*Number 8* *August 2003*

# North Carolina Medicaid Bulletin

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

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

## Attention: All Providers

## CPT Code Update: Time Limit Override for New 2002 Codes

EDS has completed the necessary system changes to allow time-limit override of claims submitted with CPT codes that were new in 2002 that are past the timely filing dates. Providers are encouraged to file electronically. These claims must be submitted by 12:00 p.m. on December 31, 2003. Any claim with new 2002 CPT codes received after December 31, 2003 that does not meet timely filing guidelines will be denied.

Updates on covered CPT codes can be found in the July 2003 general Medicaid bulletin on DMA's website at http://www.dhhs.state.nc.us/dma/bulletin.htm

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

## Attention: All Providers

## Electronic Submissions of FL2s

Effective July 1, 2003, providers may elect to submit FL2 information for nursing facility level of care authorizations electronically to EDS by using a service developed by ProviderLink, Inc. This company provides web-based communications technology to enable health care providers and payors to manage all of their patient-related external communication through a single browser interface. The FL2e is one of many prior approval-related forms on the ProviderLink system. However, this is the only form that is used by the N.C. Medicaid program.

To learn more about the electronic process for the FL2e, contact ProviderLink, Inc. at http://www.providerlink.com or by phone at 919-465-1855.

**Gloria Corbett, R.N., Medical Policy Section**
**DMA 919-857-4020**

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

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## Attention: All Providers

## HIPAA Update: Change to Implementation Date

Previously, N.C. Medicaid announced an implementation date of August 1, 2003 for American National Standard Institute (ANSI) Accredited Standards Committee (ASC) X12N standards, Version 4010A1 standard transactions. This date has changed to September 14, 2003. The following standard transactions will become effective on that day:

- Health Care Claim (Professional, Institutional, Dental) – 837 Transaction
- Health Care Claim Payment Advice – 835 Transaction
- Claim Inquiry and Response – 276/277 Transaction
- Payroll Deducted and Other Group Premium Payment for Insurance Products – 820 Transaction

In addition to the ANSI (ASC) X12, Version 4010A1 standard transactions, N.C. Medicaid will implement the National Council for Prescription Drug Programs (NCPDP), Version 1.1 Batch standard effective September 14, 2003. NCPDP Version 5.1 Point-of-Sale will be implemented August 1, 2003 as previously published.

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

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

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

## Attention: All Providers

## Unlisted Procedure Code Claims and EOB 1224 Revision

EOB 1224 was revised on November 18, 2002 to read "Resubmit claim with special report and operative notes and/or medical records." Providers receive this EOB when they submit a claim using an unlisted CPT code without the required documentation explaining the nature, extent, and need for the procedure including the time, effort, and equipment that was necessary to provide the service.

Providers are required to bill the CPT code that most accurately describes the service performed. If no such procedure code exists, providers are requested to bill the service using an appropriate unlisted CPT code. The claim must be submitted on paper and include a special report and operative notes or medical records. Medicaid cannot evaluate and reimburse the service or procedure without adequate documentation.

Medicaid does not reimburse for unlisted CPT codes that are billed for noncovered services or procedures or for services that are experimental or investigational in nature. Medicaid does not reimburse for unlisted codes that are billed in place of new CPT codes that are still under review by Medicaid.

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

## Attention: All Providers

## Remittance and Status Report Changes

Effective September 14, 2003, the Remittance and Status Report (RA) will be revised to include a new field labeled "DIFF." This field denotes the difference between the Medicaid projected payment (a calculation of the Medicaid allowable minus the Medicare payment) and the actual Medicaid paid amount when Medicaid pays only up to the Medicare coinsurance and deductible amount. Initially, this field will only be used on RAs sent to providers filing outpatient hospital Medicare primary claims on the UB-92 claim form.

The "DEDUCTIBLE" and the "PAT LIAB" fields will be shortened to "DED" and "PT LIB." There will be no changes to the information that is currently recorded in these fields.

An example of the revised RA is on page 5.

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

NORTH CAROLINA MEDICAID
REMITTANCE AND STATUS REPORT

**RECIPIENT, JOE**
**123 ANY STREET**
**ANY CITY, NC 12345**

PROVIDER NUMBER **3400000** REPORT SEQ. NUMBER DATE **08/01/2003** PAGE **2**

| NAME / RECIPIENT ID | SERVICE DATE FROM | SERVICE DATE TO | DAYS OR UNITS | PROCEDURE/ACCOMODATION/DRUG CODE AND DESCRIPTION | TOTAL BILLED | NON ALLOWED | TOTAL ALLOWED | PAYABLE CUTBACK | PAYABLE CHARGE | OTHER DEDUCTED CHARGES | PAID AMOUNT | EXPLA-NATION CODES |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Paid Claims** | | | | | | | | | | | | |
| **Outpatient** | | | | | | | | | | | | |
| *RECIPIENT* *JANE A* | **CO=92** | **RCC=** | **CLAIM NUMBER= 252002001001001NCXIX** | | | | | | | | | |
| **900000000k** | | | | | | **MED REC= 123456** | | | | **ATTN PROV= 0.8000 8926** | | |
| **NCXIX** | **10162002** | **10162002** | **2 B** | **250 PHARMACY-GEN** | **78 00** | **00** | **78 00** | **38 68** | **39 32** | **3932** | **00** | **8926** |
| **NCXIX** | **10162002** | **10162002** | **1 B** | **341 NUCLEAR MEDICINE** | **576 00** | **00** | **576 00** | **285 69** | **290 31** | **20110** | **89 21** | **8826** |
| *DED= .00* | *PT LIB= .00* | *CO* | *PAY= .00* | *TPL= 88.01* | *DIFF= 152.41* | *654 00* | *0* | *65400* | *324 87* | *329 63* | *24042* | *89 21* |
| *ORIGINAL BILLED AMOUNT= 654.00* | | | | *ORIGINAL DETAIL COUNT = 2* | | | *TOTAL FINANCIAL PAYERS= 1* | | | | | |

# Attention: Adult Care Home Providers

## HIPAA Code Conversion for Adult Care Homes Personal Care Services

To comply with the implementation of national code sets as mandated by the Health Insurance Portability and Accountability Act (HIPAA), it is necessary to end-date all N.C. Medicaid state-created codes and convert to national codes.

The following state-created procedure codes will be **end-dated** effective with date of service **September 30, 2003**:

| Procedure Code | Description |
|---|---|
| W8251 | Basic ACH/PC (Facility beds 1-30) |
| W8258 | Basic ACH/PC (Facility beds 31 and above) |
| W8255 | Enhanced ACH/PC (Ambulation/Locomotion) |
| W8256 | Enhanced ACH/PC (Eating) |
| W8257 | Enhanced ACH/PC (Toileting) |
| W8259 | Enhanced ACH/PC (Eating and Toileting) |

Effective with date of services **October 1, 2003**, the following services must be billed using both a revenue code and the corresponding HCPCS code.

| Revenue Code | HCPCS Code | Description |
|---|---|---|
| 599 | T1020 | Personal Care Services, per diem |
| 229 | T2002 | Non-emergency Transportation, per diem |

**Note:** Therapeutic leave is billed using revenue code 183 only. It is not necessary to bill for this service with both a revenue code and a HCPCS code.

