Number 8 *August 1999*

North Carolina Medicaid Bulletin

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

Attention: All Providers

Holiday Observance

The Division of Medical Assistance (DMA) and EDS will be closed on Monday, September 6, 1999, in observance of Labor Day.

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

Attention: All Carolina ACCESS Primary Care Providers

Revision of the Carolina ACCESS Emergency Room Reimbursement Policy

The Carolina ACCESS Emergency Room Reimbursement Policy establishes criteria for Medicaid reimbursement of emergency room services. Effective May 1, 1999, the policy was rewritten to clarify the covered services, and the ICD-9 Code List for Identified Emergencies has been expanded. The policy also includes procedures for claims payment through the retrospective medical record review process. Refer to page 14.

Contact Carolina ACCESS at (919) 857-4022 for additional copies or questions regarding the policy.

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1999 SPECIAL OLYMPICS WORLD SUMMER GAMES VOLUNTEERS

We want to thank the physicians, nurses, nurse practitioners, physician assistants, athletic trainers, behavioral specialists, emergency medical technicians and the administrative assistants who participated in the 1999 Special Olympics World Summer Games.

WHAT A GREAT JOB YOU DID. Excellent medical care was provided to athletes, members of delegations and Games Organizing Committee staff at 26 locations including all sports venues, the residence halls, the University of North Carolina and North Carolina State University Student Health Services, airport arrival center, opening and closing ceremonies and the Olympic villages. Special thanks to the UNC Memorial, Duke, Rex and WakeMed hospitals for providing ER and inpatient services.

We hope you enjoyed this great adventure as much as we did. Your great work contributed to making the 1999 Special Olympics World Summer Games the best ever.

Paul R. Perruzzi
Medical Commissioner

H. David Bruton, M.D.
Secretary, Department of Health and Human Services

Attention: All Providers

Automated Re-enrollment of Medicaid and NC Health Choice Recipients

Effective June 1, 1999, DMA implemented a process to automate re-enrollment of Medicaid for Infants and Children (MIC) and NC Health Choice for Children recipients. An annual determination of financial eligibility must be made to continue the child's eligibility. The state generates a re-enrollment form (DMA-5063R) at the beginning of the month and mails it to those recipients whose enrollment period ends on the last day of the following month. For example, re-enrollment forms are mailed early August to recipients whose current eligibility ends September 30, 1999.

A cover letter enclosed with the form instructs the recipient to complete and sign the form, attach proof of income, and return the form to the local county department of social services by a specific date. An envelope is enclosed for the form to be mailed back to the county department of social services. The form is imprinted with the address of the social services department and can be folded so the address appears in the window of the envelope.

- Providers who become aware that a family has received their re-enrollment form in the mail should remind them to complete and return the form right away.

- Failure to return the form in a timely manner may cause a delay in or termination of benefits, resulting in the family having to reapply for health coverage.

If you have questions about the re-enrollment process please contact the: DMA Eligibility Unit at (919) 857-4019.

Attention: All Providers

Change of Address for State Offices

Beginning July 1, 1999 mail service for State Government Offices was centralized. As a result, the mailing addresses, including zip code, for State Offices have changed. (Mail addressed to the previous post office boxes will be forwarded for approximately six months.) Listed below are the new addresses for DMA. Please note that **the name of the individual and/or section and a box number must be used** to ensure receipt by the appropriate DMA section. Copy and post this article in your billing office or make the necessary changes in your office records to ensure that mail to the Division of Medical Assistance is correctly addressed to prevent delay in receipt.

(Director or Deputy Director)
Division of Medical Assistance
2517 Mail Service Center
Raleigh, NC 27699-2517

(Carolina ACCESS, Managed Care)
Division of Medical Assistance
2516 Mail Service Center
Raleigh, NC 27699-2516

(Third Party Recovery or Health Insurance Premium Payment Program (HIPP))
Division of Medical Assistance
2508 Mail Service Center
Raleigh, NC 27699-2508

(Audit)
Division of Medical Assistance
2507 Mail Service Center
Raleigh, NC 27699-2507

(Provider Enrollment)
Division of Medical Assistance
2506 Mail Service Center
Raleigh, NC 27699-2506

(Program Integrity)
Division of Medical Assistance
2515 Mail Service Center
Raleigh, NC 27699-2515

(Medical Policy/Utilization Control)
Division of Medical Assistance
2511 Mail Service Center
Raleigh, NC 27699-2511

(Administration and Regulatory Affairs)
Division of Medical Assistance
2504 Mail Service Center
Raleigh, NC 27699-2504

(Financial Operations)
Division of Medical Assistance
2509 Mail Service Center
Raleigh, NC 27699-2509

(Hearing Office)
Division of Medical Assistance
2505 Mail Service Center
Raleigh, NC 27699-2505

(Information Services)
Division of Medical Assistance
2514 Mail Service Center
Raleigh, NC 27699-2514

(Mail Management)
Division of Medical Assistance
2513 Mail Service Center
Raleigh, NC 27699-2513

(Claims Analysis and Medicare Buy-In)
Division of Medical Assistance
2519 Mail Service Center
Raleigh, NC 27699-2519

(Community Care)
Division of Medical Assistance
2502 Mail Service Center
Raleigh, NC 27699-2502

(Medicaid Mgt. Info. System (MMIS))
Division of Medical Assistance
2510 Mail Service Center
Raleigh, NC 27699-2510

(Quality Control)
Division of Medical Assistance
2518 Mail Service Center
Raleigh, NC 27699-2518

If you do not know to which DMA section or unit to send your request or correspondence, use the following general address:

(Name of DMA employee or Director)
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501

Attention: All Providers

Newly Enhanced Automated Voice Response (AVR) System

The Automated Voice Response (AVR) System has recently been updated. Providers should already have received a special bulletin describing how to use the new system. The current 1-800-723-4337 telephone number is still used for the new system. Some of the features of the AVR include (new features are in **bold**):

- An **expansion** of service hours to 24 hours each day – 7 days a week (*refer to Note below)
- An **increased** number of inbound phone lines
- The **expansion** of the eligibility and coordination of benefits (COB) response
- Recipient eligibility and **coordination of benefits (COB)**
- Claims status
- Checkwrite information
- Procedure codes requiring prior approval
- Procedure code pricing **(with modifiers and coverage status)**
- Drug coverage information
- **Sterilization consent form information**
- **Hysterectomy statement information**
- **Optical refraction history**
- **Verification of dental x-ray, appliance, sealant and extraction history**
- **DME Prior Approval Verification**
- **Verification of Carolina ACCESS**
- **CAP status**

The new AVR system works very similar to the previous system. Providers should follow the prompts in order to obtain the required information. One change has been made in the sequence of keys used to enter alphabetic information. The letters "Q" and "Z" use a different code sequence (see bolded changes below). The following codes are often used in MID number entries.

A- *21	F- *33	K- *52	P- *71	U- *82	Z-*12
B- *22	G- *41	L- *53	Q-*11	V- *83	
C- *23	H- *42	M- *61	R- *72	W- *91	
D- *31	I- *43	N- *62	S- *73	X- *92	
E- *32	J- *51	O- *63	T- *81	Y- *93	

As in the past, EDS' Service Relations Analysts are available between 8:00 a.m. and 4:30 p.m. Monday-Friday to discuss concerns not addressed by the Voice Inquiry System. Please call EDS Provider Services at 1-800-688-6696 if you have further questions regarding the new AVR System.

Note: Refer to the June 1999 Special Medicaid Bulletin for detailed instructions on the Voice Inquiry System. The voice inquiry system is available 24 hours with the exception of 1:00 a.m. to 5:00 a.m. on the 1st, 2nd, 4th, & 5th Sunday, and 1:00 a.m. to 7:00 a.m. on the 3rd Sunday.

