Number 10 *October 2003*

North Carolina Medicaid Bulletin

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

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

Attention: All Providers

New Mailing Address for the Division of Medical Assistance

Beginning September 1, 2003, the Division of Medical Assistance consolidated the mail service center addresses for each section or unit, except Third Party Recovery, into one mail service center address. Providers must include the name of the section or unit on the second line of the address to ensure that correspondence is routed correctly. The new address is as follows:

Division of Medical Assistance
Name of Section or Unit
2501 Mail Service Center
Raleigh, NC 27699-2501

The address for the Third Party Recovery unit is:

Division of Medical Assistance
Third Party Recovery Unit
2508 Mail Service Center
Raleigh, NC 27699-2508

All certified mail, UPS or Federal Express must be sent to:

Division of Medical Assistance
Name of Section or Unit
1985 Umstead Drive
Raleigh, NC 27502

Note: Providers must continue to send their Medicaid Credit Balance Report forms to Third Party Recovery at the address listed above. These forms may also be submitted by fax to 919-715-4725.

Gina Rutherford, Provider Services Unit
DMA, 919-857-4017

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Attention: All Providers

Carolina ACCESS Response to Hurricane Isabel

Carolina ACCESS enrollees in the following 15 counties are exempted from the Carolina ACCESS primary care provider authorization requirement for dates of service September 19, 2003 through October 31, 2003:

Bertie	Gates	Northampton
Camden	Halifax	Pasquotank
Chowan	Hertford	Perquimans
Currituck	Hyde	Tyrell
Dare	Martin	Washington

This exemption applies only to the residents of these counties.

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

Attention: Nursing Facility Providers

Emergency Procedures and Billing Guidelines for Nursing Facility Residents Relocated Due to Hurricane Isabel

As required by the Division of Facility Services, all nursing facilities in North Carolina must have a safety policy in place to follow during emergencies and disasters (10 NCAC 03H.2208). The nursing facility should designate an alternate facility or hospital as a location that residents can be transported to if evacuation becomes necessary. If the residents are transported to another nursing facility, the facility must be certified by Medicare and Medicaid.

The following billing procedures apply in an emergency evacuation situation.

1. Transportation for evacuation must be provided by the nursing facility. If the resident requires transport by ambulance, this service may be billed to Medicaid by the ambulance provider.
2. Nursing facilities that transport residents to other nursing facility locations and provide their staff for resident care may bill Medicaid in the same manner as they would if the resident was at their original location.
3. Nursing facilities may bill the days that a resident spends with family during an emergency situation to Medicaid as therapeutic leave.
4. The requirement to submit an FL2 will be waived for those nursing facilities affected by a disaster or an emergency situation.
5. Hospitals that accept residents during a disaster or emergency situation may bill Medicaid at the lower level of care rates.

Linda R. Perry, Long-Term Care Nurse Consultant
Gloria Corbett, Long-Term Care Nurse Consultant
DMA, 919-857-4020

Attention: All Providers

HIPAA Implementation Update

HIPAA Compliant Transactions

Effective October 13, 2003, the N.C. Medicaid program will implement the following American National Standard Institute (ANSI) Accredited Standards Committee (ASC) X12N standards, Version 4010A1 standard transactions:

- Health Care Claim (Professional, Institutional, Dental) – 837 Transaction
- Health Care Claim Payment Advice – 835/Unsolicited 277 Transaction
- Claim Inquiry and Response – 276/277 Transaction

Transactions previously implemented by N.C. Medicaid include:

- Eligibility Benefit Inquiry/Response – 270/271 Transaction
- Request for Services – 278 Transaction

All of the ANSI outbound transactions are certified through Claredi. The certification status for N.C. Medicaid can be viewed on the Claredi website under the Group Name "Division of Medical Assistance."

In addition to the ANSI (ASC) X12, Version 4010A1 standard transactions, N.C. Medicaid will implement the National Council for Prescription Drug Programs (NCPDP), Version 1.1 Batch standard effective October 13, 2003. NCPDP Version 5.1 for Point-of-Sale was implemented August 1, 2003. Effective October 12, 2003, N.C. Medicaid will accept the metric decimal quantity for claims submitted using NCPDP Version 5.1 and 1.1.

Please note the following key points with the implementation of the HIPAA standard transactions:

- Claims submitted using the 837 that have more than 28 service lines will be accepted by N.C. Medicaid but separated into multiple claims or bundled for adjudication. Each separated claim will be returned on the printed RA, tape RA, and 835 electronic RA as individual claims.
- The 277 transactions will be implemented so that claim information is returned to the trading partner at the header level only.

Non-Compliant Electronic Transactions

After the October 16, 2003 HIPAA compliance date, N.C. Medicaid will continue to accept and process the existing, non-compliant claim formats. Additionally, the current tape RA format produced on cartridge and CD-ROM will continue to be distributed.

The N.C. Medicaid program is implementing these contingencies to assure uninterrupted service to Medicaid recipients and continued cash flow for the provider community while providers and trading partners work to complete their testing of the standard transactions.

The Division of Medical Assistance and EDS will continue to assess the readiness of N.C. Medicaid trading partners to determine how long the non-compliant transactions will be exchanged. Please refer to future general Medicaid bulletins for information on the duration of accepting and returning the current electronic formats.