While the claim form has not changed, HIPAA requires a diagnosis code to be included with all claim submissions. Therefore, effective with date of service October 1, 2003, providers must include the primary diagnosis code V606, Person Living in Residential Institution, in the appropriate field (form locator 67 for paper claims) on the claim form.

For those who file claims electronically, the new NCECS web-based tool will introduce several new fields for data entry. Providers will not be required to enter information in these fields with the exception of the primary diagnosis code (V606) and the bill type (893).

Finally, for claims to process correctly, current licensed bed information for each facility must be on file with Medicaid. Failure to report this information before these changes take effect in October may result in a denied claim. If you have any questions or need additional information about licensed bed information on file with Medicaid, contact Angela Langston at 919-857-4020.

**Bill Hottel, Adult Care Home Services**
**DMA, 919-857-4020**

# Attention: Dialysis Facilities

## Doxercalciferol, 1 mcg (Hectorol, J1270) – Billing Guidelines

Effective with date of service July 1, 2003, N.C. Medicaid covers the injectable doxercalciferol (Hectorol) for use by dialysis facilities when the oral route is contraindicated. Doxercalciferol is indicated for the reduction of elevated iPTH levels in the management of secondary hyperparathyroidism in patients undergoing chronic renal dialysis. The FDA recommends an initial dose of 4 mcg administered three times weekly at dialysis. Dosages may be adjusted to a maximum recommended dose of 6 mcg administered three times a week at dialysis. For Medicaid billing, **one unit** of coverage is **1 mcg**. The maximum reimbursement rate per unit is $5.42 per 1 mcg unit. Providers must bill their usual and customary charge.

This drug should be added to the lists of injectable drugs published in the June 2002 and August 2002 general Medicaid bulletins and noted that it is only covered for use by dialysis treatment facilities.

Dialysis treatment facilities may bill for doxercalciferol in addition to the dialysis composite rate. Administration supply costs are included in the dialysis composite rate.

Doxercalciferol is covered for recipients with the following diagnoses:

1. Hyperparathyroidism of Renal Origin, 588.8
2. Renal Osteodystophy, 588.0
3. Hypoparathyroidism, 252.1

**Dialysis Treatment Facility Billing Requirements:**

- Use the UB-92 claim form.
- Enter revenue code 250 in form locator 42.
- Enter the description of the drug in form locator 43.
- Enter HCPCS code **J1270** in form locator 44.
- Enter the date of service in form locator 45.
- Enter the units given in form locator 46 (1 mcg = 1 unit).
- Enter the total charges in form locator 47.
- Enter diagnosis code **588.8, 588.0** or **252.1** in form locator 67.

**Example:**

| 42<br>Rev Code | 43<br>Description | 44<br>HCPCS/Rate | 45<br>Serv Date | 46<br>Serv Units | 47<br>Total Charges |
|---|---|---|---|---|---|
| 250 | Hectorol<br>1 mcg | J1270 | 07072003 | **4** | $ |

| 67<br>Prin Diag Cd | 68<br>Code | 69<br>Code | 70<br>Code | 71<br>Code | 72<br>Code | 73<br>Code | 74<br>Code | 75<br>Code |
|---|---|---|---|---|---|---|---|---|
| 588.8, 588.0 or 252.1 | | | | | | | | |

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

# Attention: Durable Medical Equipment Providers

## HCPCS Code Changes

The following HCPCS codes were changed effective with date of service August 1, 2003. This change was made to comply with the implementation of national codes mandated by the Health Insurance Portability and Accountability Act (HIPAA).

| Old Code | New Code | Description | Quantity Limitation or Lifetime Expectancy | Maximum Reimbursement Rate | |
|---|---|---|---|---|---|
| K0183 | A7034 | Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap | 2 per year | New Purchase: | $ 73.80 |
| K0184 | A7032 | Replacement cushion for nasal application device, each | 2 per year | New Purchase: | 22.39 |
| K0184 | A7033 | Replacement pillows for nasal application device, pair | 2 per year | New Purchase: | 22.39 |
| K0185 | A7035 | Headgear used with positive airway pressure device | 2 per year | New Purchase: | 33.47 |
| K0186 | A7036 | Chinstrap used with positive airway pressure device | 1 per year | New Purchase: | 14.51 |
| K0187 | A7037 | Tubing used with positive airway pressure device | 2 per year | New Purchase: | 36.96 |
| K0188 | A7038 | Filter, disposable, used with positive airway pressure device | 1 per month | New Purchase: | 4.96 |
| K0189 | A7039 | Filter, non-disposable, used with positive airway pressure device | 6 per year | New Purchase: | 11.93 |
| W4010 | K0531 | Humidifier, heated, used with positive airway pressure device | 2 years | Rental:<br>New Purchase:<br>Used Purchase: | 79.72<br>797.23<br>597.93 |
| W4116 | K0268 | Humidifier, non-heated, used with positive airway pressure device | 2 years | Rental:<br>New Purchase:<br>Used Purchase: | 13.16<br>131.57<br>98.68 |

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

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

# Attention: Certified Nurse Midwives

## CPT Code 59025

Effective with date of service January 1, 2003, when billing for only the professional component of CPT code 59025, fetal non-stress test, modifier 26 must be appended to the code. It is not necessary to append modifier 26 to CPT code 59025 when billing for both the professional and technical components of the test.

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

## Attention: Health Departments

## Code Crosswalk Clarification

The May 2000 Special Bulletin I, *CPT Code Conversion*, included CPT codes used by health departments to bill for family planning services. Following is a complete list of codes that can be billed for initial preventive medicine family planning visits and periodic preventive medicine family planning visits.

| CPT Code | Description |
|---|---|
| | Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; |
| 99383 | 5 through 11 years |
| 98384 | 12 through 17 years |
| 99385 | 18 through 39 years |
| 99386 | 40 through 64 years |
| 99387 | 65 years and over |
| | Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; |
| 99393 | 5 through 11 years |
| 99394 | 12 through 17 years |
| 99395 | 18 through 39 years |
| 99396 | 40 through 64 years |
| 99397 | 65 years and over |

To indicate that this is a family planning service, providers must append modifier "**FP**" to the procedure code in block 24D on the CMS-1500 claim form. Claims must be billed using one of the appropriate ICD-9-CM diagnosis code from the code range V25.0 through V25.8. Laboratory procedures conducted in-house may be billed in addition to the codes listed above.

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

# Attention: Hospitals

## Clarification on Preadmission Review for Psychiatric/Substance Abuse Treatment

When the diagnosis for a recipient is mental illness or substance abuse, ValueOptions needs to be contacted for review regardless of bed location or physician specialty.

**Indications for Hospitalization for Substance Abuse Treatment**
The following criteria (ages 21 through 64) are to be utilized for **preadmission review** for psychiatric treatment of adult alcohol or other substance dependency or abuse.

Any DSM-IV diagnosis of substance abuse or dependency and one of the following:

a. Need for skilled observation (including instance of coma or stupor) or therapeutic milieu necessitating inpatient treatment.

b. Need for detoxification and not manageable by alternative treatment.

c. Potential danger to self or others and not manageable by alternative treatment.

d. Onset of, or impending, convulsions or delirium tremens or toxic psychosis.

e. Presence of significant medical disorder or other disabling psychiatric disorder necessitating inpatient treatment.

This is used in combination with ASAM criteria when appropriate.

