North Carolina Medicaid Bulletin

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

Number 8 August 2004

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

Attention: All Providers

Updated EOB Code Crosswalk to HIPAA Standard Codes

The list of standard national codes used on the Electronic Remittance Advice (ERA) has been cross-walked to EOB codes as an informational aid to adjudicated claims listed on the RA. An updated version of the list is available on the Division of Medical Assistance's website at http://www.dhhs.state.nc.us/dma/prov.htm.

With the implementation of standards for electronic transactions mandated by the Health Insurance Portability and Accountability Act (HIPAA), providers now have the option to receive an ERA in addition to the paper version of the Remittance and Status Report (RA).

The EOB codes that providers currently receive on a paper RA are not used on the ERA. Because the EOB codes on the paper RA provide a greater level of detail on claim denials, all providers will continue to receive the paper version of the RA, even if they choose to receive the ERA transaction. The list is current as of the date of publication. Providers will be notified of changes to the list through the general Medicaid bulletin.

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

Attention: All Providers

NCMMIS Update

ACS is currently working with the State to review the new North Carolina Medicaid Management Information System (NCMMIS) business requirements that will best meet North Carolina's needs. As mentioned in last month's bulletin, we will be soliciting provider participation in testing the system next year as we prepare for implementation in June 2006.

ACS is using many components of their recently-certified Mississippi MMIS to customize for use in North Carolina. The NCMMIS will be called **NCLeads**. One Mississippi provider, Mr. Jamey Boudreaux, Executive Director of the Louisiana-Mississippi Hospice and Palliative Care Organization, has this to say about Mississippi's MMIS:

> "ACS has been very responsive in terms of trying to resolve issues – much more responsive than other states. I get calls from Fred Hinds [ACS Account Manager] on a regular basis and I know when I attend national meetings, other directors do not have that kind of relationship or response from their fiscal intermediaries."

Remember – while you can continue to submit claims using any current method(s) with the new system, you can also enter and adjudicate claims online ("real time" processing instead of overnight processing) in the new system. If you have questions about the **NCLeads** implementation, please e-mail ncmmis.provider@ncmail.net.

Thomas Liverman, NCMMIS Provider Relations
919-855-3112

A Word from ACS

In June 2006, North Carolina will "go live" with a new Medicaid Management Information System (MMIS) developed and managed by Affiliated Computer Services (ACS). The change to ACS not only enables the development of a modern, efficient, and cost effective technology system for the State, but also means improvements in the way providers interact with the Medicaid program.

ACS understands that there is often apprehension and concern about the quality and efficiency of service when changing MMIS systems and vendors. This situation is particularly understandable due to the longevity of the current vendor. EDS has been the N.C. Medicaid claims processing provider for nearly three decades, and many of you have come to rely on their service. You have my commitment that we will work closely and collaboratively with our EDS counterparts to ensure that you receive uninterrupted service throughout the transition to the new system. While there are normally challenges during the deployment of a new and large system, my pledge to you is that we will be responsive to your concerns and issues and will work diligently to quickly address them as they arise.

ACS is a national leader in Medicaid claims processing. We process 400 million health claims a year worth $50 billion in payments to several hundred thousand healthcare providers in 12 states and the District of Columbia.

ACS, in partnership with the state of North Carolina, is committed to building on a legacy of excellence in delivering the highest level of service to the State's Medicaid recipients and providers. As the North Carolina Medicaid claims processor, ACS will be accountable to manage nearly 90 million healthcare claims a year worth more than $7 billion in payments to 65,000 health providers across the State. We take the responsibility for providing the system that serves 1.3 million North Carolinians very seriously.

Please know that one of our primary objectives is to ensure that the North Carolina provider community is ready for the new system and that the new system processes claims in an accurate and timely manner. To keep you informed of our progress over the next two years, we will be using a number of communication methods, including the general Medicaid bulletin. In future editions of this newsletter, ACS will be providing you information about the status of the new system, the features and benefits it will offer providers and the State, and other related matters that will keep you up-to-date on this important project.

We will also be telling you about ways you can become actively involved in the evaluation of the system prior to implementation. Specifically, we will need a wide variety of providers to participate in system testing. Be on the lookout for additional information on this topic in future newsletter features.

We are excited about this opportunity and look forward to working with you—not only during the transition period but also after implementation of the new North Carolina Medicaid claims processing system.