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

Attention: All Providers

HIPAA Transaction Testing

The EDS Electronic Commerce Services (ECS) Unit is available to assist providers, their billing agents, and vendors in testing each of the HIPAA transaction sets.

837 Claim Transactions (Institutional, Professional, and Dental)

In an effort to expedite the trading partner testing, the ECS Transaction Testing Team has compiled the following list of issues from trading partner testing:

- Incorrect value sent in the 2010BB Loop of the 837 Professional and 837 Institutional claims for the Payer ID value. Segment – NM1 Element 09 – "NCXIX" is being sent incorrectly. The correct value should be "DNC00."
- Value sent in Segment – GS Element 08. N.C. Medicaid is receiving the version number with a letter "D" before the A1 addendum indication on the end of the Transaction Version Release ID Code. The "D" does not need to be sent for our trading partner testing and if submitted may report errors on the 997 acknowledgement.
- Incorrect values sent in the ISA06 and GS02 "Sender ID" elements. This value should reflect the Trading Partner Mailbox that the ECS Unit assigns and discusses with the tester when making initial contact about testing.

835 Electronic Remittance Advice Transaction

The ECS Unit has created sample 835 transactions that are available to trading partners to download for testing. These test transactions provide the tester with a sample of the 835 produced from the N.C. Medicaid system. A test transaction is available for each of the claim types – Institutional, Professional, Dental, and Pharmacy.

Additional Transaction Information

Additional information on each of the HIPAA transactions can be found in the North Carolina Medicaid HIPAA Companion Guides. The Companion Guides are available on DMA's website at http://www.dhhs.state.nc.us/dma/hipaa/compguides.htm.

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

Attention: All Providers

Abortion Procedures – Revision to Billing Guidelines

ICD-9-CM procedure code 69.59 has been added to the list of non-therapeutic abortion codes for hospital claims published in the September 2003 general Medicaid bulletin.

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, were 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, 69.59	630, 631, 632	Possible (medical records may be requested)

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

Attention: All Providers

Influenza Vaccine Reimbursement Guidelines

The N.C. Medicaid program reimburses for vaccines in accordance with guidelines from the Advisory Committee on Immunization Practices (ACIP). Information regarding the risk categories pertinent to the influenza vaccine may be found at http://www.cdc.gov/nip/ACIP/default.htm.

The North Carolina Immunization Branch distributes childhood vaccines to local health departments, hospitals, and private providers for use in accordance with the North Carolina Universal Childhood Vaccine Distribution Program/Vaccine for Children (UCVDP/VFC) coverage criteria, N.C. General Statutes, and the N.C. Administrative Code.

UCVDP/VFC influenza vaccine is available at no charge to the provider for children who meet one of the following criteria:

Group 1: All healthy children ≥ 6 months through 23 months of age

Group 2: Pediatric household contacts (≥ 6 months through 18 years of age) of all Healthy children in Group 1

Group 3: All high-risk children ≥ 6 months through 18 years of age

Group 4: Pediatric household contacts (≥ 6 months through 18 years of age) of high-risk children in Group 3

Note: Children ≥ 6 months through 8 years of age who have not received the influenza vaccine in previous years should receive 2 doses, 30 days apart. The recommended dosage for children ≥ 6 months through 35 months is 0.25 ml. The recommended dosage for children ≥ 3 years is 0.5 ml.

Billing Reminders

1. Medicaid does not cover influenza vaccine that is supplied through UVCDP/VFC for recipients through 18 years of age. Report CPT code 90655 or 90657 for children ≥ 6 months through 35 months of age and CPT code 90658 for children ≥ 3 years through 18 years of age.
2. All providers, except local health departments, may bill for an administration fee using CPT code 90471 or 90471 and 90472, as appropriate. Local health departments may bill CPT code 90471 with the EP modifier for any visit other than a Health Check screening.
3. All providers may bill Medicaid for influenza vaccine for high-risk adults ≥ 19 years of age using CPT code 90658 and for the administration fee using CPT code 90471.
4. An Evaluation and Management (E/M) code cannot be reimbursed to any provider on the same day that injection administration fee codes (90471, or 90471 and 90472) are reimbursed, unless the provider bills an E/M code for a separately identifiable service by appending modifier 25 to the E/M code.

Use the following codes to **report** an influenza vaccine administered to a recipient under 19 years of age:

CPT Code	Description
90655	Influenza virus vaccine, preservative free, for children 6-35 months of age, for intramuscular use
90657	Influenza virus vaccine, split virus, 6-35 months dosage, for intramuscular of jet injection use
90658	Influenza virus vaccine, split virus, 3 years and above dosage, for intramuscular or jet injection use*

Use the following code to **bill** Medicaid for an influenza vaccine administered to a recipient 19 years of age or older.

CPT Code	Description
90658	Influenza virus vaccine, split virus, 3 years and above dosage, for intramuscular or jet injection use

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

Attention: All Providers

Dexamethasone Acetate (HCPCS Code J1094, 1 mg Injection) – Billing Guidelines

The N.C. Medicaid program end-dated HCPCS code J1095 (injection, dexamethasone acetate, 8 mg), effective with date of service September 30, 2003. Effective with date of service October 1, 2003, providers must bill **J1094** (injection, dexamethasone, **1 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 rate per unit is $0.68.

Add J1094 to the lists of injectable drugs published in the June 2002 and August 2002 general Medicaid bulletins and delete J1095.