**Indications for Hospitalization for Psychiatric Treatment**
The following criteria (ages 21 through 64) are to be utilized for **preadmission review** for psychiatric treatment of adult non-substance abuse and all other conditions.

Any DSM-IV Axis I or II diagnosis and one of the following:

a. Impaired reality testing (e.g., delusions, hallucinations), disordered behavior or other acute disabling symptoms not manageable by alternative treatment.

b. Potential danger to self or others and not manageable by alternative treatment.

c. Concomitant severe medical illness or substance abuse necessitating inpatient treatment.

d. Severely impaired social, familial, occupational or developmental functioning that cannot be effectively evaluated or treated by alternative treatment.

e. Failure of or inability to benefit from alternative treatment, in the presence of severe disabling psychiatric illness.

f. Need for skilled observation, special diagnostic or therapeutic procedures or therapeutic milieu necessitating inpatient treatment.

**Psychiatric Admission Criteria/Medicaid Beneficiaries Under Age 21 (N.C. Administrative Code 10A: 22O.0112)**
Medicaid criteria for the admission of those persons under age 21 to psychiatric hospitals or psychiatric units of general hospitals is limited herein. To be approved for admission, the patient must meet criteria in Items (1), (2) and (3) of this Rule as follows:

(1) Client meets criteria for one or more DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition -- a manual whose purpose is to provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study, and treat various mental disorders) diagnoses. This manual is hereby incorporated by reference including subsequent amendments and editions. Copies may be obtained from the American Psychiatric Association; and

(2) At least one of the following criteria:

(a) Client is presently a danger to self (e.g., engages in self-injurious behavior, has a significant suicide potential, or is acutely manic). This usually would be indicated by one of the following:

(i) Client has made a suicide attempt or serious gesture (e.g., overdose, hanging, jumping from or placing self in front of moving vehicle, self-inflicted gunshot wound), or is threatening same with likelihood of acting on the threat, and there is an absence of supervision or structure to prevent suicide of the client who has made an attempt, serious gesture or threat.

(ii) Client manifests a significant depression, including current contemplation of suicide or suicidal ideation, and there is an absence of supervision or structure to prevent suicide.

(iii) Client has a history of affective disorder:

(A) with mood which has fluctuated to the manic phase, or

(B) has destabilized due to stressors or non-compliance with treatment.

(iv) Client is exhibiting self-injurious behavior (cutting on self, burning self) or is threatening same with likelihood of acting on the threat; or

(b) Client engages in actively violent, aggressive or disruptive behavior or client exhibits homicidal ideation or other symptoms which indicate he is a probable danger to others. This usually would be indicated by one of the following:

(i) Client whose evaluation and treatment cannot be carried out safely or effectively in other settings due to impulsivity, impaired judgment, severe oppositionalism, running away, severely disruptive behaviors at home or school, self-defeating and self-endangering activities, antisocial activity, and other behaviors which may occur in the context of a dysfunctional family and may also include physical, psychological, or sexual abuse.

(ii) Client exhibits serious aggressive, assaultive, or sadistic behavior that is harmful to others (e.g., assaults with or without weapons, provocations of fights, gross aggressive over-reactivity to minor irritants, harming animals) or is threatening same with likelihood of acting on the threat. This behavior should be attributable to the client's specific DSM-IV diagnosis and can be treated only in a hospital setting; or

(c) Acute onset of psychosis or severe thought disorganization or clinical deterioration in condition of chronic psychosis rendering the client unmanageable and unable to cooperate in treatment. This usually would be indicated by the following: Client has recent onset or aggravated psychotic symptoms (e.g., disorganized or illogical thinking, hallucinations, bizarre behavior, paranoia, delusions, incongruous speech, severely impaired judgment) and is resisting treatment or is in need of assessment in a safe and therapeutic setting; or

(d) Presence of medication needs, or a medical process or condition which is life-threatening (e.g., toxic drug level) or which requires the acute care setting for its treatment. This usually would be indicated by one of the following:

(i) Proposed treatments require close medical observation and monitoring to include, but not limited to, close monitoring for adverse medication effects, capacity for rapid response to adverse effects, and use of medications in clients with concomitant serious medical problems.

(ii) Client has a severe eating disorder or substance abuse disorder which requires 24-hour-a-day medical observation, supervision, and intervention.

(iii) Client has Axis I or Axis II diagnosis, with a complicating or interacting Axis III diagnosis, the combination of which requires psychiatric hospitalization in keeping with any one of these criteria, and with the Axis III diagnosis treatable in a psychiatric setting (e.g., diabetes, malignancy, cystic fibrosis); or

(e) Need for medication therapy or complex diagnostic evaluation where the client's level of functioning precludes cooperation with the treatment regimen, including forced administration of medication. This usually would be indicated by one of the following:

(i) Client whose diagnosis and clinical picture is unclear and who requires 24 hour clinical observation and assessment by a multi-disciplinary hospital psychiatric team to establish the diagnosis and treatment recommendations.

(ii) Client is involved in the legal system (e.g., in a detention or training school facility) and manifests psychiatric symptoms (e.g., psychosis, depression, suicide attempts or gestures) and requires a comprehensive assessment in a hospital setting to clarify the diagnosis and treatment needs; and

(3) To meet the federal requirement at 42 CFR 441. 152, all of the following must apply:

(a) Ambulatory care resources available in the community do not meet the treatment needs of the recipient.

(b) Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.

(c) The services can reasonably be expected to improve the recipient's condition or prevent further regression so that services will no longer be needed.

Criteria for continued acute stay in an inpatient psychiatric facility can be found in N.C. Administrative Code 10A: 22O.0113.

**Note:** The references to HRI-R High in NCAC 10A: 22O.0113 are being revised to reflect current language and status.

The criteria for psychiatric admissions for recipients under the age of 21 and for continued acute stay for recipients through the age of 64 addresses psychiatric units in general hospitals or psychiatric hospitals. In addition, these criteria are used for hospital admissions with mental illness or substance abuse diagnoses regardless of bed location.

**Carolyn Wiser, Behavioral Health Services**
**DMA, 919-857-4040**

# Attention: Hospitals

## Change to Medicare Part B

Effective September 14, 2003, claims filed to Medicaid when Medicare Part B has made a payment, must have the sum of both the coinsurance and the deductible in form locator 55, estimated amount due. Medicaid will begin reimbursing providers the lesser of the coinsurance and deductible or the difference between the Medicaid allowable and the Medicare payment. This change only applies to dates of service after October 1, 2002. Providers should refer to the September 2002 Special Bulletin VI (revised November 14, 2002) for detailed billing instructions.

Below is an example of a section of the UB-92:

| 50 Payer | 51 Provider No | 52 Rel Info | 53 Asg Ben | 54 Prior Payments | 55 Est. Amount Due | 56 |
|---|---|---|---|---|---|---|
| M0000 | 34XXXX | | | $50.00 | | |
| DNC00 | 34XXXXX | | | | $100.00 | |

**Example:**

Medicare payment = $50
Medicare coinsurance = $75
Medicare deductible = $25
Contractual adjustment = $10

In the above example, the payment from Medicare Part B was $50.00, as indicated in form locator 54. The coinsurance plus the deductible was $100.00, as indicated in form locator 55.

These claims can be filed electronically. Do not add the contractual adjustment to the payment listed in form locator 54.

