*Number 10* *October 2006*

# North Carolina Medicaid Bulletin

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

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**Providers are responsible for informing their billing agency of information in this bulletin.**
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## Attention: All Providers

## Gadolinium-Based Magnetic Resonance Contrast Agent, per ml, (HCPCS Procedure Code Q9952) – Billing Guidelines

The NC Medicaid Bulletin dated November 2005 informed providers that for dates of service **April 1, 2005, and after, HCPCS procedure codes Q9945 through Q9951** must be billed for low osmolar contrast media (LOCM) used in radiologic diagnostic studies. Recognizing that Q9952 (gadolinium-based magnetic resonance contrast agent) is frequently billed for MRI studies, **Medicaid will reimburse for Q9952 effective with date of service January 1, 2006.**

For Medicaid billing, one unit of Q9952 equals 1 ml. The maximum reimbursement rate per unit of Q9952 is $2.89. Providers who have had claims denied because of billing **HCPCS procedure code Q9952** for dates of service on or after January 1, 2006, may resubmit the claims for processing.

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

## Attention: All Providers

## Non-Covered Services

The following services have been determined by Divisional of Medical Assistance (DMA) to be experimental or investigational and are not covered. Please note that this is not an inclusive list of all Medicaid non-covered services. When these services are billed to Medicaid, reimbursement will be denied. Providers are reminded that it is fraudulent to bill for non-covered services using a covered CPT code.

- Intralesional/intra-articular pain management systems, including, but not limited to, ON-Q, Stryker, Pain Buster, C-bloc, Homepump Eclipse, I-Pump, ambIT, Accufuser, AutoMed, and On-Q Soaker Infusor System
- Horizontal therapy, also referred to as Hako-Med horizontal therapy
- Vestibular autorotation test—a computerized test to measure the vestibular ocular reflex during high-frequency head rotations
- Ambulatory attended cardiac event monitoring of less than 24 hours/day
- Intervertebral differential dynamics therapy, or IDD (such as Accu Spina)
- Category II and Category III CPT procedure codes
- Applications of radiofrequency ablation for tumors outside of the liver and osteoid osteoma, including, but not limited to, renal cell carcinoma, breast cancer, breast fibroadenomas, tumors of the lung and head and neck, adrenal cancer, chordoma, ovarian cancer, and pelvic/abdominal metastases of unspecified origin
- Stretta procedure—a minimally invasive endoscopic procedure for the treatment of gastroesophageal reflux disease

According to the Basic Medicaid Billing Guide, March 2006: "When a non-covered service is requested by a recipient, the provider must inform the recipient either orally or in writing that the requested service is not covered under the Medicaid program and will, therefore, be the financial responsibility of the recipient. This must be done prior to rendering the service." The billing guide is available online at the DMA Web site at http://www.dhhs.state.nc.us/dma/prov.htm.

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

## Attention: All Providers

## Physician Drug Program Pricing List Update

Effective with date of service October 1, 2006, the maximum reimbursement rates for procedure codes in the Physician Drug Program have been updated. Rates are based on the average sales price plus six percent (ASP+6%), the pricing point used by Medicare. For drugs not covered by Medicare and where the ASP+6% price is not available, the rates are based on the average wholesale price less ten percent (AWP-10%) of the lowest generic.

Providers must continue to bill electronically or on the CMS-1500 or UB-92 claim form, as previously instructed, with their usual and customary charge. Adjustments will not be made to previously processed claims.

The new rate schedule for the Physician Drug Program is available on DMA's Web site at http://www.dhhs.state.nc.us/dma/fee/fee.htm.

For procedure codes J3490, J3590, and J9999, providers must continue to submit a copy of the original invoice along with the CMS-1500 claim form as previously instructed. Providers must write the name of the recipient, the recipient's Medicaid identification number, the name of the medication, the dosage given, the National Drug Code(s) (NDC) from the vial(s) used, the number of each vial administered, and the cost per dose on the invoice. Payment is based on the invoice cost, less shipping and handling.