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

THIS DOCUMENT IS A YEAR 2000 READINESS DISCLOSURE

UNDER UNITED STATES FEDERAL LAW

Attention: All Providers

Update on Year 2000 Activities

EDS continues the effort to comply with year 2000 requirements. Starting in July, EDS began testing with providers who have completed the changes to submit year 2000 compliant claim formats. In September EDS will release the new NCECS software. Providers should continue to monitor bulletin articles on the status of year 2000 testing and implementation. It is important that claims using the new software or formats not be submitted before the final dates published by the ECS unit. This information will be provided in the instructions released with the software.

DMA will accept claims in their current non-Y2K compliant format until the end of the transition period for various indicated methods of submission. This capability provides a high degree of comfort and flexibility as providers make the transition to Y2K compliant formats. However, all providers are reminded that they will be required to make the conversion to Y2K claims compliance. Details applicable to the various submission forms are provided below.

NECS Submitters

The current NECS software will be replaced by a window-like software to be renamed the North Carolina Electronic Claims Submission (NCECS) software. As an added feature this software will output a file or diskette of claims that is not only Y2K compliant, but will also be in the ANSI 837 format. The NCECS software will be distributed to providers in September 1999. NCECS providers will not require testing by EDS prior to accepting claims since the software will be internally tested by EDS and providers will simply key data enter claims into the software.

Tape Submitters

EDS sent providers specifications for the new format in February 1999. All tape submitters will need to pass testing with EDS before Y2K compliant claims will be accepted. Providers are reminded to give as much notice as possible to their vendors or data processing support staff so that these changes can be made in a timely basis.

ECS Submitters

EDS sent providers specifications for the new format in March 1999. All ECS submitters will need to pass testing with EDS before Y2K compliant claims will be accepted. Providers are reminded to give as much notice as possible to their vendors or data processing support staff so that these changes can be made in a timely basis.

Paper Submitters

There will be no changes to the various paper claim forms. As space permits on the forms providers should input a four-digit year. Where only the provider indicates a two-digit year, EDS' data entry staff will enter a four-digit year that is appropriate. For example, a 00 will be keyed as 2000; a 99 will be keyed as 1999.

ANSI 837 Submitters

Some providers not using the NCECS software will want to start submitting claims in the ANSI 837 format once EDS is capable of accepting them. The new NCECS software will provide claims in that format. EDS will use translator software to accept any ANSI 837 compliant claim. Each ANSI submitter not using NCECS software will be individually tested and then allowed to submit the ANSI format. EDS will begin accepting ANSI formats from non-NCECS submitters beginning in the 4th calendar quarter of 1999.

	Current formats	NCECS	Tape	ECS / Vendors	Paper
Providers Install		beginning Sept 1999	beginning March 1999	beginning April 1999	
EDS Accepting Claims	until transition date established by DMA	beginning Sept 1999	beginning July 1999	beginning July 1999	continuous

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

Attention: All Providers

North Carolina Electronic Claims Submission Software (NCECS)

As mentioned in several recent bulletins, Medicaid is replacing the current NECS software with newer NCECS software. The new software creates files for transmission over modem as well as on a mail-in diskette. The NECS software is DOS based; the NCECS will run in Windows 95, Windows 98 or Windows NT 4.0, which are classified as 32 bit operating systems. NCECS will not operate in a Windows 3.1 environment since it is not a year 2000 compliant system.

Minimal PC requirements for the use of NCECS include:

- Pentium series recommended; 486 machines will function
- minimum of 32 megabytes of memory
- minimum 20 megabytes of hard drive storage
- a browser such as Microsoft Internet Explorer (version 3.0 or higher) or Netscape (version 3.0 or higher)
- a modem – minimal 2400 baud rate; at least 9600 baud rate recommended

Providers must supply the browser. These are on a release diskette as part of the windows 95, 98 and NT Software, or may be downloaded and installed from one of the following addresses:

The Microsoft version is found at http://www.microsoft.com/catalog.
The Netscape version is available at http://home.netscape.com/computing/download/.

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

Attention: All Providers Using Modifiers

Modifiers 25 and 57

Evaluation and management services billed on the same day as surgery are included in the service of surgery and not routinely allowed separate reimbursement.

Modifier 25 is used by providers when billing for an evaluation and management service rendered on the same day that a minor surgical service was performed on the same recipient. Minor procedures are defined as those with "0" or "10" post-operative days. Because the global period for minor procedures begins the day of the surgery, the physician should have determined, prior to billing, that the evaluation and management service is a service that is clearly distinct from the surgical service. When modifier 25 is appended to an evaluation and management service and billed on the same day as a minor surgical service, separate reimbursement is considered for both services.

During the recent modifier workshops questions concerning the use of various evaluation and management codes appended with modifier 25 were raised. The following is a guide for the use of modifier 25.

1. Initial evaluations and consultations are paid separately even if performed on the date of surgery. Therefore, modifier 25 does not have to be appended to these codes when a minor surgical procedure is performed in addition to a separately identifiable evaluation and management code:

   92002-92004, 99201-99205, 99251-99255, 99281-99285, 99321-99323, 99241-99245, 99271-99275, 99295-99298, 99301-99303, 99311-99313, 99315-99316, 99341-99343, 99431-99432, and 99435-99436

2. The provider is allowed the option of billing the modifier with the above codes, which contain the word "new" or "new or established patient", as defined by CPT. Because of the special needs of Medicaid providers, DMA includes nursing facility visits, newborn visits, and neonatal intensive care codes in this range. Appending modifier 25 on those codes is allowed, but is not necessary.

3. The evaluation and management codes which **must** have modifier 25 appended in addition to a minor surgical procedure in order to be considered for reimbursement are:

   92012-92014, 99211-99215, 99217, 99218-99220, 99221-99223, 99231-99233, 99234-99236, 99238-99239, 99261-99263, 99291-99292, 99331-99333, 99347-99350, and 99433

Modifier 57 should be appended to an evaluation and management code only when the decision for surgery was made during the pre-operative period of a major surgery. A major surgical procedure has 60 or 90 follow-up days. The pre-operative period of a major surgical procedure is the day prior to surgery. The post-operative day does not begin until the day following a major surgery. Therefore, modifier 57 may also be appended to the evaluation and management code on the same day as a major surgical procedure.
The following is a guide for the use of modifier 57:

1. Modifier 57 applies to the same CPT evaluation and management codes as modifier 25.
2. Modifier 57 is not required on initial evaluation and consultation codes.
3. Modifier 57 can not be appended to an evaluation and management service provided during the pre-operative period of a minor procedure.
4. Modifier 57 should only be used for situations in which the decision for surgery was made during the pre-operative period of a surgical procedure with a 90 day follow-up, i.e., the day before or the day of surgery.

Modifiers 25 and 57 are part of a group of modifiers that allow the provider to bill for services that are not normally part of the global surgery package. This group also includes modifiers 24, 58, 78 and 79.

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

Attention: All Providers

Modifier Questions and Answers

EDS recently conducted modifier workshops across the state. Each workshop had an interactive question and answer session during which providers could ask questions. In order to allow all providers required to bill under modifier guidelines to benefit from questions asked by their peers, EDS will use the next few general bulletins as a forum to present some commonly asked questions and answers.

1. **Question:** Can modifier 80 be used for the physician assistant when he assists the cardiologist during a cardiac catheterization?

   Answer: No. The procedure codes for cardiac catheterization are not approved for an assistant at surgery. (Refer to the April, 1999 Medicaid Bulletin for codes approved for assistant surgeon.) Modifier 80 can be used for approved assistant at surgery services if rendered by a physician assistant (PA) if the PA is employed by a physician. Assistant at surgery services must be billed as "incident to" services by the physician.

2. **Question:** Procedure code 58611 is used when a patient has a caesarean section and at the same time a bilateral tubal ligation is performed. Would modifier 51 be appended to procedure code 58611?

Answer: No. Code 58611 is used "in addition to code for primary procedure." Add on codes cannot be billed with modifier 51.

3. **Question:** How does a provider bill surgical procedures repeated on the same day, by the same or different provider?