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

# Attention: Optical Providers

## New Ophthalmic Frames for Children

The following children's frames have been added to the Medicaid selection:

Manufacturer: EyeQ
Model: **QPanda** (metal frame)
Sizes: 33□17/115CC, 35□17/120CC, 37□17/125CC
Colors: Amber, Pink Swirl

**Note:** The manufacturer's name for this frame is Panda, but Medicaid uses the name "QPanda" to differentiate between this frame and the current Medicaid frame, Hart Panda.

Manufacturer: EyeQ
Model: **Pony** (zyl frame)
Sizes: 34□15/115CC, 36□15/120CC
Colors: Honey, Pink

To obtain samples of these frames to add to the your office Medicaid fitting selection, contact EyeQ Eyewear at 1-800-403-3937.

**Nash Optical Plant, 1-888-388-1353**

# Attention: Physicians, Health Departments, Nurse Practitioners

## Agalsidase Beta, 35 mg (Fabrazyme, J3490) – Billing Guidelines

Effective with date of service August 1, 2003, the N.C. Medicaid program covers the injectable drug agalsidase (Fabrazyme) for use in the Physician's Drug Program. The FDA-approved indication for agalsidase is Fabry disease. The **ICD-9-CM** diagnosis code appropriate to bill for agalsidase is **272.7** (lipidoses**)**. Add this drug to the lists of injectable drugs published in the June 2002 and August 2002 general Medicaid bulletins.

Providers must bill **J3490**, the unclassified drug code, with an invoice attached to the CMS-1500 claim form. **An invoice must be submitted with each claim.** The paper invoice must indicate the name of the recipient, the recipient's 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, and the cost per dose. Providers must indicate the number of units given in block 24G on the CMS-1500 claim form. For Medicaid billing, **one unit** of coverage is **35 mg, one 20 ml vial**. The maximum reimbursement rate per unit is $4,275.00. Providers must bill their usual and customary charge.

Providers will not be reimbursed for an E/M code in addition to an administration code, unless the E/M code is billed with modifier 25 for a separately identifiable service. Supplies for this intravenous infusion may be reimbursed in addition to the administration code billed.

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

## Attention: Physicians, Health Departments, Nurse Practitioners

## Alefacept, 7.5 mg IV; 15 mg IM (Amevive, J3490) – Billing Guidelines

Effective with date of service July 1, 2003, the N.C. Medicaid program covers alefacept (Amevive) for use in the Physician's Drug Program. Alefacept is an injectable monoclonal antibody. The FDA-approved indication for alefacept is the treatment of adults with moderate to severe plaque psoriasis who are candidates for systemic therapy or phototherapy. It is not indicated for other forms of psoriasis other than chronic plaque psoriasis. Dosage forms currently available for alefacept are intravenous (IV bolus injection – 7.5 mg) and intramuscular (IM – 15 mg). The **ICD-9-CM** diagnosis code appropriate to bill with alefacept is **696.1**.

Providers must bill **J3490**, the unclassified drug code, with an invoice attached to the CMS-1500 claim form. **An invoice must be submitted with each claim.** The paper invoice must indicate the name of the recipient, the recipient's 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, and the cost per dose. The maximum reimbursement rate is $630.00 per injection for the 7.5 mg vial (IV) and $895.50 per injection for the 15 mg vial (IM). Providers must bill their usual and customary charge.

Providers will not be reimbursed for an E/M code in addition to an administration code, unless the E/M code is billed with modifier 25 for a separately identifiable service. Routine supplies necessary to administer the IV bolus and IM injections of the drug are included in the reimbursement for the administration and are not separately reimbursed.

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

## Attention: Physicians, Health Departments, Nurse Practitioners

## Bortezomib, 3.5 mg (Velcade, J9999) – Billing Guidelines

Effective with date of service August 1, 2003, the N.C. Medicaid program covers injectable bortezomib (Velcade) for use in the Physician's Drug Program. The FDA states that bortezomib, an antineoplastic agent, is indicated for the treatment of multiple myeloma patients who have received at least two prior therapies and have documented disease progression on the last therapy. The **ICD-9-CM** diagnosis code appropriate to bill for bortezomib is **203.00** (multiple myeloma**)**. Add this drug to the lists of injectable drugs published in the June 2002 and August 2002 general Medicaid bulletins.

Providers must bill **J9999**, the unclassified antineoplastic drug code, with an invoice attached to the CMS-1500 claim form. **An invoice must be submitted with each claim.** The paper invoice must indicate the name of the recipient, the recipient's 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, and the cost per dose. Providers must indicate the number of units given in block 24G on the CMS-1500 claim form. For Medicaid billing, **one unit** of coverage is **3.5mg/10ml**. The maximum reimbursement rate per unit is $974.70. Providers must bill their usual and customary charge.

Providers will not be reimbursed for an E/M code in addition to an administration code, unless the E/M code is appended with modifier 25 for a separately identifiable service. Routine supplies necessary to administer the drug by IV bolus are included in the reimbursement for the administration and are not separately reimbursed.

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

## Attention: Physicians, Nurse Practitioners

## Laronidase, 2.9mg/5ml (Aldurazyme, J3490) – Billing Guidelines

Effective with date of service August 1, 2003, the N.C. Medicaid program covers laronidase (Aldurazyme) for use in the Physician's Drug Program. The FDA approved using laronidase for patients with Hurler and Hurler-Scheie forms of mucopolysaccharidosis I (MPS I) and for patients with the Scheie form who have moderate to severe symptoms. The FDA recommends a dose of 0.58 mg/kg of body weight administered once weekly as an IV infusion. The **ICD-9-CM** diagnosis code appropriate to bill for laronidase is **277.5** (mucopolysaccharidosis). This drug should be added to the lists of injectable drugs published in the June 2002 and August 2002 general Medicaid bulletins.

Providers must bill **J3490**, the unclassified drug code, with an invoice attached to the CMS-1500 claim form. **An invoice must be submitted with each claim.** The paper invoice must indicate the name of the recipient, the recipient's 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, and the cost per dose. Providers must indicate the number of units given in block 24G on the CMS-1500 claim form. For Medicaid billing, **one unit** of coverage is **2.9 mg, one 5 ml vial**. The maximum reimbursement rate per unit is $508.50. Providers must bill their usual and customary charge.

Providers will not be reimbursed for an E/M code in addition to an administration code, unless the E/M code is billed with modifier 25 for a separately identifiable service. Supplies for this intravenous infusion may be reimbursed in addition to the administration code billed.

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

## Attention: NCECS Billers

## North Carolina Electronic Claims Submission Web-Based Tool

Beginning August 1, 2003, providers will have access to the Lists Management function of the North Carolina Electronic Claims Submission web-based tool (NCECS-Web) and can begin creating and maintaining claims-related information on recipients, procedure codes, diagnosis codes, etc. The Reference Materials function is also available. Beginning September 14, 2003, providers can begin using NCECS-Web to submit HIPAA-compliant claims to N.C. Medicaid.

The current NCECS software for electronic claim submission is being replaced with a web-based program to comply with the implementation of data content standards required by the Health Insurance Portability and Accountability Act (HIPAA). The new claim submission program will be compatible with N.C. Medicaid only. NCECS-Web will support the Professional, Institutional, and Dental claims submission transactions.

Current NCECS software users may access the tool, using current NCECS Login ID and password, at https://webclaims.ncmedicaid.com/ncecs.