**Financial Management**
**DMA, 919-855-4200**

## Attention: All Providers

## Policy and Procedures for Prescribing Synagis for 2006–2007 Respiratory Syncytial Virus Season

On October 15, 2006, N.C. Medicaid will begin coverage of Synagis prescriptions for respiratory syncytial virus (RSV). This year, Synagis prescriptions will not require prior approval. However, health care and pharmacy providers are expected to ensure the appropriate usage of Synagis. The clinical criteria utilized in this policy are consistent with currently published American Academy of Pediatrics guidelines at http://aappolicy.aappublications.org/cgi/content/full/pediatrics.

Please ensure that either

- the conditions exist and are accurate, and are verified by completion and submission of the Synagis for RSV Prophylaxis Form ("in-criteria form") at http://www.dhhs.state.nc.us/dma/Forms/SynagisCriteriaForm.pdf, or

- the patient does not fit the published criteria, but the Request for Medical Review for Synagis Outside of Criteria Form at http://http://www.dhhs.state.nc.us/dma/Forms/SynagisMedicalReview.pdf has been completed and submitted.

**Note:** Processing delays can occur if the patient does not have a Medicaid identification number or the form is not complete.

**Note:** During the RSV season, **no more than five monthly doses of Synagis can be obtained for each recipient** by using these forms. The number of doses should be adjusted if an infant received the first dose prior to a hospital discharge.

Submitting the In-Criteria Form

Infants born on or after October 15, 2004, meet the medical criteria for Synagis if they have one or more of the following conditions:

| Diagnosis | Comments |
|---|---|
| Chronic lung disease of prematurity (bronchopulmonary dysplasia) | The infant has chronic lung disease (bronchopulmonary dysplasia) and has needed treatment (supplemental oxygen, bronchodilator, diuretic, or corticosteroid) in the six months before the start of the season. |
| Hemodynamically significant congenital heart disease | Infants less than 12 months of age who are most likely to benefit include those receiving medication to control congestive heart failure, moderate to severe pulmonary hypertension, or cyanotic heart disease. Infants NOT at increased risk from respiratory syncytial virus who generally should NOT receive immunoprophylaxis include those with hemodynamically insignificant heart disease such as secundum atrial/septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, patent ductus arteriosus, lesions adequately corrected by surgery unless the infant continues on medication for congestive heart failure, and mild cardiomyopathy where the infant is not receiving medical therapy. |
| Cystic fibrosis | The infant has cystic fibrosis and either requires chronic oxygen or has been diagnosed with nutritional failure. |
| Severe congenital immunodeficiency | Severe combined immunodeficiency disease or severe acquired immunodeficiency syndrome. |

Other infants may meet the medical criteria for Synagis as follows:

| Infant Is Born at an Estimated Gestational Age of | Other Criteria |
|---|---|
| Less than or equal to 28 weeks **AND** | Date of birth on or after October 15, 2005 |
| 29 weeks through 32 weeks **AND** | Date of birth on or after April 15, 2006 |
| 32 weeks and 1 day through 35 weeks and 0 days **AND** | Date of birth on or after April 15, 2006 **AND two or more** of the following risk factors:<br>--Has school-age siblings<br>--Attends day care<br>--Has severe neuromuscular disease<br>--Is exposed to prolonged wood-burning heaters as the primary source of heat for the family (tobacco smoke is NOT a risk factor because it can be controlled by the family)<br>--Has congenital abnormalities of the airways |

When it has been verified that one or more of the above conditions exist and are accurate, submit the in-criteria form by doing the following:

- Prescriber signs and submits to the pharmacy distributor of choice **(not to DMA).**
- Pharmacy distributor must maintain the form on site.
- Every week, pharmacy distributor must send DMA copies of the forms submitted that week.
    - Mail to N.C. Division of Medical Assistance, Pharmacy Program, 1985 Umstead Drive, 2501 Mail Service Center, Raleigh, N.C. 27699-2501.
    - Or submit high-volume Synagis claims on a diskette. Please call Charlene Sampson at (919) 855-4306 to coordinate this process.