Answer: If the surgical procedure is performed by the same provider on the same day, modifier 51 is appended to the surgical procedure code. If the surgical procedure is performed by a different provider on the same day as the original procedure, no modifier should be billed.

4. **Question:** Can a physician turn over follow up care if they are in the same practice and use modifier 55?

Answer: Yes, as long as the dates in block 16 of the HCFA-1500 format do not overlap. The provider who performed the procedure must append modifier 54 for surgical care only. The provider(s) performing post-op management must append modifier 55 to the procedure code and enter the dates he is responsible for the patient's care in block 16 of the HCFA-1500 or in the post-op dates field on ECS formats.

5. **Question:** What modifier should the provider use if the provider performs both the technical and professional component of an x-ray?

Answer: There are two answers to this question. Either the procedure is billed as a complete procedure with no modifier, or the provider can submit the procedure code with modifier 26 on one detail, and procedure code with modifier TC on the next detail.

6. **Question:** When using modifier 50, is the procedure code listed twice with the modifier on both procedure codes?

Answer: No, list the procedure once and append modifier 50. Bill with one unit. Watch the code descriptions carefully. If the code description includes the term "bilateral", the code cannot be appended with modifier 50.

7. **Question:** Would modifier 25 be appended to an E/M code or a procedure code?

Answer: Modifier 25 is appended to the E/M service rendered on the same day as a minor surgical procedure. Modifier 25 is not needed when the E/M is an initial or new patient code.

8. **Question:** After insertion of ear tubes, care is sometimes needed after the 10-day post-op period. Are modifiers needed for problems and treatment after the post-op period?

Answer: No.

9. **Question:** A patient in the post-op period returns to the OR for post-op related problem. Will the surgeon be paid for History and Physical (H&P) admission at the hospital?

Answer: If the patient is re-admitted during the post-op period for a return to the OR as a result of complications related to the original surgery, another H&P at the time of readmission is not allowed. Also, if the return to the OR is a result of a staged or planned procedure from the original procedure, an additional H&P is not allowed.

10. **Question:** When billing non-covered routine foot care by appending modifier YR, will the patient be responsible for payment?

Answer: The patient can only be billed for non-covered services if informed prior to rendering the Medicaid non-covered service that he or she will be responsible for payment. If the patient is not told prior to rendering the service that the service is non-covered, the provider cannot bill the patient. In addition, the provider cannot bill the patient if Medicaid is billed.

11. **Question:** When using modifier 58 on a subsequent procedure in the post-op period, does the same physician have to perform both procedures?

Answer: Yes. When appending modifier 58 to the subsequent procedure, it must be rendered by the same provider who performed the original procedure. But if a different provider renders the subsequent procedure, modifier 58 is not required.

12. **Question:** What modifier is used when a procedure, unrelated to the original procedure, is performed during the post-op period by a different physician?

Answer: No modifier should be used in this case. However, if performed by the same physician, append modifier 79.

13. **Question:** How does a CRNA or anesthesiologist bill when they perform an epidural and continue to monitor the patient?

Answer: The surgical procedure code is billed with modifier QS, and the total time spent performing the epidural and monitoring the patient during the procedure should be billed as the number of units. 1 unit = 1 minute.

14. **Question:** If an E/M service and a procedure are performed by providers of different specialties on the same date of service, what modifier is used?

Answer: No modifier should be billed in this case. The provider performing the E/M service should bill for the E/M code, and the provider performing the procedure should bill the procedure code.

15. **Question:** Is insertion of a Swan Ganz catheter included in the global anesthesia policy? How does a provider get reimbursed for insertion of a Swan Ganz when modifiers are implemented?

Answer: Insertion of a Swan Ganz catheter is not included in the global anesthesia policy. A provider is reimbursed separately by billing the procedure code with no modifier.

16. **Question:** If anesthesia was administered but the procedure was discontinued prior to starting due to hypotension, is a modifier needed in this case?

Answer: For physicians, modifier 53 is billed if the provider discontinues a procedure either after the induction of anesthesia or after initiation of the procedure if circumstances occur that put the patient at risk. If the service is performed in an ambulatory surgical facility, the facility bills modifier 73 if the procedure is discontinued prior to the administration of anesthesia, or modifier 74 if it is discontinued after the administration of anesthesia.

17. **Question:** Is onychomycosis of the nail covered only in the non-ambulatory patient or does it include ambulatory patients as well?

Answer: Refer to the June, 1999 bulletin for the policy on foot care. Coverage includes both ambulatory as well as non-ambulatory recipients as long as there is marked limitation or pain, and criteria is met to justify the service.

18. **Question:** Patient has x-rays in the physician's office prior to casting and has repeat x-rays after casting by the same physician on the same day. What modifier should be used?

Answer: Modifier 76 should be appended to the subsequent procedure. If the subsequent procedure is performed by a different physician on the same day as the original procedure, modifier 77 would be appended to the subsequent procedure.

19. **Question:** Why would a provider bill a service with modifier 90 to Medicaid since it will not be covered?

Answer: It would be best not to bill modifier 90 because Medicaid doesn't cover purchased services. However, Medicaid implemented modifier 90 as a means of allowing providers to use it if they want the denial for their records. Also, some providers bill Medicare for these services. If modifier 90 is billed to Medicaid, it will deny as a non-covered service.

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

Attention: Durable Medical Equipment (DME) Providers

Addition of Oversized Equipment to the DME Fee Schedule

Effective with date of service August 1, 1999, the following codes for oversized equipment have been added to the DME Fee Schedule.

Inexpensive or Routinely Purchased Items

HCPCS CODE	DESCRIPTION	MEDICAID MAXIMUM		LIFETIME EXPECTANCY
		New	Used	
W4684	replacement pail for oversized bedside commode	6.32		1 year
W4685	bathtub transfer bench for weights 251# to 350#	115.00	86.25	3 years
W4686	bathtub transfer bench for weights 351# to 650#	560.00	420.00	3 years
W4687	bath seat for weights 251# to 650#	198.00	148.50	3 years
W4688	single point cane for weights 251# to 500#	25.50	19.13	3 years
W4689	quad cane for weights 251# to 500#	63.04	47.28	3 years
W4690	crutches for weights 251# to 500#	159.90	119.93	3 years
W4691	fixed-height forearm crutches for weights to 600#	400.00	300.00	3 years
W4692	oversized walker, adjustable, rigid, w/o wheels for weight 301# and greater	180.00	135.00	3 years
W4693	oversized walker, adjustable, folding, w/o wheels for weights 301# and greater	126.94	95.20	3 years
W4694	oversized walker, adjustable, folding, w/ wheels for weights 301# and greater	228.00	171.00	3 years
W4695	glides/skis for use with walker	30.00		2 years
W4720*	oversized 2” foam cushion	140.00	105.00	3 years
W4733	replacement oversized innerspring mattress for hospital bed w/ width to 39”	325.00	243.75	3 years
W4734	replacement oversized innerspring mattress for hospital bed w/ width to 48”	400.00	300.00	3 years
W4735	replacement oversized innerspring mattress for hospital bed w/ width to 54”	410.00	307.50	3 years
W4736	replacement oversized innerspring mattress for hospital bed w/ width to 60”	430.00	322.50	3 years

Capped Rental/Purchased Equipment

HCPCS CODE	DESCRIPTION	MEDICAID MAXIMUM			LIFETIME EXPECTANCY
		Rental	New	Used	
W4679	bedside commode for weights 251# to 650#	19.80	198.00	148.50	3 years
W4680	bedside commode for weights 651# to 1000#	62.00	620.00	465.00	3 years
W4681	bedside commode for weights 1001# and greater	75.00	750.00	562.50	3 years