Providers interested in using NCECS-Web may contact the EDS Electronic Commerce Services Unit at 1-800-688-6696, option 1 for more information.

**Electronic Commerce Services Unit**
**EDS, 1-800-688-6696 or 919-851-8888**

# Attention: Providers and Case Managers for Community Alternatives Program Services for Disabled Adults

## Authorizations and Claims for Community Alternatives Program Services for Disabled Adults

Providers and case managers for Community Alternatives Program Services for Disabled Adults (CAP/DA) must ensure that they are providing accurate and complete information on the authorization forms for CAP/DA services, the claims reimbursement forms, and electronic claims submitted to EDS. The Division of Medical Assistance's Program Integrity Section has noted an increase in the number of discrepancies on service authorization forms completed by case managers requesting service for clients from community providers; on claims submitted by providers to case managers for review after services have been provided and before claims are submitted to EDS; and in lead agency documentation for the resolution of reimbursement issues with providers.

Case managers must sign and date the authorization form for each CAP/DA service, provide the period of service covered by the authorization (meaning the beginning and ending calendar dates), and indicate the correct service code. Authorization forms sent to in-home aide agencies must also specify the aide service tasks, the days of week for the service, and the specific times of each day the client should receive service.

Authorization forms received by providers from case managers must be reviewed carefully and any discrepancies or questions resolved with the case manager **before** the service is initiated. If there are changes to the information on the authorization form, the case manager must complete a revised authorization form correcting the erroneous information and send the revised form to the provider of the service. Providers are responsible for services as authorized on the revised form.

Reimbursement claims submitted by service providers to the CAP/DA case managers for approval must reflect the correct service codes and dates for the service that was provided. If the dates of service do not correspond with the information on the authorization form, the case manager must resolve this discrepancy with the provider **before** approving a claim and document in the case record how the matter was settled.

When completing an authorization notice, case managers are advised to "end-date" the service to correspond with the end of the month **following** the Continuing Need Review (CNR) month. This will allow client services to continue into the month following the CNR month. New service authorizations are issued by case managers once the CNR is approved by the local designated authority.

**Mary Jo Littlewood, Medical Policy Section**
**DMA, 919-857-4021**

# Attention: Providers and Case Managers for Community Alternatives Program Services for Disabled Adults

## Billing Changes for the Community Alternatives Program for Disabled Adults

Effective with date of service October 1, 2003, providers of services to recipients in the Community Alternatives Program for Disabled Adults (CAP/DA) must use new codes to bill for each service. The Division of Medical Assistance (DMA) must make these changes to comply with the implementation of the national code sets mandated by the Health Insurance Portability and Accountability Act (HIPAA). Because there are no national codes with descriptions that exactly match the existing descriptions of the CAP/DA services, providers should carefully note all of the changes involved in this conversion to the new codes. The key points include:

- The code conversion requires the use of some national codes with descriptions that may imply a change in coverage. However, there are no changes to the current CAP/DA coverage policy, service definitions or requirements. Providers must be alert to the use of the national code as it applies to CAP/DA.

- Because there are several new national codes that are used for multiple CAP programs as well as regular Medicaid services, DMA will identify CAP recipients as members of a "population group" for their specific CAP program. This is required to control and monitor billing for services. Please see **Population Groups** below for details.

- There will be only one code for CAP/DA In-Home Aide Services. Providers will no longer bill for the separate levels of in-home aide services. CAP/DA plans of care and service authorizations will list only "CAP/DA In-Home Aide Services." Provider agencies are responsible for providing the appropriate level of aide to meet the needs identified by the case manager.

- There are separate codes for each type of waiver supply. Please note that the codes for enteral formulae must be billed with modifier "BO" to denote that the supplement was administered by mouth.

**Population Groups**

DMA implemented population groups in 2001 to designate, control, and track specific benefit packages for designated groups of Medicaid recipients. Providers may be familiar with the population groups related to Carolina ACCESS. For a provider, population groups mean two things:

1. In order to provide services to the CAP/DA population group, agencies must be enrolled specifically as CAP/DA providers. DMA Provider Services will automatically enroll current CAP providers into the appropriate CAP population group(s). Please refer to your enrollment records to confirm which CAP services you are enrolled to provide. If you have questions, please contact DMA Provider Services at 919-857-4017.

2. The Remittance and Status Report (RA) provides information by population group. The population payer code is printed at the beginning of each claim detail line on the RA. The code denotes the special program/population group from which a recipient is receiving Medicaid benefits. The payer code for CAP/DA is "CAPDA."

**End-Dated Codes**
The following codes will be end-dated for dates of service after September 30, 2003.

| Code | Description |
|---|---|
| W8102 | CAP/DA Case Management 1/4 Hour |
| W8116 | CAP/DA Respite Care Non-Institutional |
| W8117 | CAP/DA Respite Care Institutional |
| W8104 | CAP/DA Adult Day Health Care |
| W8127 | CAP/DA Telephone Alert |
| W8141 | CAP/DA In-Home Aide Level II |
| W8142 | CAP/DA In-Home Aide Level III Personal Care |
| W8137 | CAP/DA Waiver Supplies |
| W8125 | CAP/DA Preparation and Delivery of Meals |
| W8112 | CAP/DA Home Mobility Aids |

**New Codes**
Effective with date of service October 1, 2003, CAP/DA providers must use the following codes to bill for CAP/DA services. However, the national code descriptions listed in the following table do not change or expand the existing CAP/DA service descriptions. The RA will list the national code description.

| When billing for… | Use this code… | Maximum Reimbursement Rate |
|---|---|---|
| CAP/DA Case Management | T1016 Case management, each 15 minutes | $ 10.64 |
| CAP/DA Respite Care Non-Institutional | S5150 Unskilled respite care, not hospice, each 15 minutes | 3.48 |
| CAP/DA Respite Care Institutional | H0045 Respite care services, not in the home, per diem | 113.91 |
| CAP/DA Adult Day Health Care | S5102 Adult day care services, per diem | 36.51 |
| CAP/DA Telephone Alert | S5161 Emergency response system, per month service fee | 29.67 |
| CAP/DA In-Home Aide (Level II and Level III-Personal Care) | S5125 Attendant care services, per 15 minutes | 3.48 |
| Reusable Incontinence Undergarments | T1500 Diaper/incontinent pant, reusable/washable, any size, each | 22.36 |
| Disposable Liners for Reusable Incontinence Undergarments | S8409 Disposable liner/shield for incontinence, each | 0.34 |

| When billing for… | Use this code… | Maximum Reimbursement Rate |
|---|---|---|
| Nutritional Supplements Taken by Mouth When Ordered by Physician | B4150 BO Enteral formulae; category I; semi-synthetic intact protein/protein isolates, 100 calories = 1 unit<br>[National code modifier BO denotes administered by mouth] | $ 0.58 |
| | B4151 BO Enteral formulae; category I; natural intact protein/protein isolates, 100 calories = 1 unit<br>[National code modifier BO denotes administered by mouth] | 1.37 |
| | B4152 BO Enteral formulae; category II; intact protein/protein isolates (calorically dense), 100 calories = 1 unit<br>[National code modifier BO denotes administered by mouth] | 0.49 |
| | B4153 BO Enteral formulae; category III; hydrolyzed protein/amino acids, 100 calories = 1 unit<br>[National code modifier BO denotes administered by mouth] | 1.66 |
| | B4154 BO Enteral formulae; category IV; defined formula for special metabolic need, 100 calories = 1 unit<br>[National code modifier BO denotes administered by mouth] | 1.07 |
| | B4155 BO Enteral formulae; category V; modular components, 100 calories = 1 unit<br>[National code modifier BO denotes administered by mouth] | 0.83 |
| | B4156 BO Enteral formulae; category VI; standardized nutrients, 100 calories = 1 unit<br>[National code modifier BO denotes administered by mouth] | 1.18 |
| Medication Dispensing Boxes | T2028 Specialized supply, not otherwise specified, waiver | 11.71 |
| CAP/DA Preparation and Delivery of Meals | S5170 Home delivered meals including preparation, each meal | 3.14 |
| CAP/DA Home Mobility Aids | S5165 Home modifications, per service | 1,500.00 |