Joe Wewerka
ACS Account Manager

About Joe Wewerka
Joe Wewerka brings more than 35 years of experience to the North Carolina Medicaid claims processing project and has been with ACS since 1998. Before joining ACS, he spent 29 years at EDS. He has lived in North Carolina for more than 20 years and directed EDS' North Carolina Medicaid work for four years.

Attention: Ambulatory Surgical Centers, Hospitals, and Physicians

Deflux Injectable Gel for the Treatment of Vesicoureteral Reflux – Coverage Notice

The N.C. Medicaid program is in the process of implementing system changes to allow providers to submit claims for reimbursement for Deflux, an FDA approved injectable gel indicated for the treatment of children with grades II through IV vesicoureteral reflux.

Providers will be notified of the implementation date and of detailed billing instructions in an upcoming general Medicaid bulletin.

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

Attention: Community Alternatives Program Case Managers

Reimbursement Rate Increase for Case Management

Effective with date of service July 1, 2004, the Medicaid maximum reimbursement rate for CAP/AIDS, CAP/C, and CAP/DA case management is $13.82 per 15-minute unit.

Providers must continue to bill their usual and customary charges.

Robyn Slate, Financial Operations
DMA, 919-857-4015

Attention: All Providers

Medicare Crossovers

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

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

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

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

Medicare Crossover Reference Request

Provider Name: _____

Contact Person (required): _____ Telephone (required): _____

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

Medicare Part A Intermediaries

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

Medicare Part B Carrier

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

Medicare Regional DMERC

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

*Trading Partners currently in testing phase.

Action to be taken:

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

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

Medicare Provider number: _____ Medicaid Provider number: _____

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

PVS002 Revised 07/04

Attention: Dental Providers and Health Departments Dental Clinics

Dental Seminar Schedule

Seminars for dental providers are scheduled for September 2004. This seminar will focus on upcoming changes to the clinical coverage policy for dental services and will include guidelines for completing the ADA claim form, changes in covered procedure codes, the most common denials for dental claims, and other general Medicaid issues. Medicaid billing personnel, supervisors, and office managers are encouraged to attend.

The seminars will 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. Lunch will not be provided at the seminars. 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 seminars by completing and submitting the registration form on page 7 or by registering online at http://www.dhhs.state.nc.us/dma/provsem.htm. Please indicate on the registration form the session you plan to attend.

Special Bulletin VI, *Dental Services Coverage Policy and Billing Guidelines*, will be used as the primary training document for the seminar. The special bulletin will be available on DMA's website beginning September 1, 2004 at http://www.dhhs.state.nc.us/dma/bulletin.htm. Please print the special bulletin and bring it to the seminar.

Because the seminar also will briefly address the general Medicaid billing guidelines, providers may wish to bring a copy of the *General Medicaid Billing/Carolina ACCESS Policies and Procedures Guide* (http://www.dhhs.state.nc.us/dma/medbillcaguide.htm) to the seminar.

Wednesday, September 8, 2004
Jane S. McKimmon Center
1101 Gorman Street
Raleigh, NC

Tuesday, September 28, 2004
Coast Line Convention Center
501 Nutt Street
Wilmington, NC

Thursday, September 23, 2004
Park Inn Gateway Conference Center
909 Highway 70 SW
Hickory, NC

Thursday, September 30, 2004
Holiday Inn Conference Center
530 Jake Alexander Blvd., S
Salisbury, NC

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

Directions to the Dental Seminars

Jane S. McKimmon Center – Raleigh
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 at 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 at the corner of Gorman Street and Western Boulevard.

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

Coast Line Convention Center – Wilmington
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
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.

(cut and return the registration form only)

Dental Seminar Registration Form
(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: Durable Medical Equipment Providers

Addition of HCPCS Code E1161 to the DME Fee Schedule

HCPCS code E1161, "manual adult size wheelchair, includes tilt-in space" was added to the Capped Rental category of the DME Fee Schedule effective with date of service January 1, 2004. The maximum reimbursement rates are:

- $236.61 for monthly rental
- $2366.09 for new purchase
- $1774.59 for used purchase

The lifetime expectancy is three years. Prior approval is required. The medical coverage criteria are the same as those for a standard manual wheelchair base and the tilt in space component. Thus, the criteria are as follows:

- the recipient's condition is such that without the use of a wheelchair the recipient would otherwise be bed- or chair-confined; and
- the recipient's medical status/diagnosis is such that the recipient requires tilt-in space for proper positioning during daily activities, such as eating; or
- the tilt-in space feature is required to facilitate improved postural control or spinal alignment or to preserve skin integrity if the recipient is unable to actively change his/her upright seating position; or
- the tilt-in space feature is required because the recipient's respiratory status is so compromised that the tilting feature allows significantly improved pulmonary function; and
- the recipient must spend at least four hours per day in the wheelchair to qualify for the tilt-in space feature.

