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North Carolina Medicaid Bulletin

An Information Service of the Division of Medical Assistance
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Visit DMA on the Web at: http://www.dhhs.state.nc.us/dma

Attention: All Providers

HIPAA Update: Change to Implementation Date

The American National Standard Institute (ANSI) Accredited Standards Committee (ASC) X12N standards, Version 4010A1 for electronic transactions will not be implemented on September 14, 2003 as announced in the August 2003 general Medicaid bulletin. The decision to delay the implementation of the standard transactions applies to the:

- Health Care Claim (Professional, Institutional, Dental) – 837 Transaction
- Health Care Claim Payment Advice – 835 Transaction
- Claim Inquiry and Response – 276/277 Transaction
- Payroll Deducted and Other Group Premium Payment for Insurance Products – 820 Transaction
- National Council for Prescription Drug Programs (NCPDP), Version 1.1 Batch Transaction

Note: NCPDP Version 5.1 Point-of-Sale was implemented on August 1, 2003 as previously published.

Providers will be notified in the October 2003 general Medicaid bulletin of the status of the implementation of HIPAA electronic transactions.

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

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

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Attention: NCECS Billers

North Carolina Electronic Claims Submission Web-Based Tool

The introduction of the new North Carolina Electronic Claims Submission web-based tool (NCECS-Web) for electronic claim submission scheduled for September 14, 2003 has been delayed. Providers will be notified of the status of the implementation project in the October 2003 general Medicaid bulletin.

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

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

Current users can access the Lists Management function of the NCECS-Web tool and begin creating and maintaining claims-related information for their clients, and compile procedure codes, diagnosis codes, etc. The Reference Materials function is also available.

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

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

Attention: All Providers

Anesthesia Services – Conversion to CPT Anesthesia Codes

To comply with the implementation of national standard codes mandated by the Health Insurance Portability and Accountability Act (HIPAA), effective October 1, 2003, providers must bill anesthesia services using CPT anesthesia codes (00100 - 01999) instead of CPT surgical codes. The Division of Medical Assistance will not publish a crosswalk conversion guide. Providers should refer to the American Society of Anesthesiologists' *Crosswalk Guide* and bill the anesthesia code that is indicated. There is no change in anesthesia base units. Providers should continue to bill the number of units as 1 minute = 1 unit. Additional information will be published in future general Medicaid bulletins.

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

Attention: All Providers

Endoscopy CPT Base Codes and Their Related Procedures

The following table represents a current and updated list of covered base and related endoscopy codes as designated in the 2002 and 2003 Resource Based Relative Value System (RBRVS). A new base code and a new related code were added to group **1**. New codes were added to the related side for groups **10, 11, 17, 18,** and **30**.

Scopy Base and Related Code Group

Group	Base Code	Related Codes	Comments
1	**29805**	**29806**, 29819 - 29826	Effective 01/01/02 new "base" code added from 2002 RBRVS and new code added to related codes
2	29830	29834 - 29838	
3	29840	29843 - 29847	
4	29860	29861 - 29863	
5	29870	29871, 29874 - 29877, 29879 - 29887	
6	31505	31510 - 31513	
7	31525	31527 - 31530, 31535, 31540, 31560, 31570	
8	31526	31531, 31536, 31541, 31561, 31571	
9	31622	31623 - 31625, 31628 - 31631, 31635, 31640 -31641, 31645	
10	43200	**43201** - 43202, 43204 - 43205, 43215 - 43217, 43219 - 43220, 43226 - 43228	Effective 03/01/03 new code added to related codes
11	43235	43231 - 43232, **43236**, 43239, 43241 - 43247, 43249 - 43251, 43255 - 43256, 43258 - 43259	Effective 03/01/03 new code added to related codes
12	43260	43240, 43261 - 43265, 43267 - 43269, 43271-43272	
13	44360	44361, 44363 - 44366, 44369, 44370, 44372-44373	

Scopy Base and Related Code Group, continued

Group	Base Code	Related Codes	Comments
14	44376	44377 - 44379	
15	44388	44389 - 44394, 44397	
16	45300	45303, 45305, 45307 - 45309, 45315, 45317, 45320 - 45321, 45327	
17	45330	45331 - **45335**, 45337 - **45340**, 45345	Effective 03/01/03 new code added to related codes
18	45378	45379 - **45381**, **45382 - 45387**	Effective 03/01/03 new code added to related codes
19	46600	46604, 46606, 46608, 46610 - 46612, 46614 -46615	
20	47552	47553 - 47556	
21	50551	50555, 50557, 50559, 50561	
22	50570	50572, 50574-50576, 50578, 50580	
23	50951	50953, 50955, 50957, 50959, 50961	
24	50970	50974, 50976	
25	52000	52007, 52010, 52204, 52214, 52224, 52250, 52260, 52265, 52270, 52275 - 52277, 52281 -52283, 52285, 52290, 52300 - 52301, 52305, 52310, 52315, 52317-52318	
26	52005	52320, 52325, 52327, 52330, 52332, 52334, 52341 - 52344	
27	52335	52336 - 52339	End-dated due to 2001 CPT update
28	56300	56301 - 56309, 56311, 56343 - 56344, 56314	End-dated due to 2000 CPT update
29	56350	56351 - 56356	End-dated due to 2000 CPT update
30	57452	**57454 - 57456**, 57460 - **57461**	Effective 03/01/03 new code added to related codes
31	49320	38570, 49321 - 49323, 58550 - 58551, 58660 -58662, 58670	
32	58555	58558 - 58563	
33	52351	52345 - 52346, 52352 - 52355	
34	31575	31576-31579	

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

Attention: All Providers

Medicare – Medicaid Matching Project

In the coming months, the N.C. Medicaid program will participate in a project with Medicare to detect erroneous payments, abuse, and fraud. Medicare will receive the N.C. Medicaid claim file and combine it with the Medicare claim file to create a single database of all billings. A Medicare Program Safeguard Contractor (PSC) will then "data mine" the information to identify potentially improper billings.