**Billing Instruction Change for Waiver Supplies**
Providers must list each type of supply for which they are billing separately in block 24 on the CMS-1500. This change affects the following:

**24A. DATES OF SERVICE, FROM/ TO:** Enter the date that the supply is provided to the client in the FROM block. Enter the same date in the TO block.

**24D. PROCEDURES, SERVICES OR SUPPLIES:** Enter the appropriate HCPCS code for the supply item.

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

**24G. DAYS OR UNITS:** Enter the number of units provided on the date of service.

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

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

# Attention: Providers and Case Managers for Community Alternatives Program Services for Children

## Billing Changes for the Community Alternatives Program for Children

Effective with date of service October 1, 2003, providers of services to recipients in the Community Alternatives Program for Children (CAP/C) must use new codes to bill for each service. The Division of Medical Assistance (DMA) must make these changes to comply with the implementation of the national code sets mandated by the Health Insurance Portability and Accountability Act (HIPAA). Because there are no national codes with descriptions that exactly match the existing descriptions of the CAP/C services, providers should carefully note all the changes involved in this conversion to the new codes. The key points include:

- The code conversion requires the use of some national codes with descriptions that may imply a change in coverage. However, there are no changes to the current CAP/C coverage policy, service definitions or requirements. Providers must be alert to the use of the national code as it applies to CAP/C.

- Because there are several new national codes that are used for multiple CAP programs as well as regular Medicaid services, DMA will identify CAP recipients as members of a "population group" for their specific CAP program. This is required to control and monitor billing for services. Please see **Population Groups** below for details.

- There is only one code for CAP/C In-Home Aide Services. Provider agencies are responsible for providing the appropriate level of aide to meet the needs identified by the case manager.

- There are separate codes for each type of waiver supply. Please note that the codes for enteral formulae must be billed with modifier "BO" to denote that the supplement was administered by mouth.

**Population Groups**
DMA implemented population groups in 2001 to designate, control, and track specific benefit packages for designated groups of Medicaid recipients. Providers may be familiar with the population groups related to Carolina ACCESS. For a provider, population groups mean two things:

1. In order to provide services to the CAP/C population group, agencies must be enrolled specifically as CAP/C providers. DMA Provider Services will automatically enroll current CAP providers into the appropriate CAP population group(s). Please refer to your enrollment records to confirm which CAP services you are enrolled to provide. If you have questions, please contact DMA Provider Services at 919-857-4017.

2. The Remittance and Status Report (RA) provides information by population group. The population payer code is printed at the beginning of each claim detail line on the RA. The code denotes the special program/population group from which a recipient is receiving Medicaid benefits. The payer code for CAP/C is "CAPCH."

**End-Dated Codes**
The following codes will be end-dated for dates of service after September 30, 2003.

| Code | Description |
|---|---|
| W8146 | CAP/C Case Management 1/4 Hour |
| W8145 | CAP/C Respite Care In-Home |
| W8154 | CAP/C Respite Care- Institutional |
| W8139 | CAP/C Nursing Services |
| W8143 | CAP/C Personal Care |
| W8148 | Home Mobility Aids (wheelchair ramps, safety rails, non-skid surfaces [rough surfaced strips of adhesive material that adhere to non-carpeted areas such as concrete, linoleum, wood, tile, porcelain, or fiberglass], handheld showers, grab bars and widening of doorways for wheelchair access) |
| W8150 | CAP/C Waiver Supplies (reusable incontinence undergarments, disposable liners for reusable incontinence undergarments, and nutritional supplements taken by mouth when ordered by a physician) |

**New Codes**
Effective with the date of service October 1, 2003, CAP/C providers must use the following codes to bill for CAP/C services. The national code descriptions listed in the following table do not change or expand the existing CAP/C service descriptions. The RA will list the national code description.

| When billing for… | Use this code… | Maximum Reimbursement Rate |
|---|---|---|
| CAP/C Case Management | T1016 Case management, each 15 minutes | $ 10.64 |
| CAP/C Respite Care In-Home | S5150 Unskilled respite care, not hospice, each 15 minutes | 3.48 |
| CAP/C Respite Care Institutional | H0045 Respite care services, not in the home, per diem | 941.80 |
| CAP/C Nursing Services | T1000 Private Duty/Independent nursing service(s) – licensed, up to 15 minutes | 8.84 |
| CAP/C Personal Care | S5125 Attendant care services, per 15 minutes | 3.48 |
| Reusable Incontinence Undergarments | T1500 Diaper/incontinent pant, reusable/washable, any size, each | 22.36 |
| Disposable Liners for Reusable Incontinence Undergarments | S8409 Disposable liner/shield for incontinence, each | 0.34 |

| When billing for… | Use this code… | Maximum Reimbursement Rate |
|---|---|---|
| Nutritional Supplements Taken by Mouth When Ordered by a Physician | B4150 BO Enteral formulae; category I; semi-synthetic intact protein/protein isolates, 100 calories = 1 unit<br>[National modifier BO denotes administered by mouth] | $ 0.58 |
| | B4151 BO Enteral formulae; category I; natural intact protein/protein isolates, 100 calories = 1 unit<br>[National modifier BO denotes administered by mouth] | 1.37 |
| | B4152 BO Enteral formulae; category II; intact protein/protein isolates (calorically dense), 100 calories = 1 unit<br>[National modifier BO denotes administered by mouth] | 0.49 |
| | B4153 BO Enteral formulae; category III; hydrolized protein/amino acids, 100 calories = 1 unit<br>[National modifier BO denotes administered by mouth] | 1.66 |
| | B4154 BO Enteral formulae; category IV; defined formula for special metabolic need, 100 calories = 1 unit<br>[National modifier BO denotes administered by mouth] | 1.07 |
| | B4155 BO Enteral formulae; category V; modular components, 100 calories = 1 unit<br>[National modifier BO denotes administered by mouth] | 0.83 |
| | B4156 BO Enteral formulae; category VI; standardized nutrients, 100 calories = 1 unit<br>[National modifier BO denotes administered by mouth] | 1.18 |
| CAP/C Home Mobility Aids | S5165 Home modifications, per service | 1,500.00 |

**Note:** Please continue to use W9934 to bill Enteral Formula Pediatric; Infant and Toddler; Semi-Synthetic Intact Protein and Protein Isolates (Calorically Dense), which includes: Enfamil Premature Formula, Enfamil Premature Formula w/Iron, Neosure, Similac PM, Similac Special Care, Similac Special Care w/Iron.