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

Attention: All Providers

Depo-Provera (Medroxyprogesterone Acetate, HCPCS Code J1051, 50 mg Injection) – Billing Guidelines

The N.C. Medicaid program end-dated HCPCS code J1050 (Injection, medroxyprogesterone acetate, 100 mg, Depo-Provera), effective with date of service September 30, 2003. Effective with date of service October 1, 2003, providers must bill **J1051** (injection, medroxyprogesterone**, 50 mg**) for Depo-Provera.

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 rate per unit is $4.72.

Add J1051 to the lists of injectable drugs published in the June 2002 and August 2002 general Medicaid bulletins and delete J1050.

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

Attention: All Providers

Insulin Injection (Per 5 Units, HCPCS Code J1815) – Billing Guidelines

The N.C. Medicaid program end-dated HCPCS code J1820 (Injection, insulin, up to 100 units), effective with date of service September 30, 2003. Effective with date of service October 1, 2003, providers must bill **J1815** (Injection, insulin, per 5 units).

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 5 units is $0.10.

Add J1815 to the lists of injectable drugs published in the June 2002 and August 2002 general Medicaid bulletins and delete J1820.

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

Attention: NCECS Billers

North Carolina Electronic Claims Submission Web-Based Tool

Beginning October 13, 2003, concurrent with the implementation of the American National Standard Institute (ANSI) Accredited Standards Committee (ASC) X12N standards, Version 4010A1 837 Health Care Claim (Professional, Institutional, Dental) transaction, providers will have access to all menu options on the North Carolina Electronic Claims Submission web-based tool (NCECS-Web). Menu options include:

- List Management – allows the user to create and maintain claims-related information on recipients, procedure codes, diagnosis codes, etc.
- Claims Entry – allows the user to add, edit, delete, copy, and view claims prior to submission to N.C. Medicaid.
- Claims Submission – allows the user a portal through which NCECS-Web claims are submitted to N.C. Medicaid for processing.
- Reports – offers the user a log of claims submitted through NCECS-Web.
- Reference – offers the user tutorial exercises on the functionality of NCECS-Web, including a helpful Users Guide.

NCECS-Web allows users to submit HIPAA-compliant claims to N.C. Medicaid. NCECS-Web supports the Professional, Institutional, and Dental claim transactions. NCECS-Web is compatible with N.C. Medicaid only.

NCECS-Web will ultimately replace the NCECS software currently in use and is free to providers to file claims electronically to N.C. Medicaid. The replacement is necessary to comply with the implementation of data content standards required by the Health Insurance Portability and Accountability Act (HIPAA). However, claims filed using NCECS software will continue to be accepted until further notice.

Providers who are interested in using NCECS-Web and do not currently have a Login ID and a password may contact the EDS Electronic Commerce Services Unit at 1-800-688-6696, option 1 for assistance. Providers currently assigned an NCECS Login ID and password may access the tool at https://webclaims.ncmedicaid.com/ncecs.

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

Attention: All Providers

Sterilization Procedures – Revision to Billing Guidelines

Two additional procedure codes have to been added to the list of sterilization procedure codes published in the September 2003 general Medicaid bulletin. CPT procedure code 55450 has been added to the list of procedure codes for elective male sterilization and ICD-9-CM procedure code 63.72 has been added to the list of codes for hospital claims.

To comply with the implementation of national codes mandated by the Health Insurance Portability and Accountability Act (HIPAA), state-created procedure code W5075 was 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 codes for male sterilization (vasectomy): 55250 and 55450
- 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, 63.72, 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

Medical Coverage Policies

Updated policies for the following programs are now available on the Division of Medical Assistance's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm:

1D-1	Refugee Health Assessments Provided in Health Departments
4A	Dental Services
4B	Orthodontic Services
5	Durable Medical Equipment
8H	Local Education Agencies

These policies supersede previously published policies and procedures. Providers may contact EDS at 1-800-688-6696 or 919-851-8888 with billing questions.

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

Attention: Adult Care Home Providers

Adult Care Home Personal Care Services Rate Increase

A rate increase to the basic Adult Care Home (ACH) personal care services has been calculated and approved for implementation effective with reimbursements beginning October 1, 2003. The reimbursement rates effective on October 1, 2003 are:

Procedure Code	Description	Old Rate	New Rate
W8251	Basic ACH/PC Facility Beds 1 - 30	$ 13.03	$ 14.71
W8258	Basic ACH/PC Facility Beds 31 and Above	14.43	16.11
W8255	Enhanced ACH/PC Ambulation and Locomotion	2.64	2.64
W8256	Enhanced ACH/PC Eating	10.33	10.33
W8257	Enhanced ACH/PC Toileting	3.69	3.69
W8259	Enhanced ACH/PC Eating and Toileting	14.02	14.02
W8299	Enhanced ACH/PC Assessment Fees - Miscellaneous	0.15	0.15

The transportation rate will remain at $0.60 per Medicaid resident per day. The "Enhanced ACH/PC Assessment Fee – Miscellaneous" is for a single 30-day period relating to the completion of the Level I Mental Health Assessment.

Providers must bill their usual and customary charges. Adjustments will not be made to previously processed claims.