Submitting the Request for Medical Review Form

When a patient does not explicitly meet the guidelines but the provider still wishes to prescribe Synagis, submit the Request for Medical Review Form by doing the following:

- Prescriber completes the form, including the medical necessity justification, sign it, and fax it to DMA at **919-715-1255. This is the only form that prescribers should fax to DMA.**
- The request will be reviewed and either approved or denied. Notification of the result will be sent to prescribers.
- Pharmacy distributor maintains a copy of the approval letter on site.

Medicaid will allow Synagis claims processing to begin on October 10, 2006, to allow sufficient time for pharmacies to provide Synagis by October 15, 2006. Payment of Synagis claims prior to October 10, 2006, and after March 31, 2007, will not be allowed. Pharmacy providers should always indicate an accurate days' supply when submitting claims to N.C. Medicaid. Physicians and pharmacy providers are subject to audits of Synagis records by DMA Program Integrity.

**Pharmacy and Ancillary Services**
**DMA, 919-855-4300**

## Attention: All Providers

## Quarterly Update to the 2006 Physician Fee Schedule Database

The Centers for Medicare and Medicaid Services (CMS) develops payment files annually based upon the Medicare Physician Fee Schedule Final Rule. CMS issues quarterly updates as deemed necessary. Based on the quarterly updates, the N.C. Medicaid program has made the following changes effective with date of service October 1, 2006. The CPT codes listed below are valid codes with N.C. Medicaid. All applicable edits, audits, limitations, and modifier combinations continue to apply to these codes.

**Codes Billed with Modifier 51, Multiple Procedures**

- CPT codes 20926 and 29873 **are no longer valid** services when billed in combination with Modifier 51. If billed with Modifier 51 for date of service on or after October 1, 2006, these codes will be denied.

- CPT code 50320 **is now a valid** service when billed in combination with Modifier 51.

**Codes Billed with Modifier 50, Bilateral**

- The following CPT codes **are no longer valid** services when billed in combination with Modifier 50:

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 20931 | 20937 | 20938 | 22226 | 27358 | 27692 | 33141 | 33508 | 35390 | 35600 | 35681 |
| 35685 | 35686 | 35700 | 36215 | 36216 | 36217 | 49568 | 57267 | 61609 | 61610 | 61611 |
| 61612 | 61864 | 61868 | 66990 | 67320 | 67331 | 67332 | 67334 | 67335 | 67340 | |

If billed with Modifier 50 for date of service on or after October 1, 2006, the above codes will be denied.

- The following CPT codes **are now valid** services when billed in combination with Modifier 50:

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 20690 | 27165 | 28285 | 32000 | 32002 | 32020 | 34900 | 36005 | 50080 | 50120 | 50125 |
| 50130 | 50135 | 50200 | 50220 | 50230 | 50387 | 60260 | 64450 | 64640 | 67810 | 67825 |
| 67830 | 67835 | 67840 | 67850 | 67875 | 67880 | 67882 | 67930 | 67935 | 67938 | 67950 |
| 67966 | 67973 | 67974 | 67975 | 68020 | 68040 | 68100 | 68110 | 68115 | 68130 | 68135 |
| 68320 | 68325 | 68326 | 68328 | 68330 | 68335 | 68340 | 68360 | 68362 | 68400 | 68420 |
| 68440 | 68500 | 68505 | 68510 | 68520 | 68525 | 68530 | 68540 | 68550 | 68700 | 68705 |
| 68720 | 68745 | 68750 | 68770 | 68840 | 68850 | 73701 | 73702 | 73706 | | |

**Codes Billed with Modifier 62, Co-surgery**

- CPT codes 63304 and 63308 **are now valid** services when billed in combination with Modifier 62.