**Billing Instruction Change for Waiver Supplies**

Providers must list each type of supply that they are billing for separately in block 24 on the CMS-1500. This change affects the following:

**24A. DATES OF SERVICE, FROM/TO:** Enter the date that the supply is provided to the client in the FROM block. Enter the same date in the TO block.

**24D. PROCEDURES, SERVICES or SUPPLIES:** Enter the appropriate HCPCS code for the supply item.

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

**24G. DAYS or UNITS:** Enter the number of units provided on the date of service.

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

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

# Attention: Providers and Case Managers for Community Alternatives Program Services for Persons with AIDS

## Billing Changes for the Community Alternatives Program for Persons with AIDS

Effective with date of service October 1, 2003, providers of services to recipients in the Community Alternatives Program for Persons with AIDS (CAP/AIDS) must use new codes to bill for each service. The Division of Medical Assistance (DMA) must make these changes to comply with the implementation of the national code sets mandated by the Health Insurance Portability and Accountability Act (HIPAA). Because there are no national codes with descriptions that exactly match the existing descriptions of the CAP/AIDS services, providers should carefully note all of the changes involved in this conversion to the new codes. The key points include:

- The code conversion requires the use of some national codes with descriptions that may imply a change in coverage. However, there are no changes to the current CAP/AIDS coverage policy, service definitions or requirements. Providers must be alert to the use of the national code as it applies to CAP/AIDS.

- Because there are several new national codes that are used for multiple CAP programs as well as regular Medicaid services, DMA will identify CAP recipients as members of a "population group" for their specific CAP program. This is required to control and monitor billing for services. Please see **Population Groups** below for details.

- There will be only one code for CAP/AIDS In-Home Aide Services. Providers will no longer bill for the separate levels of in-home aide services. CAP/AIDS plans of care and service authorizations will list only "CAP/AIDS In-Home Aide Services." Provider agencies are responsible for providing the appropriate level of aide to meet the needs identified by the case manager.

- There are separate codes for each type of waiver supply. Please note that the codes for enteral formulae must be billed with modifier "BO" to denote that the supplement was administered by mouth.

- There is only one code for CAP/AIDS Respite Care Non-institutional Nurse Level services. Please note that the code must be billed with modifier "TD" to indicate that the service was provided by an RN or with modifier "TE" to indicate that the service was provided by an LPN.

**Population Groups**

DMA implemented population groups in 2001 to designate, control, and track specific benefit packages for designated groups of Medicaid recipients. Providers may be familiar with the population groups related to Carolina ACCESS. For a provider, population groups mean two things:

1. In order to provide services to the CAP/AIDS population group, agencies must be enrolled specifically as CAP/AIDS providers. DMA Provider Services will automatically enroll current CAP providers into the appropriate CAP population group(s). Please refer to your enrollment records to confirm which CAP services you are enrolled to provide. If you have questions, please contact DMA Provider Services at 919-857-4017.

2. The Remittance and Status Report (RA) provides information by population group. The population payer code is printed at the beginning of each claim detail line on the RA. The code denotes the special program/population group from which a recipient is receiving Medicaid benefits. The payer code for CAP/AIDS is "CAPAI."

**End-Dated Codes**
The following codes will be end-dated for dates of service after September 30, 2003.

| Code | Description |
|---|---|
| W8166 | CAP/AIDS Case Management 1/4 Hour |
| W8167 | CAP/AIDS Respite Care Non-Institutional, Aide Level |
| W8168 | CAP/AIDS Respite Care Non-Institutional, Nurse Level |
| W8169 | CAP/AIDS Respite Care Institutional |
| W8170 | CAP/AIDS Adult Day Health Care |
| W8171 | CAP/AIDS Personal Emergency Response System |
| W8172 | CAP/AIDS In-Home Aide Level II |
| W8173 | CAP/AIDS In-Home Aide Level III Personal Care |
| W8175 | CAP/AIDS Waiver Supplies |
| W8174 | CAP/AIDS Preparation And Delivery of Meals |
| W8176 | CAP/AIDS Home Mobility Aids |

**New Codes**
Effective with date of service October 1, 2003, CAP/AIDS providers must use the following codes to bill for CAP/AIDS services. However, the national code descriptions listed in the following table do not change or expand the existing CAP/AIDS service descriptions. The RA will list the national code description.

| When billing for… | Use this code… | Maximum Reimbursement Rate |
|---|---|---|
| CAP/AIDS Case Management | T1016 Case management, each 15 minutes | $ 10.64 |
| CAP/AIDS Respite Care Non-Institutional Aide Level | S5150 Unskilled respite care, not hospice, each 15 minutes | 3.48 |
| CAP/AIDS Respite Care Non-Institutional Nurse Level | T1005 TD Respite care services, up to 15 minutes-RN<br>[National code modifier TD denotes service provided by RN] | 8.84 |
| | T1005 TE Respite care services, up to 15 minutes-LPN<br>[National code modifier TE denotes service provided by LPN] | 8.84 |
| CAP/AIDS Respite Care Institutional | H0045 Respite care services, not in the home, per diem | 113.91 |
| CAP/AIDS Adult Day Health Care | S5102 Adult day care services, per diem | 36.51 |
| CAP/AIDS Personal Emergency Response System | S5161 Emergency response system, per month service fee | 29.67 |

| When billing for… | Use this code… | Maximum Reimbursement Rate |
|---|---|---|
| CAP/AIDS In-Home Aide (Level II and Level III-Personal Care) | S5125 Attendant care services, per 15 minutes | $ 3.48 |
| Reusable Incontinence Undergarments | T1500 Diaper/incontinent pant, reusable/washable, any size, each | 22.36 |
| Disposable Liners for Reusable Incontinence Undergarments | S8409 Disposable liner/shield for incontinence, each | 0.34 |
| Nutritional Supplements Taken by Mouth When Ordered by Physician | B4150 BO Enteral formulae; category I; semi-synthetic intact protein/protein isolates, 100 calories = 1 unit<br>[National code modifier BO denotes administered by mouth] | 0.58 |
| | B4151 BO Enteral formulae; category I; natural intact protein/protein isolates, 100 calories = 1 unit<br>[National code modifier BO denotes administered by mouth] | 1.37 |
| | B4152 BO Enteral formulae; category II; intact protein/protein isolates (calorically dense), 100 calories = 1 unit<br>[National code modifier BO denotes administered by mouth] | 0.49 |
| | B4153 BO Enteral formulae; category III; hydrolyzed protein/amino acids, 100 calories = 1 unit<br>[National code modifier BO denotes administered by mouth] | 1.66 |
| | B4154 BO Enteral formulae; category IV; defined formula for special metabolic need, 100 calories = 1 unit<br>[National code modifier BO denotes administered by mouth] | 1.07 |
| | B4155 BO Enteral formulae; category V; modular components, 100 calories = 1 unit<br>[National code modifier BO denotes administered by mouth] | 0.83 |
| | B4156 BO Enteral formulae; category VI; standardized nutrients, 100 calories = 1 unit<br>[National code modifier BO denotes administered by mouth] | 1.18 |
| Medication Dispensing Boxes | T2028 Specialized supply, not otherwise specified, waiver | 11.71 |
| CAP/AIDS Preparation and Delivery of Meals | S5170 Home delivered meals including preparation, each meal | 3.14 |
| CAP/AIDS Home Mobility Aids | S5165 Home modifications, per service | 1,500.00 |

**Billing Instruction Change for Waiver Supplies**
Providers must list each type of supply for which they are billing separately in block 24 on the CMS-1500. This change affects the following:

**24A. DATES OF SERVICE, FROM/TO:** Enter the date that the supply is provided to the client in the FROM block. Enter the same date in the TO block.