Bruce Habeck, Financial Operations
DMA, 919-857-4015

Attention: CAP-MR/DD Service Providers

Cost Reports for CAP-MR/DD Services

On July 2, 2003, a memorandum was sent to all providers from the Division of Medical Assistance (DMA) announcing that the 2003 CAP-MR/DD Cost Report and exemption form were available and due on September 30, 2003. Based on the knowledge of the implementation of substantially new service definitions for CAP-MR/DD services, it has recently been determined that cost data provided on the 2002-2003 cost report will not be used to establish the new service rates. Therefore, the CAP-MR/DD cost report **is not required** for the period of July 1, 2002, through June 30, 2003.

For those providers who have already sent in an exemption form or cost report, DMA thanks you for your efforts and timely response. Providers with questions may call or e-mail Susan Kesler at 919-857-4015 or Susan.Kesler@ncmail.net.

Susan Kesler, Financial Operations
DMA, 919-857-4015

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 was 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: Case Managers and Providers of CAP/DA and CAP/AIDS Services

Clarification on Billing for In-Home Aide Services

This article clarifies the information published in the August 2003 general Medicaid bulletin regarding billing for in-home aide services by CAP/DA and CAP/AIDS providers and case managers.

As stated in the articles, there is only one code (S5125) used when filing a claim for in-home aide services; providers can no longer file claims for the different levels of in-home aide services. CAP/DA and CAP/AIDS case managers must continue to indicate either Level II or Level III in-home aide services on the authorization form. Providers are responsible for providing the appropriate level of aide services as authorized. In addition, CAP/DA and CAP/AIDS case managers must continue to indicate Level II or Level III in-home aide services on CAP/DA and CAP/AIDS plans of care.

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

Attention: Carolina ACCESS Primary Care Providers

New Primary Care Provider Application Packet

The contractual agreement that is required of all Carolina ACCESS (CA) primary care providers (PCPs) has been rewritten to incorporate mandatory changes in federal regulations. The new application packet will be distributed to all current CA PCPs along with the October 2003 enrollment reports. Please review the packet and complete all of the forms.

There are three parts to the application packet with this revision:

- Carolina ACCESS Application for Participation
- Agreement for Participation as a Primary Care Provider
- Provider Confidential Information and Security Agreement

A copy of the Carolina ACCESS Provider Enrollment Packet, including the Provider Confidential Information and Security Agreement, is also available on DMA's website at http://www.dhhs.state.nc.us/dma/provenroll.htm. **The completed application packet must be returned by mail with original signatures to DMA by October 31, 2003.** Return completed forms to:

Division of Medical Assistance
Provider Services
2501 Mail Service Center
Raleigh, North Carolina 27699-2501

Carolina ACCESS Enrollment, Referral, Emergency Room and Quarterly Utilization Reports

DMA's Managed Care Section is beginning the process of replacing paper copies of the Carolina ACCESS Enrollment, Referral, Emergency Room, and Quarterly Utilization reports with web-based versions of the reports. PCPs must complete and submit the **Provider Confidential Information and Security Agreement**, which is now a required component of the provider application packet, to obtain access to the web-based reports.

Each individually contracted provider must complete a Security Agreement whether he/she is practicing independently or with a group. Each individually contracted provider or individually contracted provider practicing in a group must act as or designate an employee to act as the Security Contact. Individually contracted providers practicing in a group may designate the same employee to act as the Security Contact. Providers contracted as a group must designate one employee to act as the Security Contract for the group and only need to submit one Security Agreement.

Security Contacts must sign every Agreement that lists them as the Security Contact and provide an e-mail address to receive security correspondence and other CA information. The contracted provider must witness the Security Contact's signature. All signatures must be original.

The Security Contact will have access to the reports and will be responsible for:

- Requesting system access to the CA reports for additional users. It is recommended that each provider have at least one backup. Each Security Contact must read the Provider Confidential Information and Security Agreement before signing and submitting the Agreement to DMA.
- Notifying DMA immediately when an approved user has left the practice.
- Contacting the Help Desk with any system questions. The Help Desk number will be published in a subsequent bulletin article.

In accordance with the Department of Health and Human Services' Security Policy, all providers must retain a copy of the Agreement in their office. When the Agreement is approved by DMA, the Security Contact will be notified at the e-mail address indicated on the Agreement with instructions for accessing the web-based reports.

The July 2003 general Medicaid bulletin included an article describing the system requirements and minimum hardware and software requirements necessary to access web-based reports. Additional information will be published in future general Medicaid bulletins.

Managed Care Section
DMA, 919-857-4022

Provider Services Unit
DMA, 919-857-4017

Attention: Ambulatory Surgery Centers

CPT Code Update for 2003

The N.C. Medicaid program covers new 2003 CPT codes for Ambulatory Surgery Centers effective with date of service July 1, 2003 as published in the March 3, 2003 Federal Register.

The following CPT codes may be billed.

21046	21047	43201	43236	45335	45340	45381	45386	58545	58546

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

Attention: Dialysis Treatment Facilities, Nurse Practitioners, and Physicians

Ferrlecit (Sodium Ferric Gluconate Complex in Sucrose, HCPCS Code J2916, 12.5 mg Injection) – Billing Guidelines

The N.C. Medicaid program end-dated HCPCS code J2915 (Injection, sodium ferric gluconate complex in sucrose injection, 62.5 mg, Ferrlecit), effective with date of service September 30, 2003. Effective with date of service October 1, 2003, providers must bill **J2916** (Injection, sodium ferric gluconate complex in sucrose injection, **12.5 mg**).

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 $7.74.