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

## Attention: All Providers

## Tetanus, Diphtheria Toxoids and Acelluar Pertussis Vaccine (TDAP) - HCPCS Code 90715

The reimbursement rate for the HCPCS code 90715 has been changed to reflect the AWP minus 10% effective March 1, 2006. The new rate is $38.21.

Prior claims submitted for HCPCS code 90715 will not be adjusted.

**Financial Management**
**DMA, 919-855-4200**

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## Attention: Adult Care Home Providers

## Fee Schedule for Adult Care Home Special Care Unit for Persons with Alzheimer's and Related Disorders

N. C. Session Law 2005-276 provided for additional Medicaid funding for the care of residents with a Primary Diagnosis of Alzheimer's and Related Disorders residing in Special Care Units for Persons with Alzheimer's and Related Disorders (SCU-A) located in Adult Care Homes (ACHs) and who meet the Prior Approval criteria. Effective with date of service October 1, 2006, the N.C. Medicaid Program will implement a special care rate for ACH providers operating a SCU-A.

The applicable HCPCS codes and daily rates are as follows:

| | | |
|---|---|---|
| W8291 | $46.79 | ACH facilities with 1 to 30 beds and a SCU-A |
| W8292 | $51.25 | ACH facilities with more than 30 beds and a SCU-A |

Please note:

1. Recipients must receive, and providers must bill for, Basic PCS at the same time as SCU-A services.
2. Providers will not receive payment for Enhanced ACH services for recipients in a SCU-A.
3. The SCU-A rate is only for those residents that receive prior approval from DMA.

Direct questions regarding rates to:
Patricia "Trish" Harper @919-855-4216 or trish.harper@ncmail.net
Elizabeth Grady @919-855-4207 or elizabeth.grady@ncmail.net

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

## Attention: Children's Developmental Service Agencies, Home Health Agencies, Hospital Outpatient Clinics, Independent Practitioners, Health Departments, Local Management Entities, and Physicians

## Outpatient Specialized Therapies Prior Authorization Process – Update to New Web Site and Submission Process

As indicated in the July 2006 N.C. general Medicaid bulletin, testing of the Web-based electronic submission process for prior approval has been completed by members of the Therapy Advisory Group. Based on feedback from the pilot sites, modifications were made to improve user friendliness and decrease the amount of data required.

The biggest change is to the evaluation component. When the new process is implemented, the required evaluation information will be reduced to the following:

- Date of the evaluation
- Relevant medical history supporting the need for therapy
- Measurable goals and objective baselines determined at evaluation

The medical necessity determination will be based on the medical history and measurable goals with objective baselines or, in the case of reauthorizations, objective progress. Supplemental information will be requested only if medical necessity cannot be determined from the required data.

Through the Web site, providers will also have the option to submit authorizations using a file transfer protocol (FTP). However, FTP will be the last component to be completed in the new system. Since the providers' IT vendors will need to create a data format to transfer the information, the process and data fields must first be finalized. Once the system is in place for a few months and any identified changes have been completed, a file format will be provided. For providers who choose to continue submitting prior authorization requests via fax or mail, a new form has been created to mirror the format and data fields of the Web site.

Although still required for therapy, copies of the following documentation will no longer be required at the time of prior authorization submission:

- Order for therapy
- Evaluation
- Plan of care with goals and frequency/duration of therapy

Instead, all required documentation will be submitted by completing the new form, which is composed of the following sections:

A. Recipient Demographics
B. Provider Demographics
C. Requested Dates of Service/Units or Visits
D. Order for Therapy
E. Treatment Plan of Care
F. ICD-9 Codes
G. Evaluation

H. Goals
I. Progress Towards Goals

The system changes will be pilot tested by Therapy Advisory Group members in early October. Following review of the pilot feedback, an implementation date for the new system will be determined. The provider community will be notified through bulletin articles, faxed communication from the Carolinas Center for Medical Excellence (CCME), and information on CCME's Web site available at http://www.mrnc.org.

Adequate time between notification and implementation will be given for providers to access the Web-based training and become familiar with the new prior authorization forms. Training on CCME's Web site will include audio-video clips demonstrating the electronic submission process and Web site options, FAQs, helpful hints, and a help desk for technical support.