**24D. PROCEDURES, SERVICES OR SUPPLIES:** Enter the appropriate HCPCS code for the supply item.

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

**24G. DAYS OR UNITS:** Enter the number of units provided on the date of service.

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

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

## Attention: Prescribers and Pharmacists

## Days Supply on Pharmacy Claims

Effective October 1, 2003, Medicaid recipients will be able to obtain a 90-day supply of a medication if the claim is for a generic, non-controlled, maintenance medication and they have had a previous 30-day fill of the same medication. This will be at the sole discretion of the recipient's health care provider. The claim must also pay at either the Federal or State MAC rate for a 90-day supply to be allowed. If the product is deleted from the MAC list, then the recipient will only be able to obtain a 34-day supply. Only one copay will be collected and only one dispensing fee will be paid for the 90-day supply.

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

# Attention: All Providers

## General Medicaid Billing Seminar Schedule

General Medicaid Billing seminars are scheduled for September 2003. Seminars are intended for providers who are new to the N.C. Medicaid program. Topics to be discussed will include, but are not limited to, provider enrollment requirements, billing instructions, eligibility issues, and Managed Care, including Carolina ACCESS and HMOs. Persons inexperienced in billing N.C. Medicaid are encouraged to attend.

Seminars on General Medicaid Billing are scheduled at the locations listed below. **Preregistration is required.** Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

Providers may register for the General Medicaid Billing seminars by completing and submitting the registration form on page 30 or by registering online beginning August 1, 2003 at http://www/dhhs/state.nc.us/dma/provsem.htm. Please indicate on the registration form the session you plan to attend. 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.

Providers must print the PDF version of the August 2003 *General Medicaid Billing/Carolina ACCESS Policies and Procedures Guide* from DMA's website at http://www.dhhs.state.nc.us/dma/medbillcaguide.htm and bring it to the seminar.

**Tuesday, September 9, 2003**
WakeMed
Andrews Conference Center
3000 New Bern Ave.
Raleigh, NC

**Wednesday, September 10, 2003**
Ramada Inn Plaza
3050 University Parkway
Winston-Salem, NC

**Tuesday, September 16, 2003**
Holiday Inn Conference Center
530 Jake Alexander Blvd., S.
Salisbury, NC

**Thursday, September 18, 2003**
Blue Ridge Community College
Bo Thomas Auditorium
College Drive
Flat Rock, NC

**Tuesday, September 23, 2003**
Coast Line Convention Center
501 Nutt Street
Wilmington, NC

**Thursday, September 25, 2003**
Martin Community College
Auditorium
Kehakee Park Road
Williamston, NC

Directions to the General Medicaid Billing seminars are on page 29.

The registration form for the General Medicaid Billing seminars is on page 30.

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

# Directions to the General Medicaid Billing Seminars

***Blue Ridge Community College, Bo Thomas Auditorium – 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. Take the first right-hand turn into the parking lot for the Bo Thomas Auditorium.

***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.

***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.

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

***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.

***WakeMed 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).

# Registration form for the General Medicaid Billing Seminars

(cut and return registration form only)

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**General Medicaid Seminars**
(No Fee)

Provider Name _____ Provider Number _____

Address _____

City, Zip Code _____ County _____

Contact Person _____ E-mail Address _____

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

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

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

# Attention: Area Mental Health Centers and Residential Child Care Treatment Providers for Levels II through IV

## Area Mental Health and Residential Child Care Treatment Seminar Schedule

Area Mental Health and Residential Child Care Treatment seminars are scheduled for September 2003. Seminars are intended for providers who provide mental health services to enrollees at area mental health centers or residential child care treatment facilities. The seminars will consist of two service-specific sessions and will focus on the claim filing process, obtaining authorization, and Y code conversions to standard national codes as mandated by the Health Insurance Portability and Accountability Act (HIPAA).

The Area Mental Health and Residential Child Care Treatment seminars are scheduled at the locations listed below. Due to limited seating, **preregistration is required** and limited to two staff members per office. Unregistered providers are welcome to attend if space is available. Providers may register for the Area Mental Health and Residential Child Care Treatment seminars by completing and submitting the registration form on page 33, or by registering online beginning August 1, 2003 at http://www.dhhs.state.nc.us/dma/provsem.htm. Please indicate on the registration form the session(s) you plan to attend.

The morning session on Area Mental Health begins at 9:30 a.m. and ends at 12:00 p.m. Providers are encouraged to arrive by 9:15 a.m. to complete registration. The afternoon session on Residential Child Care Treatment begins at 1:00 p.m. and ends at 3:30 p.m. Providers are encouraged to arrive by 12:45 p.m. to complete registration. Lunch will not be provided.

Providers must access and print the PDF version of the August 2003 Special Bulletin III, *HIPAA Code Conversions* from DMA's website at http://www.dhhs.state.nc.us/dma/bulletin.htm and bring it to the seminar.

**Tuesday, September 2, 2003**
Hilton Greenville
207 Greenville Boulevard SW
Greenville, NC

**Wednesday, September 3, 2003**
Park Inn
Gateway Conference Center
909 US Highway 70 SW
Hickory, NC

**Thursday, September 4, 2003**
Blue Ridge Community College
Bo Thomas Auditorium
College Drive
Flat Rock, NC

**Friday, September 5, 2003**
Jane S. McKimmon Center
1101 Gorman Street
Raleigh, NC

Directions to the Area Mental Health and Residential Child Care Treatment seminars are on page 32.

The registration form for the Area Mental Health and Residential Child Care Treatment seminars is on page 33.

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

## Directions to the Area Mental Health and Residential Child Care Treatment Seminars

***Blue Ridge Community College, Bo Thomas Auditorium – 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. Take the first right-hand turn into the parking lot for the Bo Thomas Auditorium.

***Hilton Greenville – 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.

***Jane S. 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 on the corner of Gorman Street 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.

***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.

# Registration form for the Area Mental Health and Residential Child Care Treatment Seminars

(cut and return registration form only)

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**Area Mental Health and Residential Child Care Treatment Seminars**
(No Fee)

Provider Name _____ Provider Number _____

Address _____

City, Zip Code _____ County _____

Contact Person _____ E-mail Address _____

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

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

Check the box for the session(s) you will be attending

☐ Morning Session
(Area Mental Health)

☐ Afternoon Session
(Residential Child Care Treatment)

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

## Checkwrite Schedule

| | | |
|---|---|---|
| August 12, 2003 | September 3, 2003 | October 7, 2003 |
| August 19, 2003 | September 9, 2003 | October 14, 2003 |
| August 28, 2003 | September 16, 2003 | October 21, 2003 |
| | | October 30, 2003 |

## Electronic Cut-Off Schedule

| | | |
|---|---|---|
| August 8, 2003 | September 5, 2003 | October 3, 2003 |
| August 15, 2003 | September 12, 2003 | October 10, 2003 |
| August 22, 2003 | | October 17, 2003 |
| August 29, 2003 | | October 24, 2003 |

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

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

Patricia MacTaggart
Executive Director
EDS

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