Areas that will be targeted:

1. Any alterations in billing information to Medicaid after Medicare payment has been received.

   Examples: changing units billed, reporting the incorrect Medicare payment on the Medicaid billing, changing procedure codes, etc.

2. Billing for provision of more than 24 hours of services in one day.
3. Providing treatment and services in ways more statistically significant than similar practitioner groups.
4. Up-coding and billing for services that are more expensive than the services actually performed.

Medicare and Medicaid will jointly investigate all suspicious findings. The Office of the Inspector General and the N.C. Attorney General's Medicaid Investigation Unit will also participate in the investigation and the prosecution of any criminal or civil fraud detected in this effort.

DMA Program Integrity staff will recover payments made to providers resulting from administrative errors not due to fraud. To report or refund payments from any erroneous billings to Medicaid, please contact Pat Delbridge at 919-733-6681 or by e-mail at Pat.Delbridge@ncmail.net.

Program Integrity Section
DMA, 919-733-6681

Attention: All Providers

Condition Codes D7 and D9 – Change for Medicare Overrides, Part A and Part B

To comply with the implementation of national codes mandated by the Health Insurance Portability and Accountability Act (HIPAA), state-created condition codes 87 and 89 will be end-dated effective with date of service September 30, 2003. Effective with date of service October 1, 2003, providers must submit national condition code D7 in place of 87 to override Medicare Part A, and D9 in the place of 89 to override Medicare Part B. These condition codes are entered in form locator fields 24 through 30 on UB-92 claims. Claims submitted with condition codes 87 and 89 after October 1, 2003 will deny.

This change applies to all electronic and paper claim formats.

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

Attention: All Providers

New Billing Guidelines for Sterilization Procedures

To comply with the implementation of national codes mandated by the Health Insurance Portability and Accountability Act (HIPAA), state-created procedure code W5075 will be end-dated effective with date of service September 30, 2003. Effective with date of service October 1, 2003, providers must bill with nationally recognized CPT and ICD-9-CM procedure codes. Claims billed with end-dated procedure codes for dates of service on and after October 1, 2003 will deny.

Diagnosis and Procedure Codes for Elective Sterilization

Physician Claims (CMS-1500)

The following codes are the only codes to be considered specifically for the purpose of elective sterilization:

- ICD-9-CM diagnoses for sterilization: V25.2 or V61.5
- CPT procedure code for vasectomy: 55250
- CPT procedure codes for female sterilization: 58600, 58605, 58611, 58615, 58670, and 58671

Hospital Claims (UB-92)

- ICD-9-CM procedure codes: 63.70, 63.71, 63.73, 66.21, 66.22, 66.29, 66.31, 66.32, and 66.39

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

Attention: All Providers

Proposed Medical Coverage Policies

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

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

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

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

Attention: All Providers

New Billing Guidelines for Abortion Procedures

To comply with the implementation of national codes mandated by the Health Insurance Portability and Accountability Act (HIPAA), state-created procedure codes for abortion, W8206 and W8207, will be end-dated effective with date of service September 30, 2003. Effective with date of service October 1, 2003, nationally recognized CPT and ICD-9-CM procedure codes must be billed for abortion services. Claims billed with end-dated procedure codes for dates of service on and after October 1, 2003 will deny.

Abortion Billing Chart

Therapeutic Abortions			
Claim Type	**Procedure Code**	**ICD-9-CM Diagnosis Code**	**Abortion Statement Required**
Physician (CMS-1500)	59830 - 59857	635 - 635.92	Yes, with records
	59830 - 59857	638 - 638.92	Yes, with records
	59830 - 59857	V61.8	Yes
	59830 - 59857	V71.5	Yes
Hospital (UB-92)	69.01, 69.51, 74.91, 75.0, 96.49	635 - 635.92	Yes, with records
	69.01, 69.51, 74.91, 75.0, 96.49	638 - 638.9	Yes, with records
	69.01, 69.51, 74.91, 75.0, 96.49	V61.8	Yes
	69.01, 69.51, 74.91, 75.0, 96.49	V71.5	Yes
Non-Therapeutic Abortions			
Claim Type	**Procedure Code**	**ICD-9-CM Diagnosis Code**	**Abortion Statement Required**
Physician (CMS-1500)	59870	630	No
	59812, 59820, 59821, 59830	631, 632, 634 - 634.92, 637 - 637.9	No
Hospital (UB-92)	68.0	630	No
Hospital (UB-92)	69.02, 69.52	Any OB diagnosis except 635 - 635.92, 638 - 638.92	Possible (medical records may be requested)
Hospital (UB-92)	69.09	630, 631, 632	Possible (medical records may be requested)

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

Attention: All Providers

State-Created Diagnosis Codes

Effective October 1, 2003, the following list of state-created diagnosis codes will be end-dated to comply with the implementation of national code sets mandated by the Health Insurance Portability and Accountability Act (HIPAA).

Claims submitted using these state-created codes for dates of service after September 30, 2003 will deny. Providers must use appropriate national diagnosis codes from current coding manuals when submitting claims.