While the prior approval submission process will be changing, DMA's Clinical Coverage Policy 10A, Outpatient Specialized Therapies, is not is available at http://www.dhhs.state.nc.us/dma/mp/mpinex.htm. Continue to follow all current policy guidelines. All services are subject to post-payment review.

**CCME, 1-800-228-3365, ext 2045**

## Attention: CMS-1500 Billers

## Medicare Health Maintenance Organization (HMO)

In order for Medicaid to consider payment for Medicare Health Maintenance Organization, providers are requested to bill only the **co-payment** amount shown on the **Medicare Explanation of Benefits (EOB). Medicaid liability is only for the Medicare HMO co-payment.** When filing on the CMS-1500 the following blocks must be completed:

- Blocks 24F, 28, and 30 should reflect the Medicare HMO co-payment amount only. If blocks 24F, 28, and 30 do not reflect the Medicare HMO co-payment amount the claim will be returned to the provider to correct the CMS-1500 claim form.

- Block 29 should reflect third party insurance payments only. Providers are not to indicate the Medicare HMO payment in this block. If the recipient does not have a third party insurance payment, the block should be left blank. If the Medicare HMO payment is indicated in block 29, the claim will be returned back to the provider to correct the CMS-1500 claim form.

All CMS-1500 Medicare HMO claims should be submitted with the Medicaid Resolution Inquiry Form indicating that the claim attached is a Medicare HMO. The Medicaid Resolution Inquiry Form as well as the CMS-1500 claim form and Medicare HMO EOB should be mailed to:

EDS
PO Box 300009
Raleigh, NC 27622.

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

## Attention: UB-92 Billers

## Medicare Health Maintenance Organization (HMO)

In order for Medicaid to consider payment for Medicare Health Maintenance Organization, providers are requested to bill all charges on the UB-92. The claims should not be altered for processing purposes. **The claim should be billed to Medicaid as it was billed to Medicare Health Maintenance Organization. Medicaid liability is only for the Medicare HMO co-payment.** The following information is required for claim processing:

- The claims must be submitted with a Medicare EOB. Please ensure that the Medicare EOB attached. If the EOB is on multiple pages, please submit all pages with the claim form.
- All charges should be reflected on the UB-92. Do not combine or destroy the integrity of the claim by rolling up the charges into one revenue code.
- If the recipient has patient monthly liability or deductible, the information should be reflected on inpatient stays if applicable.
- Co-payment amount should be indicated in FL 55 (Estimated Amount Due).
- Form locator 84 should indicate “This is a Medicare HMO claim”.

The UB-92 claim form and Medicare HMO EOB should be mailed to:

DMA/Third Party Recovery
2508 Mail Service Center
Raleigh, NC 27699-2508.

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

## Attention: Durable Medical Equipment Providers

## Durable Medical Equipment Rental Items

Durable medical equipment providers are reminded that the reimbursement for rental items includes service, delivery, assembly, set-up, repairs, and supplies. Refer to Clinical Coverage Policy #5A, Durable Medical Equipment, sections 1.1, 7.1, and 8.1, for additional information. The policy is available on the Web at http://www.dhhs.state.nc.us/dma under Provider Links, Provider Information, Clinical Coverage Policies and Provider Manuals.

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

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## Attention: Nursing Facility Providers

## Minimum Data Set Validation Review Update

Beginning with Federal fiscal year 2007 (October 1, 2006), DMA will exercise the right to re-review the documentation of the nursing facilities that fail their minimum data set (MDS) validation review. The facility's documentation will not be reviewed any earlier than 120 days following the exit interview of the failed MDS validation review.