Add J2916 to the lists of injectable drugs published in the June 2002 and August 2002 general Medicaid bulletins and delete J2915. Refer to the article in the January 2002 general Medicaid bulletin for detailed billing instructions.

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

Attention: Dialysis Treatment Facilities, Nurse Practitioners, and Physicians

Venofer (Iron Sucrose Injection, HCPCS Codes J1755 and J1756) – Billing Guidelines

The N.C. Medicaid program covers Venofer, iron sucrose injection, for the treatment of patients with iron deficiency anemia who are undergoing chronic hemodialysis. Venofer is covered for recipients under the following conditions:

- The recipient has a diagnosis of chronic renal failure, (ICD-9-CM **585**), **or** anemia in end-stage renal disease, (ICD-9-CM **285.21**), **and**
- The recipient has one of the following ICD-9-CM diagnoses: **280.0 – 280.1; 280.8 – 280.9; or 284.0 – 285.9; and**
- The recipient is receiving erythropoietin therapy, **and**
- The recipient is undergoing chronic hemodialysis.

Refer to the following instructions on billing Venofer for specific dates of service.

- For dates of service **January 1, 2002 through December 31, 2002**, bill HCPCS code **J1755** (injection, iron sucrose, **20 mg**) – maximum reimbursement **$12.42**
- For dates of service **January 1, 2003 and after**, bill HCPCS code **J1756** (injection, iron sucrose, **1 mg**) – maximum reimbursement **$0.63**

Dialysis facilities may be reimbursed for Venofer in addition to the dialysis composite rate. Administration supply costs are included in the dialysis composite rate. Providers must bill their usual and customary charges.

Note: Time limit override of claims submitted with J1755 will be allowed systematically. Providers are encouraged to file electronically. These claims must be submitted by 12:00 noon on December 31, 2003. Any claim billed with J1755 that is received after December 31, 2003 that does not meet timely filing guidelines will deny.

Billing Requirements for Physicians

- File the claim using the CMS-1500 claim form.
- Enter ICD-9-CM diagnosis code **585 or 285.21, and** one of the following diagnosis codes in block 21: **280.0 – 280.1; 280.8 – 280.9; or 284.0 – 285.9.**
- Enter the date of service in block 24A.
- Enter the place of service in block 24B.
- Enter HCPCS code J1755 or J1556 in block 24D.
- Enter the total charges in block 24F.
- Enter the units given in block 24G (1 mg = 1 unit or 20 mg = 1 unit, as appropriate for the HCPCS code used).

Example:

21 Diagnosis	24A Date(s) of Service	24B Place of Service	24D Procedures, Services or Supplies	24F Charges	24G Days or Units
585 280.8	09152003	11	J1756	$	20

Note: Physicians cannot bill an Evaluation and Management (E/M) code in addition to an injection administration code unless the E/M code is billed for a separately identifiable service, and the modifier 25 is appended to the E/M code. This drug should be added to the list of injectable drugs published in the June 2002 and August 2002 general Medicaid bulletins.

Billing Requirements for Dialysis Facilities

- File the claim using the UB-92 claim form.
- Enter revenue code 250 in form locator 42.
- Enter the description of the drug in form locator 43.
- Enter HCPCS code J1755 or J1556 in form locator 44.
- Enter the date of service in form locator 45.
- Enter the units given in form locator 46 (1 mg = 1 unit or 20 mg = 1 unit, as appropriate for the HCPCS code used).
- Enter the total charges in form locator 47.
- Enter diagnosis code **585** or **285.21** in form locator 67, **and**
- Enter a diagnosis code from the following list in form locators 68 through 75: **280.0 – 280.1; 280.8 – 280.9; 284.0 – 285.9**.

Example:

42 Rev Code	43 Description	44 HCPCS/Rate	45 Serv Date	46 Serv Units	47 Total Charges
250	Venofer 1 mg	J1756	09152003	20	$

67 Prin Diag Cd	68 Code	69 Code	70 Code	71 Code	72 Code	73 Code	74 Code	75 Code
585	280.1							

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

Attention: Dialysis Treatment Facilities, Health Departments, Nurse Practitioners, and Physicians

Zemplar (Paracalcitol, HCPCS Code J2501, 1 mcg Injection) – Billing Guidelines

The N.C. Medicaid program end-dated HCPCS code J2500 (Injection, paracalcitol, 5 mcg, Zemplar), effective with date of service September 30, 2003. Effective with date of service October 1, 2003, providers must bill **J2501** (Injection, paracalcitol**, 1 mcg**) for Zemplar.

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 $4.75.

Add J2501 to the lists of injectable drugs published in the June 2002 and August 2002 general Medicaid bulletins and delete J2500.

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

Attention: Durable Medical Equipment Providers

End-Dated Codes

The following codes were end-dated and deleted from the DME Fee Schedule effective with dates of service September 30, 2003. This action is being taken due to non-usage of these codes.

Code	Description
W4028	Prone stander with adjustable table
W4029	Prone stander with desk
W4030	Prone stander
W4031	Side lying positioner-child through adolescence
W4033	Side lying positioner block modules
W4042	Portable oxygen contents, liquid, per unit. 1 unit =1 cu. ft.