End-Dated Codes

042.0	042.1	042.20	042.9	043	043.0
043.1	043.2	043.3	043.9	044	044.0
044.9	095.56	095.59	303.1	303.2	303.3
305.1	305.11	305.12	305.13	404.2	404.3
640.02	640.04	640.82	640.84	640.92	640.94
641.02	641.04	641.12	641.14	641.22	641.24
641.32	641.34	641.82	641.84	641.92	641.94
643.02	643.04	643.12	643.14	643.22	643.24
643.82	643.84	643.92	643.94	651.02	651.04
651.12	651.14	651.22	651.24	651.82	651.84
651.92	651.94	652.02	652.04	652.12	652.14
652.22	652.24	652.32	652.34	652.42	652.44
652.52	652.54	652.62	652.64	652.72	652.74
652.82	652.84	652.92	652.94	653.02	653.04
653.12	653.14	653.22	653.24	653.32	653.34
653.42	653.44	653.52	653.54	653.62	653.64
653.72	653.74	653.82	653.84	653.92	653.94
654.22	654.24	655.02	655.04	655.12	655.14
655.22	655.24	655.32	655.34	655.42	655.44
655.52	655.54	655.62	655.64	655.82	655.84
655.92	655.94	656.02	656.04	656.12	656.14
656.22	656.24	656.32	656.34	656.42	656.44
656.52	656.54	656.62	656.64	656.72	656.74
656.82	656.84	656.92	656.94	657.02	657.04
658.02	658.04	658.12	658.14	658.22	658.24
658.32	658.34	658.42	658.44	658.82	658.84
658.92	658.94	659.02	659.04	659.12	659.14
659.22	659.24	659.32	659.34	659.42	659.44

End-Dated Codes, continued

659.52	659.54	659.82	659.84	659.92	659.94
660.02	660.04	660.12	660.14	660.22	660.24
660.32	660.34	660.42	660.44	660.52	660.54
660.62	660.64	660.72	660.74	660.82	660.84
660.91	660.94	661.02	661.04	661.12	661.14
661.22	661.24	661.32	661.34	661.42	661.44
661.92	661.94	662.02	662.04	662.12	662.14
662.22	662.24	662.32	662.34	663.02	663.04
663.12	663.14	663.22	663.24	663.32	663.34
663.42	663.44	663.52	663.54	663.62	663.64
663.82	663.84	663.92	663.94	664.02	664.03
664.12	664.13	664.22	664.23	664.32	664.33
664.42	664.43	664.52	664.53	664.82	664.83
664.92	664.93	665.02	665.04	665.12	665.13
665.14	665.21	665.23	665.32	665.33	665.42
665.43	665.52	665.53	665.62	665.63	665.73
666.01	666.03	666.11	666.13	666.21	666.23
666.31	666.33	667.01	667.03	667.11	667.13
669.31	669.33	669.52	669.53	669.54	669.62
669.63	669.64	669.72	669.73	669.74	670.01
670.03	671.32	671.34	671.41	671.43	672.01
672.03	674.11	674.13	674.21	674.23	674.31
674.33	674.41	674.43	674.81	674.83	674.91
674.93	712.0	712.4	712.5	712.6	712.7
715.01	715.02	715.03	715.05	715.06	715.07
715.08	715.19	715.29	715.39	715.81	715.82
715.83	715.84	715.85	715.86	715.87	715.88
715.99	716.69	718.06	718.16	718.61	718.62
718.63	718.64	718.66	718.67	718.68	718.69
718.96	719.71	719.72	719.73	719.74	795.8
948.01	948.02	948.03	948.04	948.05	948.06
948.07	948.08	948.09	948.12	948.13	948.14
948.15	948.16	948.17	948.18	948.19	948.23
948.24	948.25	948.26	948.27	948.28	948.29
948.34	948.35	948.36	948.37	948.38	948.39
948.45	948.46	948.47	948.48	948.49	948.56

End-Dated Codes, continued

948.57	948.58	948.59	948.67	948.68	948.69
948.78	948.79	948.89	V90.0	V90.1	V91.2
V91.8	Y00.0	Y09.1	001R	001RN	240R
240RN	280R	280RN	290R	290RN	320R
320RN	390R	390RN	460R	460RN	520R
520RN	580R	580RN	630R	630RN	680R
680RN	710R	710RN	740R	740RN	760R
760RN	780R	780RN	800R	800RN	V01R
V01RN					

Deborah Ireland, Medical Policy Section
DMA, 919-857-4020

Attention: All Providers

CPT Code Update 2003

New 2003 CPT codes are covered by N.C. Medicaid retroactively to date of service March 1, 2003. Claims may be filed for services performed on or after March 1, 2003. Claims that were filed and received a denial for EOB 9, "service not covered by the Medicaid program" may be refiled at this time as a new claim. Claims with codes end-dated in 2003 will deny effective with dates of service on or after September 1, 2003.

The following table lists CPT codes that may be billed.

20612	21046	21047	21048	21049	29827	29873	29899	33215	33224
33225	33226	33508	34833	34834	34900	35572	36511	36512	36513
36514	36515	36516	36536	36537	37182	37183	37500	38205	38206
38242	43201	43236	44206	44207	44208	44210	44211	44212	44238
44701	45335	45340	45381	45386	46706	49419	49904	50542	50543
50562	51701	51702	51703	55866	56820	56821	57420	57421	57455
57456	57461	58146	58290	58291	58292	58293	58294	58545	58546
58552	58553	58554	61316	61322	61323	61517	61623	62148	62160
62161	62162	62163	62164	62165	62264	64416	64446	64447	64448
66990	75901	75902	75954	76071	76801	76802	76811	76812	76817
83880	84302	85004	85032	85049	85380	87255	87267	87271	88174
88175	89055	92601	92602	92603	92604	92607	92608	92609	92610
92611	92612	92614	92616	92700	93580	93581	95990	96920	96921
96922	99293	99294	99299						

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

Attention: Ambulance Service Providers

New Ambulance Billing Guidelines

Effective with date of service October 15, 2003, the N.C. Medicaid program will end-date the following condition codes to comply with the implementation of national codes mandated by the Health Insurance Portability and Accountability Act (HIPAA): 81, 82, 83, 84, 85, 86, 90, 91, 92, 93, 94, 95, 96, 97, and 98. Providers must bill using the national condition codes listed below, effective with date of service **October 16, 2003**. Claims submitted after October 15, 2003 with end-dated condition codes will deny.