Capped Rental/Purchased Equipment					
HCPCS CODE	**DESCRIPTION**	**MEDICAID MAXIMUM**			**LIFETIME EXPECTANCY**
		Rental	**New**	**Used**	
W4682	drop-arm bedside commode for weights 251# to 650#	65.00	650.00	487.50	3 years
W4683	drop-arm bedside commode for weights 651# to 1000#	79.50	795.00	596.25	3 years
W4696 *	manual wheelchair for weights 451# to 600#	140.00	1400.00	1050.00	3 years
W4697 *	manual wheelchair for weights 601# and greater	242.00	2420.00	1815.00	3 years
W4698 *	seat width 21” and 22” for manual wheelchair	13.95	139.55	104.66	3 years
W4699*	seat width 23” and 24” for manual wheelchair	28.30	283.00	212.25	3 years
W4700 *	seat width 25” and greater for manual wheelchair	88.70	887.00	665.25	3 years
W4701 *	seat depth 19” and 20” for manual wheelchair	41.16	411.66	308.75	3 years
W4702 *	seat depth 21” and 22” for manual wheelchair	60.00	600.00	450.00	3 years
W4703 *	seat depth 23” and greater for manual wheelchair	58.83	588.33	441.25	3 years
W4704 *	power wheelchair for weights 251# to 400#	385.40	3854.00	2890.50	4 years
W4705*	power wheelchair for weights 401# to 600#	613.30	6133.00	4599.75	4 years
W4706*	power wheelchair for weights 601# and greater	700.00	7000.00	5250.00	4 years
W4707*	seat width 21” and 22” for power wheelchair	38.75	387.50	290.63	4 years
W4708*	seat width 23” and 24” for power wheelchair	77.00	770.00	577.50	4 years
W4709*	seat width 25” and greater for power wheelchair	107.50	1075.00	806.25	4 years
W4710*	seat depth 19” and 20” for power wheelchair	50.00	500.00	375.00	4 years
W4711*	seat depth 21” and 22” for power wheelchair	88.00	880.00	660.00	4 years
W4712*	seat depth 23” and greater for power wheelchair	92.90	929.00	696.25	4 years
W4713*	oversized footplates for weights 301# and greater, pair	16.00	160.00	120.00	3 years
W4714*	swingaway special construction footrests for weights 401# and greater, pair	67.70	677.00	507.75	3 years
W4715	swingaway reinforced legrest, elevating, for weights 301# to 400#, pair	40.00	400.00	300.00	3 years
W4716*	swingaway special construction legrest, elevating, for weights 401# and greater, pair	60.00	600.00	450.00	3 years
W4717*	oversized calf pads, pair	20.00	200.00	150.00	2 years
W4718*	oversized solid seat	55.00	550.00	412.00	3 years
W4719*	oversized solid back	55.00	550.00	412.00	3 years
W4721*	group 27 gel cell battery	40.00	400.00	300.00	1 year
W4722*	oversized full support footboard	20.00	200.00	150.00	3 years
W4723*	oversized full support calfboard	20.00	200.00	150.00	3 years

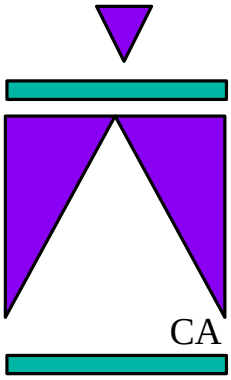
Capped Rental/Purchased Equipment					
HCPCS CODE	**DESCRIPTION**	**MEDICAID MAXIMUM**			**LIFETIME EXPECTANCY**
		Rental	**New**	**Used**	
W4724*	manual hospital bed for weights 351# to 450# w/ mattress and any type side rails	153.90	1539.00	1154.25	5 years
W4725*	semi-electric hospital bed for weights 351# to 450# w/ mattress and any type side rails	195.93	1959.33	1469.50	5 years
W4726*	total electric hospital bed for weights 351# to 450# w/ mattress and any type side rails	223.00	2230.00	1672.50	5 years
W4727*	semi-electric hospital bed for weights 451# to 1000# w/ width to 39" w/ mattress and any type side rails	737.50	7375.00	5531.25	5 years
W4728*	semi-electric hospital bed for weights 451# to 1000# w/ width to 48" w/ mattress and any type side rails	777.50	7775.00	5831.25	5 years
W4729*	semi-electric hospital bed for weights 451# to 1000# w/ width to 54" w/ mattress and any type side rails	815.00	8150.00	6112.50	5 years
W4730*	total electric hospital bed for weights 451# to 1000# w/ width to 39" w/ mattress and any type side rails	910.00	9100.00	6825.00	5 years
W4731*	total electric hospital bed for weights 451# to 1000# w/ width to 48" w/ mattress and any type side rails	935.00	9350.00	7012.50	5 years
W4732*	total electric hospital bed for weights 451# to 1000# w/ width to 54" w/ mattress and any type side rails	960.00	9600.00	7200.00	5 years
W4737*	trapeze bar, free standing, complete with grab bar for weight 451# to 750#	225.00	2250.00	1687.50	3 years

Note: Codes indicated with asterisks require prior approval.

Providers are expected to bill their usual and customary rates.

Medical necessity must be documented for all items on the Certificate of Medical Necessity and Prior Approval (CMN/PA) form regardless of the requirement for approval. The documentation must substantiate medical necessity for the comparable standard size equipment and the need for the oversized equipment. The patient's height, weight, and body measurements must be given. The body measurements must be taken in the appropriate position for the requested equipment, i.e. sitting for bedside commodes, bath seats, and wheelchairs, supine for hospital beds, and standing for canes, crutches, and walkers. The dimensions of the requested equipment and the manufacturer's specified weight capacity for the equipment must be submitted.

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



CAROLINA ACCESS EMERGENCY ROOM REIMBURSEMENT POLICY

The Carolina ACCESS Emergency Room Reimbursement Policy establishes criteria for Medicaid reimbursement of emergency room services.

- The policy covers medical screening exams without regard to prior authorization 24 hours per day, 7 days a week.
- The policy also covers the stabilization of identified emergencies **(see attached *ICD–9* diagnostic code list)** without regard to prior authorization 24 hours per day, 7 days a week.
- The list of identified emergencies **(see attached *ICD–9* diagnostic code list)** is not exclusive of other conditions determined to be an emergency through retrospective medical record review.

Treatment in the Emergency Room for non-emergent care is not generally covered.

1. A non-emergent service rendered Monday through Friday, 8 a.m. to 5 p.m. will result in a denied claim. Medicaid may be billed a medical screening exam fee of $25.16. The screening fee (W9922) must be filed on the HCFA-1500.

   Laboratory and other tests needed to evaluate the existence of an emergent condition may be covered through retrospective medical record review based upon "prudent layperson"* standards and medical necessity criteria.

   Documentation may be submitted to the Carolina ACCESS program for retrospective medical record review. This documentation must include a copy of the completed Retrospective Medical Record Review form as a cover sheet, the denied claim**,** remittance advice (RA), and medical records to demonstrate medical necessity. The Quality Management (QM) staff will review the documentation with all recommended denials receiving a physician review. The review decision will be based upon “prudent layperson” criteria and accepted standards for medical practice.

   If approved for payment, the claims will be forwarded to EDS. The hospital will be notified of any payment denials. Retrospective medical record review requests may be mailed to:

   Attention: **Division of Medical Assistance**
   Managed Care Section
   Attn: Retrospective Medical Record Review
   2516 Mail Service Center
   Raleigh, NC 27699-2516

2. The Primary Care Provider (PCP) may authorize payment for non-emergent treatment after hours (5:00 pm to 8:00 am, Monday through Friday and 24 hours on weekends) and should be contacted for an authorization number following the medical screening exam. Authorized claims for non-emergent care require the authorization number in form locator 11 on the UB-92 and in form locator 19 on the HCFA-1500.

   Retrospective authorization (i.e., authorization after the service has been provided to the recipient) may be provided at the discretion of the PCP.

Information for Hospital Coders:

1. Carolina ACCESS emergency room claims are edited against form locator 76 "Principal and Other Diagnosis" in addition to form locators 68-75. If an identified emergency diagnosis code as defined in this Carolina ACCESS ER Reimbursement Policy appears in any of these form locators, the claim will process and will not require authorization.

