Number 9 *September 2002*

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

Holiday Observance

The Division of Medical Assistance (DMA) and EDS will be closed on Monday, September 2, in observance of Labor Day.

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

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

Attention: All Providers

Change to Checkwrite and Electronic Cut-Off Schedule for September 2002 and October 2002

The checkwrite and corresponding electronic cut-off schedules for the last two weeks of September 2002 and the first week of October 2002 have been revised. The checkwrite scheduled for September 17 has been changed to September 19. The checkwrite for September 26 has been changed to October 8. The electronic cut-off date for the September 19 checkwrite has not changed. The cut-off date for the October 8 checkwrite has changed to October 4. Please refer to the following table for the revised schedules:

Electronic Cut-Off Schedule	Checkwrite Schedule
August 30, 2002	September 4, 2002
September 6, 2002	September 10, 2002
September 13, 2002	September 19, 2002
October 4, 2002	October 8, 2002
October 11, 2002	October 15, 2002
October 18, 2002	October 22, 2002
October 25, 2002	October 30, 2002

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

Attention: All Providers

Surgery Prior Approval

The Division of Medical Assistance has noted an increase in the number of retroactive surgical prior approval requests.

Retroactive prior approval is only considered when the recipient did not have Medicaid coverage at the time of the surgery **and** was later approved for Medicaid with a retroactive eligibility date. The recipient must be eligible for Medicaid coverage on the date the surgery was performed. The recipient must meet all medical necessity prior approval criteria before retroactive prior approval can be authorized.

Providers can avoid claim denials for prior approval by utilizing the Automated Voice Response (AVR) system to determine if surgery CPT codes require prior approval. The telephone number for the AVR system is 1-800-723-4337.

Providers rendering services to recipients enrolled in Carolina ACCESS are required to obtain **both** the primary care physician's referral and prior approval for the surgery.

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

Attention: All Providers

Proposed Medical Coverage Policies

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

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

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

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

Attention: All Providers

Radioactive Imaging Agent, Myoview

Radioactive imaging agent Myoview must be billed using HCPCS code A9502, supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m tetrofosmin, instead of CPT code 78990, ***supply of radiopharmaceutical diagnostic imaging agent, not otherwise classified***. Billing must be accompanied with an invoice that includes the name of the patient, the name of the agent, the dose administered, and the cost. Claims submitted with invoices that do not include this information will be denied.

CPT code 78990 will remain available for radiopharmaceutical diagnostic imaging agents, not otherwise classified, and must also be billed with an invoice.

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

Attention: All Providers

Epirubicin Hydrochloride (Ellence), 50 mg (J9180) - Billing Guidelines

Effective with date of service May 1, 2001, the N.C. Medicaid program covers epirubicin hydrochloride (Ellence) for use in the Physician's Drug Program. Providers must bill J9180, indicating the number of units given in block 24G on the CMS-1500 claim form. For Medicaid billing, one unit of coverage is 50 mg. The maximum reimbursement rate per unit is $631.97. Providers must bill their usual and customary charge. Previously denied claims for dates of service beginning May 1, 2001 can be resubmitted as adjustments.

Only the following ICD-9-CM diagnoses are covered. The diagnosis can be primary or secondary.

151.0 – 151.9
162.2 – 162.9
171.0 – 171.9
174.0 – 175.9
183.0 – 183.9
200.00 – 202.98

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

Attention: All Providers

Zoledronic Acid (Zometa), 4 mg (J3490) - Billing Guidelines

Effective with date of service January 1, 2002, the N.C. Medicaid program covers zoledronic acid (Zometa) for use in the Physician's Drug Program. Providers must bill J3490, the code for miscellaneous drugs, with an invoice attached to the CMS-1500 claim form. The paper invoice must include 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. For Medicaid billing, one unit of coverage is 4 mg. The maximum reimbursement rate per unit is $770.74. Providers must bill their usual and customary charge. Previously denied claims for dates of service beginning January 1, 2002 can be resubmitted as adjustments.

Only the following ICD-9-CM diagnoses are covered:

- One of the following diagnoses (stand alone) can either be the primary or a secondary diagnosis:
  a. Hypercalcemia of malignancy – 275.42
  b. Secondary malignant neoplasm of bone and bone marrow – 198.5
  c. Multiple myeloma – 203.00 or 203.01
- For the following indications, a primary **and** a secondary diagnosis is required in order for the claim to be processed:
  a. Prostate cancer – 185 primary with 198.5 secondary
  b. Non-small-cell lung cancer – 16210 through 162.9 primary with 198.5 secondary
  c. Breast cancer (female) – 174.0 or 174.9 primary with 198.5 secondary
  d. Breast cancer (male) – 175.0 or 175.9 primary with 198.5 secondary

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

Attention: All Providers

Provider Representative Consultations

EDS Provider Representatives will hold individual provider consultations in the following areas in October 2002. These consultations will enable providers to discuss billing issues and problem claims.