Condition Code	Description	When to Include on UB-92
AK	Air ambulance required – time needed to transport poses a threat	Use on any appropriate air ambulance claim.
AL	Specialized treatment/ bed unavailable	Use if recipient is taken to a hospital other than the nearest, due to treatment unavailable or beds unavailable.
AM	Non-emergency medically necessary stretcher transport	Use when recipient is bed-confined and his/her condition is such that a stretcher is the only safe mode of transportation.

Medicare Part B Override

Effective with date of service September 30, 2003, condition code 89 will be end-dated. Effective with date of service **October 1, 2003**, ambulance providers must submit national condition code D9 in the place of 89 to override Medicare Part B.

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

Attention: Area Mental Health Centers and Residential Treatment Providers (Level II – IV Services for Children Under the Age of 21)

Cancellation of Area Mental Health and Residential Child Care Treatment Seminars

Due to the fact that the implementation date published in the August 2003 general Medicaid bulletin and Special Bulletin III, *HIPAA Code Conversion*, has been **delayed**, the seminars scheduled for September 2, 3, 4, and 5, 2003 have been **cancelled**. Providers should continue to bill with existing procedure codes until further notice.

The seminars will be rescheduled for a later date. Providers will be notified in future general Medicaid bulletins of the new dates and registration information for the seminars.

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

Attention: Area Mental Health Centers and CAP-MR/DD Case Managers and Providers

Billing Update and Population Groups for CAP-MR/DD Services

The July 2003 general Medicaid bulletin listed the new national codes and descriptions for the CAP-MR/DD program. One rate adjustment was required. Effective with the date of service October 1, 2003, the new rate will be as noted below.

Current Local Code	Local Code Description	Current Rate	New National Code	National Code Description	New Rate
W8194	Day Habilitation, Periodic-Group (over 2 clients), per 15 minutes	$2.10 per 15 minute unit	T2021 HQ	Day Habilitation, Waiver, per 15 minutes	$3.00 per 15 minute unit
W8195	Day Habilitation, Periodic-Group (2 clients), per 15 minutes	$3.68 per 15 minute unit			

Population Groups

DMA implemented population groups in 2001 to control and track specific benefit packages for designated groups of Medicaid recipients. For a provider, population groups mean two things:

1. The provider must be enrolled to provide services to members of the CAP-MR/DD population group for claims to be paid. Existing CAP providers were enrolled in the appropriate CAP population group(s) according to current enrollment information on file with DMA as of July 11, 2003.
2. The Remittance and Status Report (RA) provides information by population group. The population payer code is printed at the beginning of each claim detail line on the RA. The code denotes the special program/population group from which a recipient is receiving Medicaid benefits. The code for CAP-MR/DD is "CAPMR." (The CAP-MR/DD indicator on the recipient's Medicaid identification card will remain "CM.") This information helps providers track receipts in their accounting systems by each CAP population group for which they are providing services.

Diane Holder, R.N., Behavioral Health Services
DMA, 919-857-4040

Attention: Children's Developmental Service Agencies

Medical Coverage Policy 8J, Children's Developmental Service Agencies

The medical coverage criteria and guidelines for the administration of North Carolina Infant-Toddler Program by Children's Developmental Service Agencies (CDSAs) are now available in Medical Coverage Policy 8J on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm.

Monica Teasley, Behavioral Health Services
DMA, 919-857-4040

Attention: Area Mental Health Centers and Residential Treatment Providers (Level II – IV Services for Children Under the Age of 21)

Clarification on the Use of the F2 Stamp

Special Bulletin III, *HIPAA Code Conversion*, August 2003, included information regarding the use of the F2 stamp. In addition to the three scenarios listed in the special bulletin regarding when a provider may use the F2 stamp, the following scenario should be added:

> If there is no enrolled Medicaid provider in the local Area Mental Health Center, the program will inform the client of other alternatives to treatment by Medicare-enrolled providers. If there are no enrolled Medicare providers within a 30-mile radius of the facility, the local Area Mental Health Center is allowed to serve the client and bill Medicaid.

Carol Robertson, Behavioral Health Services
DMA, 919-857-4040

Attention: Dialysis Treatment Facilities, Nurse Midwives, Nurse Practitioners, and Physicians

Calcitriol Injection, 0.1 mcg (J0636) – Billing Guidelines

The N.C. Medicaid program end-dated HCPCS code J0635 (Injection, calcitriol, 1 mcg ampule), effective with date of service August 31, 2003. Effective with date of service September 1, 2003, providers must bill **J0636** (Injection, calcitriol**, 0.1 mcg**).

Providers must indicate the number of units given in block 24G on the CMS-1500 claim form. Dialysis treatment facilities must indicate the units given in form locator 46 of the UB-92 claim form and must enter the total charges in form locator 47. Providers must bill their usual and customary charge. The maximum reimbursement rate per unit is $1.31.

Add this code to the lists of injectable drugs published in the June 2002 and August 2002 general Medicaid bulletins.

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

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

HCPCS Code Changes for Home Health Supplies

Effective with date of service September 30, 2003, the following HCPCS codes will be end-dated to comply with the implementation of national standard codes mandated by the Health Insurance Portability and Accountability Act (HIPAA). New codes will become effective with date of service October 1, 2003.

Old Code	New Code	Description	Billing Unit	Maximum Reimbursement Rate
W4617	T1999 *(misc.)*	Personal care item, NOS *(Fleet enema)*	Each	N/A
W4640	S1015	IV tubing extension set *(IV administration set)*	Each	$ 4.34
W4663	A4656	Needle, any size *(Needle, sterile, filter)*	Each	.44
W4740	B9999	NOC for parenteral supplies *(IV infusion start kit – sterile drape, tourniquet, 2x2's, tape, alcohol/iodine wipe, dressing)*	Each	2.72
W4741	T1999 *(misc.)*	Personal care item, NOS (*venipuncture kit*)	Each	N/A
W4742	T1999 *(misc.)*	Personal care item, NOS *(cotton-tip applicator, sterile)*	Each	N/A
	K0621	Gauze, packing strips, non-impregnated, up to 2 inches in width	Linear yard	1.88

Providers must bill their usual and customary charges.