2. Hospital coders can place the **presenting diagnosis code** in form locator 76. The American Hospital Association has recommended this form locator be used when a presenting diagnosis is the triggering diagnosis for payment.

* Refer to the information on COBRA/EMTALA/BBA Regulations on page 21.

Questions regarding this policy should be directed to the Carolina ACCESS Quality Management Section by call 919-857-4022.

ICD-9 Diagnostic Code List for Identified Emergencies

Infectious and Parasitic Diseases

036-036.9	Meningococcal infection
038-038.9	Septicemia
091.1, 091.2, 091.9, 093.9, 094.9, 091.0	Syphilis (Primary)
099.9	Venereal disease
099.50-099.56	Chlamydia
098.0, 098.11, 098.14, 098.15, 098.2, 098.19 098.31, 098.35	Gonorrhea
131.00-131.03, 131.09, 131.8, 131.9	Trichimoniasis
082.0	*Rocky Mountain Spotted Fever*[1]

Endocrine, Nutritional, Metabolic, Immunity

242-242.91	Thyrotoxicosis with or without goiter
250.1-250.13	Diabetes with ketoacidosis
250.2-250.23	Diabetes with hyperosmolar coma
250.3-250.33	Diabetes with other coma
251.0	Hypoglycemic coma
255.4	Corticoadrenal insufficiency (Addisonian crisis)
261	Nutritional marasmus - up to age 18
276-276.9	Disorders of fluid, electrolyte, and acid-base balance

Blood and Blood-forming Organs

282.62	Hb-S disease with mention of crisis
286.0-286.9	Coagulation defects

Mental Disorders

291.0-292.9	Alcoholic & drug psychoses
293.0	Acute delirium
295.00-295.94	Schizophrenic disorders (all codes except when the 5th digit=5="in remission")
296.00-296.99	Affective psychoses (all codes except when the 5th digit =6="in full remission")
489.24.1.1	Nonorganic psychoses
300.9	Suicide risk or tendencies
303.00-303.02	Acute alcoholic intoxication
312.34	Intermittent explosive disorder

[1]Italics indicates a new emergency diagnosis code.

ICD-9 Diagnostic Code List for Identified Emergencies (continued)

Nervous System and Sense Organs

320-326	Meningitis, encephalitis, intracranial abscess
345.1-345.11	Generalized convulsive epilepsy
489.24	Grand mal seizures
346.80, 346.81	Other forms of migraine headache
349.0	Headache following lumbar puncture
360.5-360.69	Intraocular foreign body
361.0-361.9	Retinal detachments and defects
362.3-362.37	Retinal vascular occlusion
364.0-364.05	Acute iridocyclitis
365.22	Acute angle-closure glaucoma
370.0-370.07	Corneal ulcer
374.81	Hemorrhage of eyelid
489.24	Retained foreign body of eye lid
376.01	*Orbital Cellulitis*
379.0-379.09	Scleritis and episcleritis
388.61	Cerebrospinal fluid otorrhea

Circulatory System

401.0	Essential hypertension, malignant
410-410.92	Acute myocardial infarction
411-411.89	Other acute and subacute forms of ischemic heart disease
413-413.9	Angina pectoris
415-415.19	Acute pulmonary heart disease
420-420.99	Acute pericarditis
421-421.9	Acute and subacute endocarditis
422-422.99	Acute myocarditis
424.0-424.99	Diseases of endocardium
426-426.9	Conductive disorders
427-427.9	Cardiac dysrhythmias
428-428.9	Heart failure
430	Subarachnoid hemorrhage
431	Intracerebral hemorrhage
432-432.9	Intracranial hemorrhage
433.01, 433.11, 433.21, 433.31, 433.81, 433 .91	Occlusion and stenosis of precerebral arteries with cerebral infarction
434.01, 434.11, 434 .91	Occlusion of cerebral arteries with cerebral infarction
435.0-435.9	Transient cerebral ischemia
436	Acute cerebrovascular disease
437.2	Hypertensive encephalopathy
441-441.9	Aortic aneurysm
444-444.9	Arterial embolism and thrombosis

Diseases of Veins and Lymphatics and other Diseases of Circulatory System

451-453.9	Phlebitis, thrombophlebitis, and thrombosis
455.2	Internal hemorrhoids with other complications

ICD-9 Diagnostic Code List for Identified Emergencies (continued)

Respiratory System

464.11	Acute tracheitis with obstruction
464.21	Acute laryngotracheitis with obstruction
464.31	Acute epiglottitis with obstruction
464.4	Croup, up to age 8
466-466.19	Acute bronchitis and bronchiolitis, up to age 8
475	Peritonsillar abscess
478.21-478.25, 478.29	Cellulitis, abscess or edema of pharynx or nasopharynx
478.6	Edema of larynx
478.71	Cellulitis and perichondritis of larynx
478.75	Laryngeal spasm
480-480.9	Viral pneumonia
481	Pneumococcal pneumonia
482-482.9	Other bacterial pneumonia
483-483.8	Pneumonia due to other specified organism
484-484.8	Pneumonia in infectious diseases classified elsewhere
485	Bronchopneumonia, organism unspecified
486	Pneumonia, organism unspecified
487.0	Influenza with pneumonia
487.1	Influenza with other respiratory manifestations
491.21	Obstructive chronic bronchitis with acute exacerbation
493.0-493.91	Asthma
507-507.8	Aspiration pneumonia
510.0-510.9	Empyema
511.1-511.9	Pleurisy with effusion
512-512.8	Pneumothorax
513-513.1	Abscess of lung & mediastinum
514	Pulmonary congestion and hypostasis
518.0	Pulmonary collapse
518.4	Acute edema of lung
518.5	Pulmonary insufficiency following trauma
518.81-518.82	Respiratory failure
519.0	Tracheostomy complication
519.2	Mediastinitis

Digestive System

530.4	Perforation of esophagus
530.7	Mallory Weiss Syndrome
530.82	Other pulmonary insufficiency, NOS
531-531.61	Gastric ulcer, acute or chronic with hemorrhage and/or perforation
532-532.61	Duodenal ulcer, acute or chronic with hemorrhage and/or perforation
533-533.61	Peptic ulcer, acute or chronic with hemorrhage and/or perforation
534-534.61	Gastrojejunal ulcer, acute or chronic with hemorrhage and/or perforation
536.2	Persistent vomiting
540-542	Appendicitis
550.1-550.13	Inquinal hernia with obstruction
552.9	Hernia with obstruction
560.0-560.2	Intestinal obstruction
560.9	Unspecified intestinal obstruction
562.01-562.03	Diverticulitis of small intestine and diverticulosis of small intestine with hemorrhage
562.11-562.13	Diverticulitis of colon and diverticulosis of colon with hemorrhage
567-567.9	Peritonitis

ICD-9 Diagnostic Code List for Identified Emergencies (continued)

Digestive System (continued)

574.0-574.11	Calculus of gallbladder with cholecystitis
574.3-574.41	Calculus of bile duct with cholecystitis
574.6-574.81	Calculus of gallbladder and bile duct with cholecystitis
575.0	Acute cholecystitis
575.4	Perforation of gallbladder
576.1	Cholangitis
577.0	Acute pancreatitis
578-578.9	Gastrointestinal hemorrhage

Genitourinary System

584-584.9	Acute renal failure
590.0-590.9	Infections of kidney
592-592.9	Calculus of kidney and ureter
599.6	Urinary obstruction
601.0	Acute prostatitis
604.0	Orchitis, epididymitis, and epididymo-orchitis, with abscess
605	Paraphimosis
607.3	Priapism
608.2	Torsion of testis
614-614.0	Acute salpingitis and oophoritis
614.3	Acute parametritis and pelvic cellulitis
614.5	Acute or unspecified pelvic peritonitis
489.24	Abscess of Bartholin's Gland