Representatives will be available from 8:30 a.m. to 5:00 p.m. for 30-minute sessions at the dates and locations listed below. Providers may schedule a consultation by completing and returning the request form below.

County	Location	Date
Pasquotank	College of the Albemarle Small Business Center Seminar Room E-121A US 17 North **Elizabeth City**, NC 27909	October 8, 2002
Brunswick	Brunswick Community College Room 120/121, Bldg. D 50 College Road NE **Bolivia**, NC 28462	October 9, 2002
Buncombe	Mountain AHEC Classroom 2 501 Biltmore Ave. **Asheville**, NC 28801	October 14, 2002
Wilkes	Wilkes Community College Thompson Hall, Room 209 1328 Collegiate Drive Highway 268 **Wilkesboro**, NC 28697	October 15, 2002

If you are interested in scheduling a session, please complete and return the following registration form by September 27, 2002 to the address listed below.

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

Medicaid Provider Consultation Request Form
(No Fee)

Provider Name _____ Provider Number _____
Address _____ Contact Person _____
City, Zip Code _____ Telephone Number (___) _____

List three specific claims/concerns you would like to discuss. Include recipient Medicaid identification number, date of service, and provider number if different from one indicated above. If time permits, more than three claims or issues can be addressed.

_____
_____
_____

Return to: Lisa Laur
EDS
P.O. Box 300009
Raleigh, NC 27622

Fax: 919-851-4014

Attention: All Providers

Provider Information Update

The N.C. Medicaid program is updating provider files to include a fax number and e-mail address. These two methods of communication will complement the already existing methods of communication and provide a quick avenue for providers to receive information. Because only one e-mail address and one fax number can be entered for a provider number, please submit the most appropriate information for the provider number given. Please complete and return the following form to EDS Provider Enrollment at the address listed below.

To report a change of ownership, name, address, tax identification number changes, group member, or licensure status, please use the Notification of Change in Provider Status form. Managed Care providers (Carolina ACCESS, ACCESS II, ACCESS III, and HMO Risk Contracting) must also report changes in daytime or after-hours phone numbers and should report changes using the Carolina ACCESS Provider Information Change form.

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

Provider Update Form

Date _____

Provider Number: _____

Provider Name: _____

Address: Street _____

City _____

State Zip Code _____

Contact Person: _____

Phone Number: ( ) _____

Fax Number: ( ) _____

E-Mail address: _____

Return completed form to:

EDS Provider Enrollment
PO Box 300009
Raleigh, NC 27622

Fax: 919-851-4014

Attention: All Providers including Carolina ACCESS Primary Care Providers

Change in Carolina ACCESS Override Policy

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

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

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

Override requests must be submitted to EDS using the Carolina ACCESS Override Request form within six months of the date of service. EDS has 30 days to evaluate the request. The Override Request form has been revised to simplify the evaluation process. Please use the revised Override Request form on page 8 for requests submitted to EDS after September 1, 2002. This form is also available in the Carolina ACCESS PCP Provider Manual and on DMA's website at http://www.dhhs.state.nc.us/dma.

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

Managed Care Section
DMA, 919-857-4022

Carolina ACCESS Override Request

Complete this form to request a Carolina ACCESS override when you have received a denial for EOB 270 or 286 **or** the Primary Care Provider (PCP) has refused to authorize treatment for **past** date(s) of service. The request must be submitted within six months of the date of service. Overrides will not be considered unless the PCP has been **contacted and refused** to authorize treatment. Attach any supporting documentation. Mail or fax completed form to EDS. EDS will telephone or fax your office within 30 days with a denial or, if approved, the override number to use for filing the claim. This form is also available in the Carolina ACCESS Primary Care Provider Manual and on DMA's website at http://www.dhhs.state.nc.us/dma.

Mail To: CA Override
EDS Provider Services
PO Box 300009
Raleigh, NC 27622

OR

Fax: CA Override
919/851-4014

Recipient MID No. _____ Recipient Name _____

Date(s) of Service _____ ICN No. _____ RA Date _____

Is this claim due to?

☐ A well visit
☐ An inpatient admission
☐ An inpatient admission via the ER

PCP on recipient's Medicaid card _____

Name of person contacted at PCP's office _____ Date contacted _____

Reason PCP stated he would not authorize treatment _____

_____

Reason recipient stated he did not go to the PCP listed on his Medicaid card _____

_____

I am requesting an override due to:

☐ Enrollee linked incorrectly to PCP. Please explain: _____

_____

Who is the correct PCP? _____

☐ This child has been placed in foster care in another area: _____

☐ This enrollee has moved to another county: _____

☐ The provider listed on the enrollee's Medicaid card is different from the PCP indicated by the AVR system (attach a copy of the Medicaid card with this form).