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

Attention: Durable Medical Equipment Providers

Deletion of Codes W4007 and W4035

Codes W4007, isolette, and W4035, compressor (Bunn equivalent) for administration of aerosol Pentamidine, were end-dated and deleted from the DME Fee Schedule effective with dates of service September 1, 2003. This action is being taken due to non-usage of the codes.

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

Attention: Durable Medical Equipment Providers

HCPCS Code Changes

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

Old Code	New Code	Description	Quantity Limitation or Lifetime Expectancy	Maximum Reimbursement Rate
W4004	E0600	Respiratory suction pump, home model, portable or stationary, electric	2 years	Rental (modifier RR): $ 42.85 New Purchase (modifier NU): 428.53 Used Purchase (modifier UE): 321.40
W4006	E0691*	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, treatment area two square feet or less	N/A	Rental (modifier RR): 127.13
W4006	E0692*	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, four foot panel	N/A	Rental (modifier RR): 127.13
W4045	A4483	Moisture exchanger, disposable, for use with invasive mechanical ventilation	60 per month	New Purchase (modifier NU): 5.97
W4667	S8490	Insulin syringes (100 syringes, any size)	2 units of 100 per month	New Purchase (modifier NU): 0.31

Note: Codes E0691 and E0692 require prior approval. Codes E0600, A4483, and S8490 do not require prior approval. However, as with all durable medical equipment, a Certificate of Medical Necessity and Prior Approval form must be completed.

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

Attention: HIV Case Management Services Providers

Change to Implementation Date and Rate Change for Procedure Code T1017

The September 1, 2003 implementation date published in the June 2003 general Medicaid bulletin instructing providers to begin using the new procedure code T1017 has been **delayed** until October 1, 2003. Continue to use procedure code Y2331 to bill for HIV Case Management Services for September dates of service.

Effective with date of service October 1, 2003, use procedure code T1017 when billing for HIV case management services. Refer to the billing instructions published in the June 2003 general Medicaid bulletin.

Effective with date of service October 1, 2003, the maximum Medicaid reimbursement rate for HIV case management services is $13.82 per 15 minutes. Providers must continue to bill their usual and customary charge.

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

Attention: Personal Care Services (in Private Residences) Providers

Change to Implementation Date for New Codes and Claim Form

The October 1, 2003 implementation date published in the July 2003 general Medicaid bulletin regarding changes for billing Personal Care Services (PCS) in private residences has been **delayed**. Continue to bill PCS on a UB-92 claim form using revenue code 599 until further notice. Providers will be notified of the new implementation date in a future general Medicaid bulletin.

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

Attention: Private Duty Nursing Providers

Change to Implementation Date for New Codes and Claim Form

The October 1, 2003 implementation date published in the July 2003 general Medicaid bulletin regarding changes for billing Private Duty Nursing (PDN) has been **delayed**. Continue to bill PDN services on a UB-92 claim form using revenue code 590 until further notice. Providers will be notified of the new implementation date in a future general Medicaid bulletin.

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

Attention: Federally Qualified Health Centers, Health Departments, and Rural Health Clinics

Home Visit for Postnatal Assessment and Follow-Up Care When There is No Delivery Code

When a home visit for postnatal assessment and follow-up care (CPT 99501) is provided and there is not a delivery code in claims history, providers receive a denial with EOB 211, "dates of service not within the authorized time period." Providers must submit an adjustment using the Medicaid Claim Adjustment form and include supporting documentation. Examples of supporting documentation include, but are not limited to: the child's birth/death certificate; the provider's verification/statement that delivery occurred; or the child's full name, date of birth, and Medicaid identification number.

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

Attention: Federally Qualified Health Centers, Health Departments, Nurse Midwives, Nurse Practitioners, Physicians, and Rural Health Clinics

Purchasing Drugs for Administration in a Provider's Office

Providers may only bill the N.C. Medicaid program for drugs they have purchased and administered to a recipient. Medicaid reimburses for drugs in one of two ways. The provider may purchase the drug and then bill the Medicaid program on the CMS-1500 claim form or the recipient may obtain the drug by prescription from a pharmacy and bring to the office for administration. When the recipient obtains the drug from a pharmacy, the pharmacy bills the Medicaid program.

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

Attention: Health Departments

Family Planning Claims Denials

Claims submitted by health departments for complete family planning visits for dates of service between December 1, 2002 and June 30, 2003 that have denied with EOB 0773 may be resubmitted as a new claim.

Beth Osborne, Medical Policy Section
DMA, 919-857-4020

Attention: Health Departments, Nurse Practitioners, and Physicians

Immune Globulin Intravenous Injection (J1563, 1 gm and J1564, 10 mg) – Billing Guidelines

Effective with date of service September 1, 2003, the N.C. Medicaid program no longer covers intravenous immune globulin when billed with CPT code 90283. This immune globulin must be billed with HCPCS code J1563 (1 gram) and/or J1564 (10 mg).

Providers must indicate their number of units given in block 24G on the CMS-1500 claim form and must bill their usual and customary charge. The maximum reimbursement rate per unit for J1563 is $74.25 and for J1564 is $0.81.

Add these immune globulin codes to the list of injectable drugs published in the August 2002 general Medicaid bulletin.