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 October 1, 2003. The 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	
E0608	E0619*	Apnea monitor, with recording feature	N/A	Rental:	$ 262.41
W4127	E1037*	Transport chair, pediatric size	4 years	Rental: New Purchase: Used Purchase:	190.20 1,902.05 1,426.54
	E1038*	Transport chair, adult size	4 years	Rental: New Purchase: Used Purchase:	190.20 1,902.05 1,426.54
W4011 W4121	E0445*	Oximeter for measuring blood oxygen levels non-invasively	N/A	Rental:	178.36
W4607	A6257	Transparent film, 16 square inches or less, each dressing (for use with external insulin pump)	16 per month	New Purchase:	1.56
W4608	A6258	Transparent film, more than 16 square inches but less than or equal to 48 square inches, each dressing (for use with external insulin pump)	16 per month	New Purchase:	4.39
W4674	K0601	Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt, each	18 per year	New Purchase:	6.88
	K0602	Replacement battery for external infusion pump owned by patient, silver oxide, 3 volt, each	18 per year	New Purchase:	6.88
	K0603	Replacement battery for external infusion pump owned by patient, alkaline, 1.5 volt, each	18 per year	New Purchase:	6.88
	K0604	Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt	18 per year	New Purchase:	6.88
	K0605	Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt, each	18 per year	New Purchase:	6.88

Code Changes, continued

Old Code	New Code	Description	Quantity Limitation or Lifetime Expectancy	Maximum Reimbursement Rate
A4232	K0552	Supplies for external infusion pump, syringe type cartridge, sterile, each	16 per month	New Purchase: $ 3.70
W4036	A7006	Administration set, with small volume filtered pneumatic nebulizer	1 per month	New Purchase: 13.62
W4018	S5560	Insulin delivery device, reusable pen; 1.5 ml size	3 years	New Purchase: 53.18
	S5561	Insulin delivery device, reusable pen; 3 ml size	3 years	New Purchase: 53.18
W4040	S8120	Oxygen contents, gaseous, 1 unit equals 1 cubic foot	N/A	New Purchase: .28
W4041	S8121	Oxygen contents, liquid, 1 unit equals 1 pound	N/A	New Purchase: 1.07

*Codes E0619, E1037, E1038, and E0445 require prior approval. Otherwise, the new codes do not require prior approval. However, with all DME, 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: Durable Medical Equipment Providers

Reimbursement Rate Correction for HCPCS Code S8490

Effective with date of service September 1, 2003, the maximum reimbursement rate for code S8490 “insulin syringes (100 syringes, any size)” is $31.00.

The rate for code S8490 was stated incorrectly in the September 2003 general Medicaid bulletin article entitled *HCPCS Code Changes.*

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

Attention: Health Departments, Nurse Practitioners, and Physicians

Billing Health Assessments for Refugees

When sponsored refugees become residents of North Carolina they are evaluated for Medicaid eligibility by the department of social services in the county in which they reside. Refugees who meet eligibility requirements are enrolled with Medicaid and issued a Medicaid identification (MID) card with the appropriate aid/program category indicated on the card. Refugees who do not qualify for any Medicaid aid/program category are eligible for Refugee Medical Assistance if they meet income requirements. Refugees receiving Refugee Medical Assistance are issued an MID card and are provided with medical coverage for an eight-month period. Recipients who are receiving services through the Refugee Medical Assistance program are assigned a program code of either MRF or RRF. (Refer to the MID card examples on page 18.)

Claims for services provided to MRF or RRF recipients are submitted to and processed for payment by N.C. Medicaid. To ensure that claims for a refugee health assessment are processed properly, please refer to the instructions in the following table:

	MRF or RRF Recipient	**All Other Medicaid Aid/Program Categories**
Refugee Less Than 21 Years	Enter V70.5 as the secondary diagnosis. Refer to the Health Check Billing Guide 2003 for additional guidelines.	No refugee diagnosis needed. Refer to the Health Check Billing Guide 2003 for additional guidelines.
Refugee 21 Years of Age or Older	Choose appropriate preventive medicine code (99385, 99386, 99387), and bill with V70.5 as primary diagnosis.	Choose appropriate preventive medicine code (99385, 99386, 99387), and bill with V70.0 as primary diagnosis.

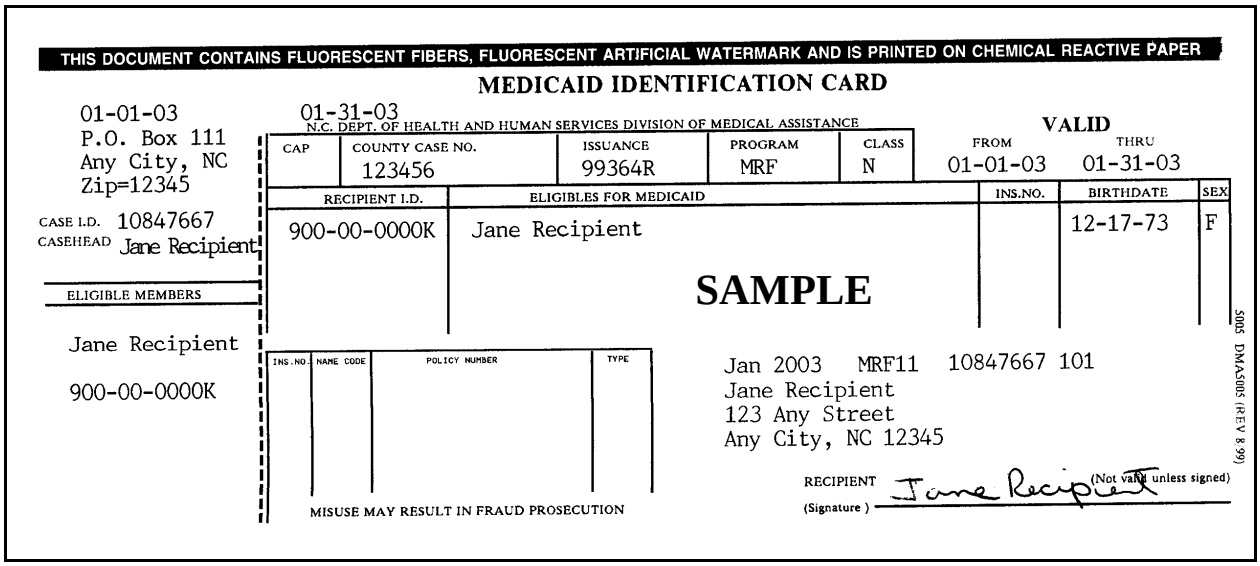
Note: ICD-9-CM diagnosis code V70.0 is defined as "Routine general medical examination at a health care facility." ICD-9-CM diagnosis code V70.5 is defined as "Health examination of defined subpopulations."