Pregnancy, Childbirth, Puerperium

632	Missed abortion
633-634.92	Ectopic pregnancy/spontaneous abortion
640-640.93	Hemorrhage in early pregnancy
641-641.93	Antepartum hemorrhage, abruptio placentae, and placenta previa
642-642.94	Hypertension complicating pregnancy, childbirth and the puerperium
643-643.93	Excessive vomiting in pregnancy
489.24.1	Early or threatened labor
646.6	UTI in pregnancy
656.4-656.43	Intrauterine death
666.00-666.34	Postpartum hemorrhage

Skin and Subcutaneous Tissue

692.4	Dermatitis due to chemical products
695.1	Erythema multiforme
708.0	Allergic urticaria

ICD-9 Diagnostic Code List for Identified Emergencies (continued)

Symptoms, Signs and Ill-Defined Conditions

780.0 - 780.09	Coma and stupor
780.1	Hallucinations
780.2	Syncope and collapse
780.3	Convulsions
780.6	Fever, age 1 year of less, temp. 100.4 or > (R)
781.4	Transient paralysis of limb
781.6	Meningismus
781.7	Tetany
782.5	Cyanosis
782.7	Spontaneous ecchymoses (petechiae)
784.7	Epistaxis
489.24	Hemorrhage from throat
490	Tachycardia
785.1	Palpitations
785.5-785.59	Shock without mention of trauma
786.0-786.09	Dyspnea and Respiratory Abnormality
786.3	Hemoptysis
786.5-786.59	Chest pain
788.0	Renal colic
788.2-788.20	Retention of urine
788.5	Oliguria and anuria
489.24.1.1	Abdominal pain
489.25	Abdominal rigidity
789.6	Abdominal rebound tenderness
798-798.9	Sudden death, cause unknown
799.0	Asphyxia
799.1	Respiratory arrest

Injury and Poisoning

800-999.9	**Entire range is covered. If claims deny within this range of diagnoses please contact the CA office at 1-800-228-8142.**
V61.21	Child abuse
V70.1	General psychiatric examination, requested by the authority
V70.4	Examination for medicolegal reasons
V71.4	Observation following other accident
V71.5	Observation following alleged rape or seduction
V71.6	Observation following other inflicted injury
94.13	ICD-9 procedure code- Evaluation for commitment

"COBRA/EMTALA/BBA REGULATIONS"

Abbreviated Review of Federal Regulations
as it applies to Emergency Department Visits

42 CFR 489 (COBRA/EMTALA)

489.24 Special Responsibilities of Medicare /Medicaid hospitals in emergency cases.

(a) *General.* In the case of a hospital that has an emergency department, if any individual (whether or not eligible for Medicare benefits and regardless of ability to pay) comes by him or herself to the emergency department and a request is made on the individual's behalf for examination or treatment of a medical condition by qualified medical personnel (as determined by the hospital in its rules and regulations), the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, to determine whether or not an emergency medical condition exists. The examinations must be conducted by individuals determined qualified by hospital by-laws or rules and regulations and who meet the requirements of 482.55 concerning emergency services personnel and direction. (482.55 states, ...that emergency services be supervised by a qualified member of the medical staff and that there be adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility).

Emergency medical condition means-

(i) A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such *that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect (BBA, Section 1932 (b)(2))the absence of immediate medical attention to result in

  (A) Placing the health of the individual (or with respect to a pregnant woman or her unborn child) in serious jeopardy;
  (B) Serious impairment to bodily functions or
  (C) Serious dysfunction of any bodily organ or part; or

(ii) With respect to a pregnant woman who is having contractions----

  (A) That there is inadequate time to safely transfer to another hospital before delivery; or
  (B) That transfer may pose a threat to the health or safety of the woman or the unborn child.

Stabilize means - That no material deterioration of the condition is likely within reasonable medical probability, to result from or occur during the transfer of the individual from a facility.

To stabilize means - With respect to an *emergency medical condition*, to provide such medical treatment of the condition necessary, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Transfer means - The movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated directly or indirectly with) the hospital.

Screening examination

CFR vol. 59, No. 119, June 22, 1994. Response to comments section, pg. 32099 and 32108. It is impossible to define in advance all of the circumstances in which an individual may come to a hospital emergency department. What will constitute an appropriate medical screening examination will vary according to the condition of the individual and the capabilities of the hospital's emergency department. Within those capabilities, the examination must be sufficient to permit the hospital to decide whether or not the individual has an emergency medical condition. The regulations presently allow a hospital to delegate its responsibility to perform initial medical screening examinations to qualified medical personnel if it does so in its by-laws.

489.24 (c) (ii) (3) *Delay in examination or treatment*

A participating hospital may not delay providing an appropriate medical screening examination or further medical examination and treatment in order to inquire about the individual's method of payment or insurance status.

If the medical screening exam is appropriate and does not reveal an emergency medical condition, the hospital has no further obligations under CFR 489.24 (TAG Number A406, Interpretive Guidelines-Responsibilities of Medicare Participating Hospital in Emergency Cases-HCFA, 05-98).

Carolina ACCESS Emergency Room Retrospective Medical Record Review Form

Patient Name _____

Patient Medicaid ID # _____ Date of Birth _____

Date of Service _____ Time of Service _____

Day of Week _____

Place of Service _____

Diagnosis Code #1 _____

Diagnosis Code #2 _____

Diagnosis Code #3 _____

Diagnosis Code #4 _____

Diagnosis Code #5 _____

Presenting symptoms met Prudent Layperson standard (as defined in BBA) for emergency.

- ☐ **Illness severity required emergency treatment**
- ☐ **Ancillary diagnostic testing required to determine emergency treatment requirements**
- ☐ **PCP not available when contact was attempted on_____(Date)by_____(Hospital Personnel)**
- ☐ **PCP would not authorize ER visit when telephoned on_____(Date)by_____(PCP Personnel)**
- ☐ **PCP call not required - Hospital/PCP written protocol for specific medical condition exists**
- ☐ Other, please explain

_____

Return To:

Managed Care
Division of Medical Assistance
Attn: Retrospective Medical Record Review
2516 Mail Service Center
Raleigh, NC 27699-2516

Please group UB-92 and HCFA-1500 claim forms with the medical record if physician and hospital services are to be reviewed.
Incomplete records will be returned

Revised 6/99

Attention: Physicians, Ophthalmologists, and Optometrists

Cataract Surgeries and Modifier Billing

With the implementation of modifiers, claims from physicians and certain other practitioners **received** on and after June 25, 1999 are processed using modifier guidelines. Eye care providers, including ophthalmologists and optometrists, were included in the implementation of modifiers. Optical suppliers were not affected.

Modifiers 54 and 55 allow a provider other than the surgeon to receive reimbursement for the follow-up care related to a major or minor surgery. Modifier 54 denotes "surgical care only" and is appended to a surgical procedure code if the surgeon agrees to relinquish the postoperative management to another provider. Modifier 55 denotes "postoperative management" only and is appended to a surgical procedure code if a provider other than the surgeon renders postoperative care.

Following is a comparison of billing before and after modifier processing and an explanation on the use of modifiers 54 and 55 as they pertain to ophthalmologists and optometrists and cataract surgery.

Prior to implementation of modifiers			***Effective with claims received June 25, 1999***
Ophthalmologists who performed only the surgical part of cataract surgery billed these codes:			Ophthalmologists performing only the surgical part of cataract surgery use the applicable CPT procedure codes 66983, 66984, or 66985 for cataract surgery and append modifier 54 to the code. "W" codes were replaced with CPT codes.
	W9931	Intracapsular cataract extraction with insertion of lens prosthesis (no follow-up care)	
	W9941	Extracapsular cataract extraction with insertion of lens prosthesis (no follow-up care)	
	W9951	Insertion of intraocular lens subsequent to cataract removal	
Ophthalmologists or optometrists who rendered only postoperative care following cataract surgery billed these codes:			Ophthalmologists or optometrists rendering part or all of the follow-up care bill the applicable CPT codes 66983, 66984, or 66985 for cataract surgery and append modifier 55 to the code. "Y" codes were replaced with CPT codes with modifier 55 appended.
	Y5575	Follow-up care for codes W9931, W9941, or W9951 (for one eye)	
	Y5576	Follow-up care for codes W9931, W9941, or W9951 (for two eyes)	

EXAMPLE I: SURGERY AND PREOPERATIVE CARE ONLY

Situation: The ophthalmologist performs procedure 66984. All postoperative care is transferred to another provider.