☐ Unable to contact PCP. Please explain: _____

_____

☐ Other. Please explain: _____

_____

Provider Name _____ Provider Number _____

Provider Contact _____ Telephone No. (___) _____ Fax No. (___) _____

CA 09/02

Attention: Carolina ACCESS Primary Care Providers

Highlights of Carolina ACCESS Contractual Compliance Survey

In the spring of 2002, the Division of Medical Assistance (DMA) Managed Care Section conducted a Contractual Compliance Survey using a random sample of participating Carolina ACCESS (CA) primary care providers (PCPs). The survey was beneficial to DMA's efforts to provide a quality Managed Care program for Medicaid. DMA Managed Care appreciates the time providers spent completing the survey.

The survey results indicate that the majority of PCPs are meeting their contractual requirements. Please review the following requirements for participation with your staff to ensure that all PCPs are meeting the needs of their enrollees.

- **Coordination of Care**
  PCPs must either schedule an appointment for enrollees based on the standards of appointment availability **or** authorize another provider to treat the enrollee. DMA sends a monthly enrollment report to each PCP to assist in the identification of their enrollees. It is the responsibility of the PCP to review the report and report discrepancies to their regional Managed Care consultant. The PCP must continue to coordinate care until the error is reported and the PCP number is changed in the system.

- **Standards of Appointment Availability**

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

- **Access to Medical Advice**
  CA PCPs must provide prompt access to a qualified medical practitioner who is able to provide medical advice, consultation, and authorization for service, when appropriate, 24 hours per day, 7 days per week. Prompt is defined as one hour. A recorded telephone message instructing members to call back during office hours or to go to the emergency room is not an acceptable option. Emergency room personnel may not be used for after-hours coverage.

- **Office Hours**
  CA PCPs must have a provider available in the office at a minimum of 30 hours per week to see patients.

- **Hospital Admitting Privileges**
  CA PCPs must establish and maintain age-appropriate hospital admitting privileges or have a Carolina ACCESS Patient Admission Agreement on file indicating a formal, written agreement with another physician or group practice for management of inpatient hospital admission of enrollees. Unassigned call doctors with the hospital are not an acceptable option.

- **Patient Disenrollment**
  If it becomes necessary to disenroll a recipient due to repeated non-compliance, medication abuse or missed appointments, the PCP must follow this procedure:
  1. Notify the enrollee in writing.
  2. Provide 30 days notice.
  3. Advise the enrollee to contact the local department of social services to choose a new PCP.
  4. Fax a copy of the disenrollment letter to the regional Managed Care consultant.
  5. Continue to provide services or authorize another provider to provide services until the system is updated to reflect the recipient's new PCP information.

- **Women, Infant, and Children (WIC) Special Supplemental Nutrition Program**
  PCPs are required to refer potentially eligible enrollees to the WIC program.

If there are questions or comments, contact your **regional Managed Care consultant**. This information is also available in the Carolina ACCESS Primary Care Provider manual on DMA's website at http://www.dhhs.state.nc.us/dma/ca.htm.

Laurie Giles, Managed Care Section
DMA, 919-857-4022

Attention: Optical Providers

Retention of Prior Approval Forms

Effective October 31, 2002, the top copy of the Request for Prior Approval for Visual Aids form will no longer be retained by EDS. EDS will retain only special optical approvals with attachments and all denials for two years. The contractor's copy must be signed or stamped by the provider. **Please remember to retain the bottom copy of the form for your office.**

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

Attention: UB-92 Billers

Filing Paper UB-92 Claims for Services Provided to Carolina ACCESS Recipients

Effective with claims received October 16, 2002, providers submitting paper UB-92 claims for services provided to Carolina ACCESS recipients must enter the recipient's primary care provider (PCP) number in form locator 83B. Prior to this change, the PCP number was entered in form locator 11. This change is being made as recommended by the National Uniform Billing Committee. Claims received after October 16, 2002 without the PCP number in form locator 83B will be denied.

Electronic claim submissions are not affected by this change. Continue to submit electronic claims in the same format.