The documentation requirements are the same for requests to renew approval.

Clinical Coverage Policy #5, *Durable Medical Equipment*, has been updated to reflect this change.

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

Attention: Hospital Providers

Correct Billing of Inpatient Hospital Transfers

This billing reminder is to help that ensure hospitals are filing their claims correctly according to North Carolina Administrative Code and Medicaid policy to help eliminate overpayment to hospitals. A report from the Office of Inspector General (OIG) dated October 8, 2003, indicated a $2,984,289 overpayment to hospitals because of improper coding of discharge/transfers of patients. It was noted in the report that transferred patients were incorrectly coded as discharged patients. The report included a recommendation that the Division of Medical Assistance (DMA) notify and train all hospitals on the proper method of billing Prospective Payment Systems (PPS) transfers. Based on this recommendation, in November 2003, DMA sent a letter to hospital administrators asking them to evaluate their billing systems and to implement appropriate internal processing systems to include audits to identify transfers. This internal processing system should help hospitals to edit their claims before they are submitted to Medicaid. The letter also reminded hospitals that Medical Review of North Carolina will continue to conduct appropriate post-payment audits of inpatient hospital transfers throughout the State.

General acute care inpatient hospital claims (excluding inpatient psychiatric and rehabilitation services) are reimbursed by Diagnosis Related Grouping (DRG) Rate Setting Methodology in accordance with 10A NCAC 22G.0200 and the State Medicaid Plan. The N.C. Administrative Code is available online at http://www.ncoah.com/rules. The State Medicaid Plan is available on DMA's website at http://www.dhhs.state.nc.us/dma/sp.htm.

Refer to the following guidelines from Section 8 of the N.C. Medicaid Hospital Services Manual when billing for hospital transfers. (The *N.C. Medicaid Hospital Services Manual* is available online at http://www.dhhs.state.nc.us/dma/hospita.htm.)

Prorated DRG
When patients must be transferred from one acute care facility to another, both the transferring facility and the receiving facility will be paid. The transferring facility is entitled to a prorated DRG amount. If the required days of the acute care stay are greater than or equal to the average length of stay assigned for the DRG, the transferring facility is eligible for the entire amount. If the required days of the acute care stay do not exceed the average length of stay assigned for the DRG, the prorated payment is calculated this way:

> *DRG prorated payment = [(DRG payment x Actual Length of Stay) / DRG Average Length of Stay]*

The receiving facility will receive the usual DRG payment unless the patient is transferred again.

Note: Patient status (Block 22) must reflect "02," patient transfer.

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

Attention: Nursing Facility Providers

Nursing Facility Level of Care Billing

After June 1, 2004, nursing facility (NF) reimbursements will only be approved at the NF-level of care. Claims for residents approved at the NF-level of care must be billed using the provider's current skilled nursing facility (SNF) provider number and skilled level bill type. If the FL-2 was approved prior to June 1, 2004, the provider must bill using the level of care approved on the FL-2. For example, if the resident was approved at the intermediate care facility (ICF) level of care, then the provider must use their ICF provider number and the ICF bill type. If the resident was approved at the SNF level of care, then the provider must use their SNF provider number and the SNF bill type.

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

Attention: Hospitals and Physicians

Essure Permanent Sterilization Procedure – Coverage Notice

The N.C. Medicaid program is in the process of implementing system changes to allow providers to submit claims for reimbursement for Essure, the permanent hysteroscopic sterilization procedure.

Providers will be notified of the implementation date and of detailed billing instructions in an upcoming general Medicaid bulletin.

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

Proposed Medical Coverage Policies

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

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

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

Checkwrite Schedule

August 10, 2004	September 8, 2004	October 5, 2004
August 17, 2004	September 14, 2004	October 12, 2004
August 26, 2004	September 23, 2004	October 19, 2004

Electronic Cut-Off Schedule

August 6, 2004	September 3, 2004	October 1, 2004
August 13, 2004	September 10, 2004	October 8, 2004
August 20, 2004	September 17, 2004	October 15, 2004

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

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

Cheryll Collier
Executive Director
EDS