the Highway 17 exit. Turn left onto Market Street. Travel approximately 4 or 5 miles to Water Street. Turn right onto Water Street. The Coast Line Inn is located one block from the Hilton on Nutt Street behind the Railroad Museum.

Greenville Hilton – Greenville, North Carolina
Take Highway 264 east to Greenville. Turn right onto Allen Road in Greenville. Travel approximately 2 miles. Allen Road becomes Greenville Boulevard/Alternate 264. Follow Greenville Boulevard for 2½ miles to the Hilton Greenville, which is located on the right.

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

(cut and return registration form only)

Medicare Part B Provider Seminar Registration Form

(No Fee)

Provider Name _____ Provider Number _____

Address _____ Contact Person _____

City, Zip Code _____ County _____

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

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

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

Checkwrite Schedule

August 13, 2002	September 4, 2002	October 15, 2002
August 20, 2002	September 10, 2002	October 22, 2002
August 29, 2002	September 17, 2002	October 30, 2002
	September 26, 2002	

Electronic Cut-Off Schedule

August 9, 2002	August 30, 2002	October 25, 2002
August 16, 2002	September 6, 2002	October 18, 2002
August 23, 2002	September 13, 2002	October 11, 2002
	September 20, 2002	

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

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

Ricky Pope
Executive Director
EDS

e

Presorted Standard
U.S. POSTAGE
PAID
Raleigh, N.C.
Permit No. 1087

P.O. Box 300001
Raleigh, North Carolina 27622