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

Attention: Home Health Agencies

Use of Revenue Codes for Home Health Skilled Nursing Claims

Effective with date of service October 1, 2003, providers must use revenue codes when submitting claims for home health skilled nursing visits. These revenue codes replace HCPCS codes W9952 through W9959, which will be end-dated with date of service September 30, 2003. Revenue codes 550 and 559, previously used to describe visits by a registered nurse and a licensed practical nurse, will now be used for the visits described in the table below. A separate code will no longer be used to bill the "one-time" skilled nursing visit. This will now be billed as a "not otherwise classified" visit. This change is being made to comply with the implementation of national standard codes mandated by the Health Insurance Portability and Accountability Act (HIPAA).

HCPCS Code	Old Description	Rev Code	New Description
W9952	Observation/Eval. of stable patient	550	SKILLED NURSING
W9953	Prefilling insulin syringes	551	SKILLED NURS/VISIT
W9954	Prefilling medicine planners	559	SKILLED NURS/OTHER
W9955	Venipuncture	580	VISIT/HOME HEALTH
W9959	Denied by Medicare for dually-eligible patient	581	VISIT/HOME HLTH/VISIT
W9957	Visit meeting Medicare criteria	589	VISIT/HOME HLTH/OTHER
W9958 W9956	Not otherwise classified	590	UNIT/HOME HEALTH

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

Attention: Home Infusion Therapy Providers

Use of Modifiers for Home Infusion Therapy Claims

Effective with date of receipt October 1, 2003, type of service codes (TOS) will be replaced with modifiers when billing HCPCS codes B9002, B9004, B9006, and E0776 for Home Infusion Therapy (HIT). The following modifiers must be used when billing these HCPCS codes.

NU for new purchase
UE for used purchase
RR for rental

The appropriate modifier must be entered in block 24D on the CMS-1500 claim form and will replace the following TOS codes: N for new purchase, U for used purchase, and E for rental.

Providers Filing Paper Claims

To ensure correct processing of paper claims, effective September 1, 2003, enter **both** the **TOS code** and the **modifier** on the claim until further notice.

Providers Filing Electronically

Effective October 1, 2003, providers filing electronically must bill using the appropriate modifiers only.

Beth Karr, RN, Community Care Section
DMA, 919-857-4021

Attention: Nurse Practitioners and Physicians

Amphotericin B – Change In Billing Guidelines

Effective with date of service September 1, 2003, the N.C. Medicaid program no longer covers amphotericin B when billed with HCPCS code J0286. Medicaid will **continue** to cover this drug when billed with HCPCS code J0285 (amphotericin B, 50 mg), and will **add** J0287 (amphotericin B lipid complex, 10 mg), J0288 (amphotericin B cholesteryl sulfate complex, 10 mg), and J0289 (amphotericin B liposome, 10 mg).

Providers must indicate the number of units given in block 24G on the CMS-1500 claim form and must bill their usual and customary charge. The maximum reimbursement rates per unit for these codes are:

J0285	$10.48 per 50 mg
J0287	$20.70 per 10 mg
J0288	$14.40 per 10 mg
J0289	$33.91 per 10 mg

Add these drug codes to the lists of injectable drugs published in the June 2002 and August 2002 general Medicaid bulletins.

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

Attention: Nurse Practitioners and Physicians

Oxaliplatin, 50 mg (Eloxatin, J9999) – Billing Guidelines

Effective with date of service September 1, 2003, the N.C. Medicaid program covers oxaliplatin (Eloxatin) for use in the Physician's Drug Program. The FDA states that oxaliplatin, an antineoplastic agent, is used in combination with infusional 5-fluorouracil/leucovorin for the treatment of patients with metastatic carcinoma of the colon or rectum whose disease has recurred or progressed during or within six months of completion of first line therapy with the combination of bolus 5-fluorouracil/leucovorin and irinotecan.

The **ICD-9-CM** diagnosis codes that support medical necessity for oxaliplatin are:

- **153.0-153.9**, **154.0** (malignant neoplasm of rectosigmoid junction),
- **154.1** (malignant neoplasm of rectum), and
- **154.8** (malignant neoplasm of other sites of rectum rectosigmoid junction and anus).

Providers must bill **J9999**, the unclassified antineoplastic drug code, with an invoice attached to the CMS-1500 claim form. **An invoice must be submitted with each claim.** The paper invoice must indicate the name of the recipient, the recipient's Medicaid identification number, the name of the medication, the dosage given, the National Drug Code (NDC) number from the vial(s) used, the number of vials used, and the cost per dose.

Providers must indicate the number of units given in block 24G on the CMS-1500 claim form. For Medicaid billing, **one unit** of coverage is **50 mg**. The maximum reimbursement rate per unit is $894.85. Providers must bill their usual and customary charge.

Add this drug to the lists of injectable drugs published in the June 2002 and August 2002 general Medicaid bulletins.

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

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

Attention: Adult Care Home Providers

Change to Implementation Date for Adult Care Home Personal Care Services Code Conversion

The October 1, 2003 implementation date published in the August 2003 general Medicaid bulletin regarding billing changes for personal care services (basic and enhanced) has been delayed. Continue to bill for these services using existing procedure codes until further notice. Providers will be notified of the new implementation date in future general Medicaid bulletins.

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

Attention: Dental Providers and Health Department Dental Clinics

ADA Code Updates for the Year 2003 and the New Dental Claim Form

The May 2003 general Medicaid bulletin described upcoming changes in American Dental Association (ADA) codes as well as the anticipated implementation of the 2002 ADA dental claim form. This article describes several additional changes in Current Dental Terminology codes (CDT-4) to be covered by the N.C. Medicaid program effective October 1, 2003. **The information in this bulletin supersedes the information published in the May 2003 general Medicaid bulletin.**

Delay for the 2002 ADA Claim Form

Due to unanticipated delays in implementing HIPAA-compliant electronic transactions, N.C. Medicaid **will not** be ready to implement the 2002 ADA dental claim form on October 1, 2003 as originally planned. At this time, no firm date has been set to switch to the new ADA claim form. Dental providers must continue to use the 2000 version of the ADA claim form as directed in both Medical Coverage Policy 4A, Dental Services, and Medical Coverage Policy 4B, Orthodontic Services, (Dental Services provider manual) on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm. Once a final date has been set to implement the new claim form, a three-month transition period will be established. Both the current claim form and the new claims form will be accepted during the transition period. Dental providers will be notified of the final date for the implementation of the new ADA claim form in future general Medicaid bulletins.