DMA's right to re-review is stated in the Nursing Facilities Provider Manual (chapter 5, p. 3, MDS review process #10). The manual is available on the Web at http://www.dhhs.state.nc.us/dma/nursingfacility.htm.
Contacts for questions about the MDS validation review are as follows:

**Myers and Stauffer's Help Desk**
1-800-763-2278

**North Carolina MDS Help Line**
Cindy DePorter, State RAI/MDS Coordinator
919-715-1872

**MDS Validation Program**
Peggy Scott, R.N., CRNAC, Nursing Facility Consultant
DMA, 919-855-4356

Margaret Comin, R.N., Facility Services Manager
DMA, 919-855-4355

**Facilities Services**
**DMA, 919-855-4350**

## Attention: Optical Service Providers

## Introducing the New Request for Prior Approval for Visual Aids Form (372-017) and Instructions

The Request for Prior Approval for Visual Aids form (372-017) has been updated. The current form will not expire; therefore providers should exhaust current supplies and the new form will be introduced gradually, as the warehouse supply of old forms is depleted.

While obsolete sections have been removed, several new sections have been added to incorporate information that must be maintained in the recipient's visual aid medical record. Revisions were implemented to provide more thorough medical records, improved clarity, and ease of use for providers, the optical contractor laboratory, and the Division of Medical Assistance. Please pay special attention to the areas that require signatures and dates.

Providers must continue to retain the fourth copy of this four-part form for office records.

The back of the form contains new provider information, including pertinent Web sites.

An example of the new Request for Prior Approval for Visual Aids form (372-017) and instructions follow.

**NOTE**: **All sections with asterisks (*) require documentation.**

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

recycled paper

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PERF PERF

Please Type or Print **REQUEST FOR PRIOR APPROVAL FOR VISUAL AIDS** Please Type or Print

1. Recipient Name - Last | 2. First | 3. MI | 4. Sex M ☐ F ☐ | 5. Recipient I.D. Number

6. Date of Birth | 7. Date of Refraction | 8. Name of Prescriber | 9. Diagnosis & ICD-9 Codes

10. Department Use Only
Decision: Agent: Date:

11. Frame: Standard Medicaid Selection — Metal ☐ Zyl ☐ Combination ☐

12. * Frame: Exception — Invoice Cost ________ Also Fill In Blocks 22, 23, 24, 25 & 26 Include Manufacturer In Block 22

13. * Exceptional Services — Gray Tint 1 2 Sun; Photogray ☐; Repair or Replacement ☐; Pink Tint 1 2; Ultraviolet Filter ☐; Other: ________

14. * Please provide documentation/medical justification for approval of requests for exceptional (*) services.

| Order (circle one) | 15. Complete Glasses | 16. Lenses Only | 17. Frame Only | 18. * Frame to Follow | 19. R Lens Only | 20. L Lens Only | 21. Lens circumference R ____ L ____ |
|---|---|---|---|---|---|---|---|

| Frame | 22. Manufacturer/Frame Name or Number | 23. Eye Size | 24. Bridge Size | 25. Temple Length | 26. Color |
|---|---|---|---|---|---|

| Lenses (circle one) | 27. Single Vision | 28. ST 28 (Bifocals) | 29. *ST 35 (Bifocals) | 30. Round (Bifocals) | 31. *Executive (Bifocals) | 32. * 7X28 (Trifocals) | 33. *8X35 (Trifocals) | 34. Cataract Lens | 35. * Other |
|---|---|---|---|---|---|---|---|---|---|

| Material (circle one) | 36. CR39 | 37. * Polycarbonate | 38. * Hi-Index | 39. Glass | 40. * Other |
|---|---|---|---|---|---|

| | 41. Sphere | 42. Cylinder | 43. Axis | 44. Prism | 45. Base | 46. Add | 47. Seg. Ht. | 48. Distance P.D. | 49. Near |
|---|---|---|---|---|---|---|---|---|---|
| R | | | | | | | | | |
| L | | | | | | | | | |

* Contact Lenses: Evaluation for approval based on documentation of medical diagnosis and necessity. Slab Off ☐