Bill with diagnosis code V70.5 when submitting a claim for a health assessment provided to an MRF or RRF recipient. Diagnosis code V70.5 is only used when billing for health assessments provided to MRF or RRF recipients. Do not enter V70.5 on claims for health assessments provided to recipients in other aid/program categories.

Claims for refugee health assessments submitted after October 1, 2002 that denied with EOB 0082, "Service is not consistent with or not covered for this diagnosis or description does not match diagnosis" may be refiled as a new claim following the instructions listed above. (Do not use the adjustment process for these claims.)

Refer to the August 2002, Special Bulletin IV, *HIPAA Code Conversion*, for additional information on the components of health assessments provided in health departments to refugees.

Examples of Medicaid Identification Card


THIS DOCUMENT CONTAINS FLUORESCENT FIBERS, FLUORESCENT ARTIFICIAL WATERMARK AND IS PRINTED ON CHEMICAL REACTIVE PAPER

MEDICAID IDENTIFICATION CARD

01-01-03 01-31-03

N.C. DEPT. OF HEALTH AND HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE

VALID FROM 01-01-03 THRU 01-31-03

CAP	COUNTY CASE NO.	ISSUANCE	PROGRAM	CLASS
	123456	99364R	MRF	N

RECIPIENT I.D.	ELIGIBLES FOR MEDICAID	INS.NO.	BIRTHDATE	SEX
900-00-0000K	Jane Recipient		12-17-73	F

P.O. Box 111
Any City, NC
Zip=12345

CASE I.D. 10847667
CASEHEAD Jane Recipient

ELIGIBLE MEMBERS

Jane Recipient

900-00-0000K

SAMPLE

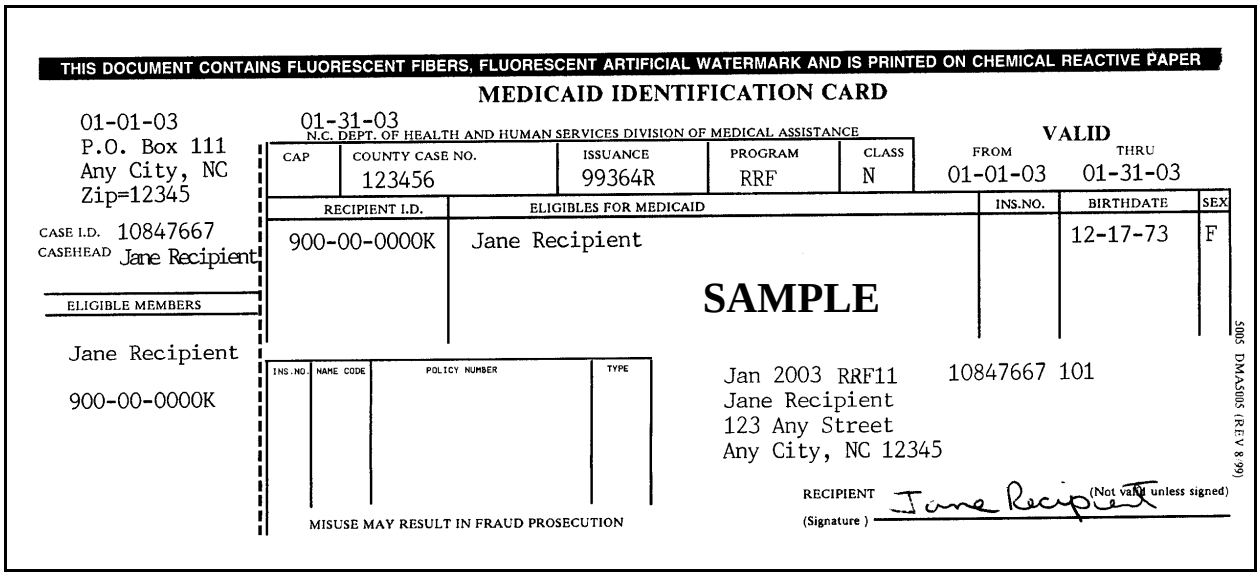
INS.NO.	NAME CODE	POLICY NUMBER	TYPE

MISUSE MAY RESULT IN FRAUD PROSECUTION

Jan 2003 MRF11 10847667 101
Jane Recipient
123 Any Street
Any City, NC 12345

RECIPIENT (Signature) Jane Recipient (Not valid unless signed)