ADA Procedure Codes Must be Billed with the "D" Prefix

Effective with date of service October 1, 2003, all dental procedure codes **must** be billed with the "D" prefix (e.g., D0120, D0150) for both electronic and paper claims. Dental procedure codes will not be accepted with the numeric zero prefix after September 30, 2003. Services billed using the numeric zero prefix procedure codes will deny with the explanation of benefit (EOB) message 0024, which states "Procedure code, procedure/modifier combination or revenue code is missing, invalid, or invalid for this bill type. Correct and rebill denied detail as a new claim."

Procedure Code Updates

Updates to CDT-4 contain procedure code deletions, procedure code additions, and revised procedure code descriptions. The N.C. Medicaid Dental Program will implement the changes listed in the following tables.

The following codes will be **end-dated** effective with date of service after **September 30, 2003**.

Procedure Code	Description
D0501	Histopathologic examinations
D2110	Amalgam-one surface, primary
D2120	Amalgam-two surfaces, primary
D2130	Amalgam-three surfaces, primary
D2131	Amalgam-four or more surfaces, primary
D2336	Resin-based composite crown-anterior-primary
D2380	Resin-based composite-one surface, posterior-primary
D2381	Resin-based composite-two surfaces, posterior-primary

End-Dated Procedure Codes, continued

Procedure Code	Description
D2385	Resin-based composite-one surface, posterior-permanent
D2386	Resin-based composite-two surfaces, posterior- permanent
D2387	Resin-based composite-three surfaces, posterior- permanent
D2388	Resin-based composite-four or more surfaces, posterior- permanent
D7110	Single tooth
D7120	Each additional tooth
D7130	Root removal-exposed roots
D7420	Radical excision-lesion diameter greater than 1.25 cm
D7430	Excision of benign tumor-lesion diameter up to 1.25
D7431	Excision of benign tumor-lesion diameter greater than 1.25

Note: All end-dated codes will be replaced with new or revised codes.

The following codes will be **added** effective with date of service **October 1, 2003**. Codes in **bold font** are in addition to those published in the May 2003 general Medicaid bulletin.

Procedure Code	Description
D0473	**Accession of tissue, gross and microscopic examination, preparation and transmission of written report**
D2390	Resin-based composite crown-anterior
D2391	Resin-based composite-one surface, posterior
D2392	Resin-based composite-two surfaces, posterior
D2393	Resin-based composite-three surfaces, posterior
D2394	Resin-based composite-four or more surfaces, posterior
D4211	**Gingivectomy or gingivoplasty – one to three teeth, per quadrant**
D4241	**Gingival flap procedure, including root planing – one to three teeth, per quadrant**
D4342	**Periodontal scaling and root planing – one to three teeth, per quadrant**
D6985	Pediatric partial denture, fixed
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7280	Surgical access of an unerupted tooth
D7411	Excision of benign lesion greater than 1.25 cm
D7472	Removal of torus palatinus
D7473	Removal of torus mandibularis

Note: Prior approval will be **required** for codes D4211, D4241, and D4342.

The following procedure code descriptions were **revised**. These new descriptions are effective with date of service **October 1, 2003**.

Procedure Code	Description
D0150	Comprehensive oral evaluation – new or established patient
D2140	Amalgam-one surface, primary or permanent
D2150	Amalgam-two surfaces, primary or permanent
D2160	Amalgam-three surfaces, primary or permanent
D2161	Amalgam-four or more surfaces, primary or permanent
D4210	Gingivectomy or gingivoplasty-four or more contiguous teeth or bounded teeth spaces, per quadrant
D4240	Gingival flap procedure, including root planing-four or more contiguous teeth or bounded teeth spaces, per quadrant
D4341	Periodontal scaling and root planing-four or more contiguous teeth or bounded teeth spaces, per quadrant
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis
D4910	Periodontal maintenance
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7410	Excision of benign lesion up to 1.25 cm
D7450	Removal of benign odontogenic cyst or tumor-lesion diameter up to 1.25 cm
D7451	Removal of benign odontogenic cyst or tumor-lesion diameter greater than 1.25 cm
D7460	Removal of benign nonodontogenic cyst or tumor-lesion diameter up to 1.25 cm
D7461	Removal of benign nonodontogenic cyst or tumor-lesion diameter greater than 1.25 cm
D7471	Removal of lateral exostosis (maxilla or mandible)
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone
D7670	Alveolus-closed reduction, may include stabilization of teeth
D7770	Alveolus-open reduction stabilization of teeth
D9220	Deep sedation/general anesthesia-first 30 minutes
D9221	Deep sedation/general anesthesia-each additional 15 minutes
D9241	Intravenous conscious sedation/analgesia- first 30 minutes
D9242	Intravenous conscious sedation/analgesia- each additional 15 minutes

Clarification of Policy and Criteria Due to Procedure Code Revisions and Additions

These changes are effective with date of service after September 30, 2003.