50. Manufacturer/Lens Name
51. Lens Type (DW, RGP, etc.)
52. Invoice Cost

53. Please specify reason for contact lens request
Keratoconus ☐ Significant Anisometropia ☐
Aphakia ☐ Significant Progressive Myopia ☐
* Other (Attach documentation of medical necessity) ☐

| Fresnell Prism | Power | Base |
|---|---|---|
| R | | |
| L | | |

54. Special Instruction for Medicaid Contractor Laboratory

55. Initial Fitting Optician/Technician (print)
56. Initial Fitting Optician/Technician (signature) Fitting Date
57. Provider Phone Number ( ) 58. Submission Date
59. Provider Address
60. Provider Number

| Recipient notified to pick up visual aids | | | |
|---|---|---|---|
| 61. Caller's Initials | | | |
| 62. Date | | | |
| 63. Method | Phone ☐ Mail ☐ | Phone ☐ Mail ☐ | Phone ☐ Mail ☐ |

64. Inspected by
65. Date Inspected
66. Dispensed by
67. Date Dispensed

Signature denotes receipt of visual aid outlined above
68. Printed name of Parent/Guardian (if recipient is under 18)
69. Signature of Recipient or Parent/Guardian (if recipient is under 18)
70. Relationship to recipient (if recipient is under 18) 71. Date

**FISCAL AGENT COPY** **Prior Approval Forms should be submitted daily** 372-017 (05/2006)

SCREENING @ 12%

PROOF

8510044041

PERF PERF

## REMINDERS FOR PRIOR APPROVAL REQUESTS

TYPE, PRINT, OR STAMP PROVIDER NAME, PROVIDER NUMBER, ADDRESS, AND TELEPHONE NUMBER WITH AREA CODE ON ALL COPIES

**REQUEST FOR PRIOR APPROVAL FORM**

Submit Fiscal Agent, Contractor and Provider Copy to:

EDS
P.O. Box 31188
Raleigh, North Carolina 27622

**VISUAL AID CLAIM FORM (CMS-1500)**

Submit to:

EDS
P.O. Box 30968
Raleigh, North Carolina 27622

Retain the provider office copy for your files.

**LIMITATIONS** One eye refraction per year for recipients under age 21, one refraction every two years for recipients 21 years and older. The same limitations apply to visual aids. Requests for additional refractions must be submitted in writing on the general Prior Approval form #372-118. Document medical necessity; surgery, injury, visual loss, *diabetes, etc.

*Diabetes: Attach physician's report (letter/documentation) that the patient's diabetic condition is controlled/stabilized.

A recipient's refractive history can be obtained from EDS by calling 1-800-723-4337 or 919-851-8888. If the recipient is eligible and has no refractive history within the 1-2 year time limitation, a verbal authorization number will be given to the provider. The 13 digit authorization number should be kept with the recipient's file.

Requests for additional visual aids must include documentation of medical necessity (post-cataract, medical condition, pharmaceutical change, etc.) and documentation of both visual acuity with current visual aid and proposed visual acuity with new prescription. Generally, a change in power of + or -.5 diopter or greater is required for approval of new lenses.

**NON-COVERED SERVICES:**

- Cosmetic Lenses
- Sport Straps
- Gradient Tints
- Safety Glasses
- Rimless Frames
- Blended Lenses
- Transitions Lenses
- Anti-reflective Coating
- Progressive Lenses
- Initialing/Engraving
- Drilling or Grooving Lenses

**EXCEPTIONAL SERVICES REQUIRE MEDICAL JUSTIFICATION** This list is not all-inclusive.

- Gray Tint 1, 2 or Gray Sun
- Pink Tint 1 or 2
- Photogray
- UV Filter
- ST-35, Executive or Trifocal Lenses
- Polycarbonate or Hi Index
- Contact Lenses

**Web site for Optical Services Policy:**
www.dhhs.state.nc.us/dma/optical.htm
click on: N.C. Division of Medical Assistance
click on: Chapter 4 - Optical Services

**Web site for Medicaid Bulletin articles:**
http://www.dhhs.state.nc.us/dma/bulletin.htm
Select year and month of bulletin article