Billing: The ophthalmologist who performs the surgery enters 66984-54 on the claim.

EXAMPLE II: PROVIDER (OTHER THAN SURGEON) RENDERS ALL POSTOPERATIVE CARE FOLLOWING SURGERY

Situation: The optometrist provides **all** follow-up care to the patient who has had cataract surgery (66984).

Billing: The optometrist submits a claim entering the surgical CPT procedure code 66984-55, with same date of service (date of surgery) and place of service as the surgeon.

The dates the provider is responsible for postoperative care must be entered in the FROM and TO dates in **block** 16 on the HCFA-1500 claim or in the designated field for tape or ECS formats.

EXAMPLE III: OPHTHALMOLOGIST PROVIDES INITIAL POSTOPERATIVE CARE AND TRANSFERS REMAINDER

Situation: Ophthalmologist provides initial postoperative care and transfers remainder of the follow-up care to another provider.

Billing: The ophthalmologist performs procedure 66985 for cataract surgery and enters procedure code 66985-54 on first detail.

On the second detail, the provider enters procedure code 66985-55 with same date of surgery and place of service as on first detail.

The dates the provider is responsible for postoperative care must be entered in the FROM and TO dates in block 16 on the HCFA-1500 claim or in the designated field for tape or ECS format.

.

Note: The provider who has accepted responsibility for the remainder of postoperative days (ophthalmologist or optometrist), will also bill the surgical procedure code with modifier 55. In the above example, the provider would bill 66985-55.

EXAMPLE IV: OPHTHALMOLOGIST PERFORMS SURGERY AND ALL POSTOPERATIVE CARE

Situation: The ophthalmologist performs procedure 66983 for cataract surgery.

Billing: Procedure code 66983 is entered on the claim without modifier 54 or 55.

Reimbursement for Modifiers 54 and 55:

Reimbursement for codes billed with modifiers 54 and 55 is based on the Federal Register Percentage Table. This table shows the percentage of the total global reimbursement amount that is allocated to the preoperative care, the surgical care, and the postoperative care. Reimbursement for global surgical care rendered by more than one physician, regardless of the number of physicians, cannot exceed the amount allowable if all services were rendered by one physician.

When a recipient is covered by both Medicare and Medicaid, the provider will follow Medicare billing guidelines. Medicaid will continue to pay coinsurance and deductible on crossover claims.

Bilateral Procedures:

When cataract surgery is performed on both eyes at the same time, modifier 50 (denotes a bilateral procedure) is added to the surgical procedure code along with either modifier 54 or 55. Appending modifier 50 indicates the procedure was performed bilaterally during the same operative session and will reimburse the lesser of the submitted charge or 150% of the fee schedule amount. For further information on modifier 50, refer to the Modifier Special Bulletin, April 1999, page 42.

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

Attention: Obstetric Providers

Codes Included in the Total OB Package Codes

The following list includes all codes that are included in the OB package. These codes should not be billed separately by the OB provider.

G0001	82544	83716	86706	87340	87490	87532	87582	99211
80049	82657	83788	86707	87350	87491	87533	87590	99212
80051	82658	83789	86708	87385	87492	87534	87591	99213
80054	82726	83891	86709	87390	87495	87535	87592	99214
80055	82731	83892	86804	87391	87496	87536	87620	99215
81000	83013	83893	87230	87420	87497	87537	87621	99241
81001	83014	83897	87260	87425	87510	87538	87622	99242
81002	83020	83901	87265	87430	87511	87539	87650	99243
81003	83021	83903	87270	87449	87512	87540	87651	99244
82016	83026	83904	87272	87450	87515	87541	87652	99245
82017	83030	83905	87274	87470	87516	87542	87797	99251
82127	83033	83906	87276	87471	87517	87550	87798	99252
82136	83036	83919	87278	87472	87520	87551	87799	99253
82139	83045	84154	87280	87475	87521	87552	87810	99254
82247	83050	84376	87285	87476	87522	87555	88141	99255
82248	83051	84377	87290	87477	87525	87556	88142	99261
82261	83055	84378	87299	87480	87526	87557	88152	99262
82379	83060	84379	87301	87481	87527	87560	99201	99263
82492	83065	85046	87324	87482	87528	87561	99202	
82541	83068	86361	87328	87485	87529	87562	99203	
82542	83069	86704	87332	87486	87530	87580	99204	
82543	83080	86705	87335	87487	87531	87581	99205	

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

Attention: All Providers

Anesthesia Policy

Following publication of the Modifier Special Bulletin in April 1999 the Division of Medical Assistance has received numerous inquiries concerning "changes" to current anesthesia policy.

Four significant changes to anesthesia policy were addressed with the completion of the modifier project. The following are those changes:

1. The addition of coverage for Monitored Anesthesia Care.
2. A review of anesthesia base units to align with Medicare. These changes can be obtained by faxing a request to Financial Operations at the Division of Medical Assistance at (919) 715-0896.
3. Implementation of modifiers allows system auditing of a previously published policy in the Medicaid Bulletin, August 1994, page 3, titled, "CPT Anesthesia Guidelines". Taken directly from the CPT anesthesia section, this continues to be the Division's policy on anesthesia services.
4. "Providers of anesthesia services are reminded that Medicaid reimbursement for anesthesia procedures follows CPT Anesthesia Guidelines. As defined, these services include the usual preoperative and postoperative visits, the anesthesia care during the procedure, the administration of fluids and/or blood and the usual monitoring services (i.e., ECG, temperature, blood pressure, oximetry, capnography and mass spectrometry). Unusual forms of monitoring (i.e., intra-arterial, central venous and SwanGanz) are not included."
5. Use of modifier 59 to "unbundle" procedures usually included in anesthesia, but considered for payment when a distinct procedural service is performed.

No other changes to existing anesthesia policy and billing requirements were made.

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

Attention: All Providers

Stand-by Procedure Code 99360

Effective with date of service July 1,1999, CPT Code 99360 cannot be used for anesthesia stand-by services or pre-anesthesia evaluations. This code is only available for physician stand-by services at high-risk deliveries. Please refer to the June 1999 Medicaid Bulletin.

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

Attention: All Providers

Prior Approval of Services

Medicaid recipients may be enrolled in a Health Maintenance Organization (HMO) through the Medicaid Program in the following counties: Davidson, Durham, Forsyth, Gaston, Guilford, Harnett, Mecklenburg, Orange, Person,
Rockingham, Stokes, and Wake. The HMO is responsible for providing the following services to its members:

- Adult Health Screenings
- Ambulance
- Chiropractic Services
- Clinic Services- Except for Mental Health and Substance Abuse
- Diagnostic Services
- Dialysis
- Durable Medical Equipment
- Emergency Room
- Eye Care
- Family Planning Services and Supplies
- Health Check (EPSDT)
- Hearing Aids
- Home Health
- Home Infusion Therapy
- Hospice
- Inpatient Hospital- Except for Mental Health and Substance Abuse
- Laboratory Services
- Midwife
- Occupational Therapy
- Optical Supplies
- Outpatient Hospital
- Physical Therapy
- Physician Services- Including Physician Assistants and Family Nurse Practitioners- Except for Mental Health and Substance Abuse
- Private Duty Nursing
- Prosthetics/Orthotics
- Radiology Services
- Speech Therapy
- Sterilization
- Total Parenteral Nutrition

Providers must contact the HMO for prior approval of these services. Providers are responsible for verifying Medicaid eligibility as well as managed care enrollment each month. The Medicaid identification (MID) card provides eligibility and HMO enrollment information. HMO enrollment is printed in the middle of the card and lists the HMO's name, address, and telephone numbers. The Member Services telephone number is first and is used to request authorization of services for HMO members. HMO enrollment can also be verified through EDS Voice Inquiry by calling 1-800-723-4337. If Voice Inquiry confirms that a Medicaid recipient is enrolled with an HMO, then the provider may call DMA's Managed Care Section at 919-857-4022 for specific HMO information. Electronic Data Interchange (EDI) is another source for eligibility and HMO enrollment information. Approved EDI vendors are listed in the February 1998 Medicaid Bulletin. All <u>other</u> Medicaid-covered services are paid by Medicaid, and prior approval is obtained from EDS Prior Approval.