Code	Description	Criteria
D0150	Comprehensive oral evaluation – new or established patient	This is allowed as the **initial exam** once per provider for each recipient.
D2390	Resin-based composite crown, anterior	This is allowed for **primary** anterior teeth only (C-H, M-R).
D2393	Resin-based composite-three surfaces, posterior	This is allowed for **permanent** posterior teeth only (1-5, 12-21, 28-32).
D2394	Resin-based composite-four or more surfaces, posterior	This is allowed for **permanent** posterior teeth only (1-5, 12-21, 28-32, 40).
D4210	Gingivectomy or gingivoplasty-four or more contiguous teeth or bounded teeth spaces, per quadrant	At least **four teeth** must be present to qualify for a quadrant. Use only quadrant codes UR, UL, LR and LL. Arch codes UP and LO will no longer be accepted as of 10/01/2003.
D4211	Gingivectomy or gingivoplasty – one to three teeth, per quadrant	Use instead of D4210 if only **one to three teeth** remain in a quadrant. Use only quadrant codes UR, UL, LR and LL. Arch codes UP and LO will no longer be accepted as of 10/01/2003.
D4240	Gingival flap procedure, including root planing-four or more contiguous teeth or bounded teeth spaces, per quadrant	At least **four teeth** must be present to qualify for a quadrant. Use only quadrant codes UR, UL, LR and LL. Arch codes UP and LO will no longer be accepted as of 10/01/2003.
D4241	Gingival flap procedure, including root planing – one to three teeth, per quadrant	Use instead of D4240 if only **one to three teeth** remain in a quadrant. Use only quadrant codes UR, UL, LR and LL. Arch codes UP and LO will no longer be accepted as of 10/01/2003.
D4341	Periodontal scaling and root planning-four or more contiguous teeth or bounded teeth spaces, per quadrant	At least **four teeth** must be present to qualify for a quadrant. Use only quadrant codes UR, UL, LR and LL. Arch codes UP and LO will no longer be accepted as of 10/01/2003.
D4342	Periodontal scaling and root planing – one to three teeth, per quadrant	Use instead of D4341 if only **one to three teeth** remain in a quadrant. Use only quadrant codes UR, UL, LR and LL. Arch codes UP and LO will no longer be accepted as of 10/01/2003.
D7471	Removal of lateral exostosis (maxilla or mandible)	This is allowed as an **arch** procedure (UP, LO).
D7472	Removal of torus palatinus	This is allowed as an **upper arch** procedure (UP).
D7473	Removal of torus mandibularis	This is allowed as a **lower arch** procedure (LO).

For a complete list of criteria specific to these procedure codes, refer to Medical Coverage Policy #4A, Dental Services.

New Coding for Supernumerary Teeth

In February 2003, the ADA published a revised coding system for supernumerary teeth. In this coding system, supernumerary teeth in the primary dentition are numbered relative to the nearest natural primary tooth. The letter "S" is added to the primary tooth letter to create a range of tooth numbers from "AS" to "TS." In the permanent dentition, supernumerary teeth are numbered from 51 to 82. The numbering begins in the upper

right quadrant, continues around the upper arch to the upper left quadrant, and then continues from the lower left to the lower right. Use of this new numbering system will be required on N.C. Medicaid claims effective with date of service October 1, 2003 and after. As of that date, the old code of "40" for supernumerary teeth ceases to be valid. Please refer to Medical Coverage Policy 4A, Dental Services, for specific procedure codes requiring valid tooth numbers.

Valid Quadrant Indicators

Due to HIPAA regulations, quadrant indicators UA (upper anterior) and LA (lower anterior) will no longer be accepted on N.C. Medicaid claims effective with date of service October 1, 2003 and after. These quadrant indicators remain valid for selected procedure codes through date of service September 30, 2003. Please refer to Medical Coverage Policy 4A, Dental Services, for specific procedure codes and valid quadrant indicators.

Eight-Digit Dates Required for Dental Paper Claims

Effective October 1, 2003, all dates on the paper ADA claim form must be formatted with eight digits (October 1, 2003 would be listed as 10012003). Using six digits for the date of service will no longer be accepted. Beginning October 1, 2003, dental claims that are submitted without eight-digit dates will deny as having missing or invalid dates.

CPT Codes Covered in the Medicaid Dental Program

The N.C. Medicaid Dental Program currently reimburses providers using both CDT codes and Current Procedural Terminology (CPT) codes published by the American Medical Association. These selected CPT codes are used primarily to reimburse for surgical services provided by dentists, including oral and maxillofacial surgeons.

HIPAA has designated the CDT-4 procedure codes as the standard national code set for electronic dental claim transactions. This regulation applies to all health care providers and health plans who conduct electronic transactions. To comply with this regulation, DMA must convert to the CDT-4 codes by October 16, 2003.

While reimbursement for CPT codes represents a very small proportion of Medicaid dental expenditures in the last fiscal year, these procedures are important to the recipients being served. The Division of Medical Assistance has been working with EDS to find a solution that can be implemented quickly and effectively to maintain the current scope of dental coverage with the least administrative burden to dental providers. It is anticipated that:

1. additional CDT-4 codes will be covered through the dental program to replace the currently covered CPT codes; and
2. reimbursement rates will be adjusted to ensure that all provider types are reimbursed equally for comparable services.

Billing instructions, code changes, and implementation dates will be published in future general Medicaid bulletins. These changes will also be incorporated into Medical Coverage Policy 4A, Dental Services.

Medical Coverage Policy Updates

A revised version of Medical Coverage Policy 4A, Dental Services, and Medical Coverage Policy 4B, Orthodontic Services will be available on October 1, 2003 on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm.

Ronald Venezie, DDS, MS, Dental Advisor
DMA, 919-857-4020

Holiday Closing

The Division of Medical Assistance (DMA) and EDS will be closed on Monday, September 1, in observance of Labor Day.

Checkwrite Schedule

September 3, 2003	October 7, 2003	November 4, 2003
September 9, 2003	October 14, 2003	November 12, 2003
September 16, 2003	October 21, 2003	November 18, 2003
	October 30, 2003	November 26, 2003

Electronic Cut-Off Schedule

September 5, 2003	October 3, 2003	October 31, 2003
September 12, 2003	October 10, 2003	November 7, 2003
	October 17, 2003	November 14, 2003
	October 24, 2003	November 21, 2003

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

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

Patricia MacTaggart
Executive Director
EDS

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