Laurie Giles, Managed Care Section
DMA, 919-857-4022

Attention: Prescribers

Valid DEA Numbers Required on Pharmacy Prescriptions

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

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

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

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

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

Fax: 919-851-4014

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

DEA Number

Provider Name _____

Medicaid Provider Number _____

Street Address _____

City _____ State _____ Zip Code _____

Telephone Number ___(___) _____

DEA Number _____

OR

Prescriber Medicaid Identification Number _____

Attention: All Providers of Criterion #5 Services, Residential Treatment Services, and Psychiatric Residential Treatment Facility Services

Bill Type Changes

Effective with date of service October 1, 2002, the following bill types, revenue codes, and procedure codes must be used when billing residential services, psychiatric residential treatment facility (PRTF) services or Criterion #5 services.

	Residential Services Level II-IV	**PRTF**	**Criterion # 5**
Bill Type			
First Claim	842 Interim	892 Interim	142 Interim
Continuing Claim	843 Interim	893 Interim	143 Interim
Last Claim	844 Interim	894 Interim	144 Interim
Revenue Code	902	911	902
Procedure Code	Appropriate Y code to denote level of care	N/A	Y2343

Because multiple claims are submitted during a recipient's stay, using the correct **bill type codes** will accurately indicate the status of the claim.

Carol Robertson, Behavioral Health Services, Medical Policy Section
DMA, 919-857-4020

Attention: Adult Care Home Providers

Request for Information

The number of licensed beds in your facility must be reported to the Division of Medical Assistance (DMA) by October 31, 2002. Mail a copy of your current license, issued by the Division of Facility Services (HAL, FCL or MHL), to the address listed below and **include your Medicaid provider number** in the upper right-hand corner of the document. **Failure to send your license or to include the provider number could affect your payment**.

DMA
Medical Policy Section
2511 Mail Service Center
Raleigh, NC 27699-2511
ATTN: Angela Langston

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

Attention: Area Mental Health Programs and Residential Treatment Services Providers

Residential Authorizations and Forms

The need for psychiatric residential services is determined by the county area mental health program (Community Mental Health Center) where the child is a resident. Once this assessment is completed and the appropriate level of care determined, the area mental health program authorizes the initial length of stay for Level II and III facilities for the first 120 days and for Level IV facilities for the first 30 days. Local departments of social services, departments of juvenile justice or private providers cannot make these authorizations. The area mental health program must submit a Request for Authorization (RAF) form to both ValueOptions and EDS informing them of the admission and the length of stay that has been authorized.

Area mental health programs are responsible for the admission and the initial length of stay up to 120 days or 30 days and may give this authorization(s) in increments of time up to the 120 or 30 days. Area mental health programs are not permitted to authorize time beyond these trigger points.

The 120 days follows the child. If the child is moved from Level II to Level III or to different homes within the same level that does NOT restart the clock. **Note:** An updated RAF must be submitted to both ValueOptions and EDS when there is a change in the level of care or a change in homes to ensure that ValueOptions knows where the child is located and that EDS makes the proper claims payment. The clock is only stopped if the child is discharged home and remains there for 15 days or more without readmission to a residential facility.

ValueOptions assumes responsibility for authorizing continued stay when:

- The trigger points of the initial 120 or 30 days have been met. (ValueOptions assumes authorization responsibility on the 121st or 31st day.)
- The child is hospitalized directly from a residential facility and returns to the residential facility (regardless if the initial authorization of 120 or 30 days has been met).
- The child is in Level IV and moves down to Level III or II and has been at Level IV more than 30 days.
- The child is in Level II or III and moves to Level IV and 30 days have passed.
- The child is discharged from a psychiatric residential treatment facility (PRTF) and is admitted to a residential facility regardless if the initial authorization of 120 days or 30 days has been met.

The guidelines listed above apply to all in-state and out-of-state cases.

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

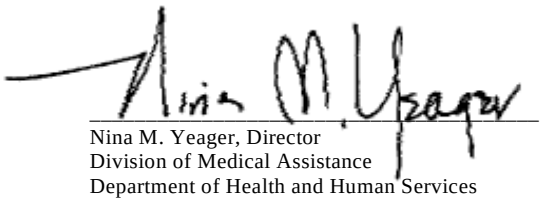
Checkwrite Schedule

September 4, 2002	October 8, 2002	November 5, 2002
September 10, 2002	October 15, 2002	November 13, 2002
September 19, 2002	October 22, 2002	November 19, 2002
	October 30, 2002	November 26, 2002

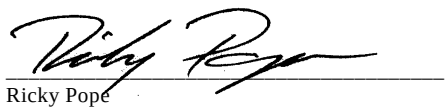
Electronic Cut-Off Schedule

August 30, 2002	October 4, 2002	November 1, 2002
September 6, 2002	October 11, 2002	November 8, 2002
September 13, 2002	October 18, 2002	November 15, 2002
	October 25, 2002	November 22, 2002

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



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



Ricky Pope
Executive Director
EDS

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