5005 DMA5005 (REV 8/99)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RECIPIENT I.D.	ELIGIBLES FOR MEDICAID	INS.NO.	BIRTHDATE	SEX
900-00-0000K	Jane Recipient		12-17-73	F

P.O. Box 111
Any City, NC
Zip=12345

CASE I.D. 10847667
CASEHEAD Jane Recipient

ELIGIBLE MEMBERS

Jane Recipient

900-00-0000K

SAMPLE

INS.NO.	NAME CODE	POLICY NUMBER	TYPE

MISUSE MAY RESULT IN FRAUD PROSECUTION

Jan 2003 RRF11 10847667 101
Jane Recipient
123 Any Street
Any City, NC 12345

RECIPIENT (Signature) Jane Recipient (Not valid unless signed)

5005 DMA5005 (REV 8/99)

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

Attention: HIV Case Management Providers

State-Created Diagnosis Codes

Effective October 1, 2003, HIV Case Management claims can no longer be billed using the state-created diagnosis codes 042.9, 043.9 or 044.9. Claims with these diagnosis codes will deny as of that date. Please use valid ICD-9-CM diagnosis codes for the client's diagnosis related to HIV disease, HIV seropositivity or CDC-defined AIDS.

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

Attention: Nursing Facility Providers

Termination of Utilization Review Committees

Effective October 1, 2003, N.C. Medicaid no longer distinguishes between skilled levels of care and intermediate levels of care for Medicaid recipients in nursing facilities. These levels of care are now referred to as **Nursing Facility Level of Care**. Providers are no longer required to document level of care changes from skilled to intermediate levels or from intermediate to skilled levels. If a resident does not meet nursing facility level of care criteria, the facility must follow transfer discharge procedures for residents changing to the adult care level.

Nursing facilities are no longer required to maintain a Utilization Review Committee to evaluate the needs and care provided to Medicaid residents. Nursing Facility Utilization Review Committee reports are also no longer required.

Providers must continue to submit prior approval requests to EDS either electronically (FL2e) or on paper (FL2). Refer to the August 2003 general Medicaid bulletin on DMA's website for information about the FL2e.

Medicaid reimbursement rates will be determined using information gathered through the Minimum Data Set (MDS).

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

Attention: Pharmacists and Prescribers

Days Supply on Pharmacy Claims

Effective October 1, 2003, Medicaid recipients can obtain a 90-day supply of a generic, non-controlled, maintenance medication that has previously been dispensed with a 30-day supply within the last six months. The medication must be listed on the Federal or State MAC list. The decision to allow dispensing of a 90-day supply is at the discretion of the physician. Only one copayment will be collected and only one dispensing fee will be paid for the 90-day supply.

Information regarding whether or not a medication is on the State or Federal MAC list is available on the N.C. Division of Medical Assistance's website at http://www.dhhs.state.nc.us/dma/prov.htm under the heading "Pharmacy." Providers may also call the Automated Voice Response (AVR) system at 1-800-723-4337 to determine whether or not a medication is on a MAC list. The provider number and 11-digit NDC number of the medication is needed in order to obtain drug coverage information from the AVR system. The system is available 24 hours a day, 7 days a week with the exception of the following: between 1:00 a.m. and 5:00 a.m. on the 1st, 2nd, 4th, and 5th Sunday of the month and between 1:00 a.m. and 7:00 a.m. on the 3rd Sunday of the month.

Melissa Weeks, Medical Policy Section
DMA, 919-857-4020

Attention: Physician Services

Outpatient Specialized Therapies

As of October 1, 2002, outpatient specialized therapy services provided in the physician's office require prior approval from the Medical Review of North Carolina (MRNC). Refer to Medical Coverage Policy #8F, Outpatient Specialized Therapy on DMA's website at http://www.dhhs.state.nc.us/dma/mpindex.htm for a copy of the policy.

Effective with claims processed on June 1, 2003 and after, a discipline-specific V diagnosis code must be included on the claim. Refer to the May 2003 general Medicaid bulletin on DMA's website at http://www.dhhs.state.nc.us/dma/bulletin.htm for additional information.

Note: The requirements to obtain prior approval and to include a discipline-specific V diagnosis code on the claim also apply to strapping and splinting, CPT procedure codes 29105 through 29131, 29200 through 29280, 29505 through 29515, and 29520 through 29590.

Paulette Jones, Medical Policy Section
Nora Poisella, Medical Policy Section
DMA, 919-857-4020

Attention: All Providers

Proposed Medical Coverage Policies

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

Darlene Creech
Division of Medical Assistance
Medical Policy Section
2501 Mail Service Center
Raleigh, NC 27699-2501

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

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

Checkwrite Schedule

October 7, 2003	November 4, 2003	December 9, 2003
October 14, 2003	November 12, 2003	December 16, 2003
October 21, 2003	November 18, 2003	December 29, 2003
October 30, 2003	November 26, 2003	

Electronic Cut-Off Schedule

October 3, 2003	October 31, 2003	December 5, 2003
October 10, 2003	November 7, 2003	December 12, 2003
October 17, 2003	November 14, 2003	December 19, 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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