DMA, Managed Care Section, 919-857-4022

Attention: All Providers Performing Laboratory Services

Clinical Laboratory Improvements Amendment (CLIA) Certification Expiration Date

HCFA has changed the certification period from 24 months to 6 months for CLIA certificates that have unpaid fees. Claims will be denied when the date of service exceeds the expiration date on file for the CLIA certificate number. Medicaid of North Carolina encourages providers to review your CLIA certification documentation to assure all applicable fees have been paid.

If there are further CLIA certification questions, contact the CLIA state agency in which the CLIA certification was obtained.

In North Carolina:

CLIA Certification
Division of Facility Services
2713 Mail Service Center
Raleigh, North Carolina 27699-2713
919-733-3032

In states other than North Carolina:

Contact the representative from the attached listing from the appropriate state:

State	Telephone	State	Telephone
Alaska	907/561-8081	**Nevada**	702/687-4475
Alabama	334/261-6525	**New Hampshire**	603/271-4832
Arizona	602/255-3454	**New Jersey**	609/530-6172
Arkansas	501/661-2201	**New Mexico**	505/827-4200
California	510/873-6327	**New York**	518/485-5352
Colorado	303/691-4712	**North Carolina**	919/733-3032
Connecticut	860/509-7400	**North Dakota**	701/328-2352
District of Columbia	202/727-7200	**Ohio**	614/644-1845
Delaware	302/577-6666	**Oklahoma**	405/271-6576
Florida	904/487-3063	**Oregon**	503/229-5854
Georgia	404/657-5448	**Pennsylvania**	610/363-8500
Hawaii	808/586-4090	**Puerto Rico**	212/264-3496
Idaho	208/334-2235	**Rhode Island**	401/277-2566
Illinois	217/782-6747	**South Carolina**	803/737-7205
Indiana	317/383-6502	**South Dakota**	605/773-3694
Iowa	515/281-3765	**Tennessee**	615/367-6266
Kansas	913/296-1638	**Texas**	512/834-6650
Louisiana	504/342-9324	**Utah**	801/584-8469
Maine	207/624-5443	**Vermont**	802/241-2345
Maryland	410/764-4695	**Virgin Islands**	212/264-3496
Massachusetts	617/983-6732	**Virginia**	804/367-2104
Michigan	517/321-6816	**Washington**	206/361-2806
Minnesota	612/643-2105	**West Virginia**	304/558-0050
Mississippi	601/354-7300	**Wisconsin**	608/266-5753
Missouri	314/751-6318	**Wyoming**	307/777-6057
Montana	406/444-1451		
Nebraska	402/471-0928		

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

Attention: Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Providers

Reimbursement for Core Services

Medicaid coverage includes the RHC/FQHC core services defined in Section 1861 (aa) (1) (A)-(C) of the Social Security Act. RHC and FQHC services are divided into 2 categories: core and ambulatory services. Core services are services covered by both Medicare and Medicaid and provided in a clinic setting. Laboratory and other diagnostic services incidental to the clinic visit are included in core services.

Medicare reimburses for core services according to the core visit rates established by HCFA. Medicare Rates are reviewed annually subsequent to the annual cost settlement for each provider. When a rate change is received from the fiscal intermediary RHC and FQHC providers are responsible for contacting the DMA Financial Operations at (919) 857-4015. This will ensure that the current core rate is on file with DMA. Core services are considered Part A Medicare services and will be reimbursed according to North Carolina Medicaid policy. Non-core ambulatory services include physician, dental, DME, home health services and services provided to hospital patients (including emergency room services). Non-core services are Part B Medicare services**.**

Medicaid billing for core services

Core services are billed with HCPCS code **Y2058** for RHC core services and **Y2089** for FQHC core services on the HCFA-1500 claim form. The RHC/FQHC alpha suffix “A” provider number must be on the claim form. (Example: 3403800A)

Medicaid billing for non-core services

Non-core services (outpatient and emergency room hospital services) are billed using the appropriate HCPCS and CPT procedure codes on the HCFA-1500 claim form. The RHC/FQHC alpha suffix “C” denotes the non-core service was rendered, and must be on the claim form. The appropriate suffix provider number must be billed for the service rendered, for example: the dental services suffix is “D” DME is “E”, Home Health is “F”. If applicable to the clinic, these provider numbers are assigned by DMA.

Crossover claims

Medicare tape crossover claims containing core visit revenue codes (RC520, RC521, or RC522) will be paid the core rate times the number of visits less the Medicare reimbursement amount for RHC and FQHC claims. Medicare crossover claims for core services that have a negative Medicare paid amount will be cost-settled at fiscal year-end by Medicare.

EDS, 1-800-688-6696 or 909-851-8888

GET THE LEAD OUT

DID YOU KNOW: That blood lead levels as low as 10 ug/dL are associated with significant harmful effects on a child's behavior and ability to learn.

DID YOU KNOW: That almost 2000 young children (3.6%) screened in NC in 1998, had blood lead levels $\geq$ 10 ug/dL.

DID YOU KNOW: That simple nutrition and environmental interventions (such as frequent and careful dusting and mopping) can reduce blood lead levels.

DID YOU KNOW: That a national study indicates that young children on Medicaid or WIC are nearly five times more likely to have an elevated blood lead level than other children.

DID YOU KNOW: That only 25% of children ages one and two in NC were screened for lead in 1998.

DO YOU RECALL: That children on Medicaid, NC Health Choice or WIC are required to be screened at ages one and two, or before 72 months if they have not been screened previously.

WHAT ARE YOU WAITING FOR: Screen young children for lead

KIDS RUN BETTER UNLEADED

Ed Norman, Division of Environmental Health (919) 715-5381

Attention: Independent Practitioner Providers (IPPs)

Independent Practitioner Seminars

Independent Practitioner seminars will be held in October 1999. The September Medicaid Bulletin will have the registration form and a list of site locations for the seminars. Please list any issues you would like addressed at the seminars. Return form to:

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

Attention: Adult Care Homes (ACH) Providers

Adult Care Home (ACH) Seminars

Adult Care Home (ACH) seminars will be held in October 1999. The September Medicaid Bulletin will have the registration form and a list of site locations for the seminars. Please list any issues you would like addressed at the seminars. Return form to:

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

Attention: All Providers

NCECS Software Training Seminars

NCECS software training seminars will be held in October 1999. The September Medicaid Bulletin will have the registration form and a list of site locations for the seminars. Please list any issues you would like addressed at the seminars. Return form to:

ECS Department
EDS
P.O. Box 300009
Raleigh, NC 27622

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

Attention: All Providers

Bulletin Article Index from February 1999 through July 1999

ALL PROVIDERS

Checkwrite Schedule

August 10, 1999	September 8, 1999	October 12, 1999
August 17, 1999	September 14, 1999	October 19, 1999
August 26, 1999	September 21, 1999	October 28, 1999
	September 30, 1999	

Electronic Cut-Off Schedule *

August 6, 1999	September 3, 1999	October 8, 1999
August 13, 1999	September 10, 1999	October 15, 1999
August 20, 1999	September 17, 1999	October 22, 1999
	September 24, 1999	

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

Paul R. Perruzzi, Director
Division of Medical Assistance
Department of Health and Human Services

James R. Clayton
Executive Director
EDS

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