**Bulletin articles that are issued after the original printing date of the Optical Services Policy, supersede the information printed in the policy.**

PROOF

BACK (HEAD to HEAD)

| Block | Field Name | Description |
|---|---|---|
| 1 | Recipient Name- Last | Print the recipient's last name as it appears on the MID card. |
| 2 | Recipient Name- First | Print the recipient's first name as it appears on the MID card. |
| 3 | Middle Initial | Print the recipient's middle initial as it appears on the MID card. |
| 4 | Sex | Mark the recipient's gender. |
| 5 | Recipient I.D. Number | Enter the recipient's 10 character MID number, which is found on the Medicaid card. (The MID is a 9 digit number followed by an alpha character.) |
| 6 | Date of Birth | Enter the recipient's date of birth in MMDDYY format. |
| 7 | Date of Refraction | Enter the date of the most recent refraction. |
| 8 | Name of Prescriber | Print the name of the prescribing doctor. |
| 9 | Diagnosis and ICD-9 Codes | Enter the diagnosis code and the ICD-9 code(s). |
| 10 | For Department Use Only | For fiscal agent prior authorization only. |
| 11 | Frame: Standard Medicaid Selection | Mark frame type. |
| 12 | *Frame Exception | Fill in the frame information in boxes 22, 23, 24, 25 and 26. Fill in the manufacturer's invoice cost of frame. |
| 13 | *Exceptional Services | An asterisk (*) Denotes exceptional services which require documentation of medical necessity. Clearly mark choice of exceptional service. |
| 14 | *Please provide documentation… | Provide documentation for requested exceptional services; may be recorded on, or attached to, the Prior Approval form. |
| 15 | Complete Glasses | Circle when complete glasses are requested. |
| 16 | Lenses Only | Circle when lenses only are requested. |
| 17 | Frame Only | Circle when Medicaid Contractor Laboratory is to supply the frame only. |
| 18 | *Frame to Follow | Frame will be forwarded from the provider to the Medicaid Contractor Laboratory. Circle when frame is to follow- requires prior approval. |
| 19 | R Lens only | Circle when right lens only is required. |
| 20 | L Lens only | Circle when left lens only is required. |
| 21 | Lens Circumference Measurement | Enter Lens circumference measurement for lens only orders. |
| 22 | Manufacturer/Frame Name or Number | Print frame manufacturer and name or model number. |
| 23 | Eye Size | Enter frame size (A measurement). |
| 24 | Bridge Size | Enter bridge size. (DBL measurement). |
| 25 | Temple Length | Enter temple length. |
| 26 | Color | Enter frame color. |
| 27 | Single Vision | Circle for single vision lenses. |
| 28 | ST28 | Circle for ST28 bifocals. |
| 29 | *ST35 | ST35 bifocal- requires documentation. |
| 30 | Round Segment | Circle for round bifocals. |
| 31 | *Executive | Executive bifocal- requires documentation. |
| 32 | *7X28 | 7X28 trifocal- requires documentation. |
| 33 | *8X35 | 8X35 trifocal- requires documentation. |
| 34 | Cataract Lens | Circle and specify lens type. |

| | | |
|---|---|---|
| 35 | *Other | Specify lens type- requires documentation. |
| 36 | CR39 | Circle for CR39. |
| 37 | *Polycarbonate | Circle for polycarbonate- age 7 and above requires documentation. |
| 38 | *Hi-index | Circle for Hi-index- requires documentation. |
| 39 | Clear glass | Circle for clear glass. |
| 40 | *Other | Enter other lens choice-requires documentation. |
| 41 | Sphere | Enter sphere power. |
| 42 | Cylinder | Enter cylinder power. |
| 43 | Axis | Enter axis. |
| 44 | Prism | Enter amount of prism. |
| 45 | Base | Enter direction of base. |
| 46 | Add | Enter bifocal power. |
| 47 | Seg. Ht. | Enter bifocal segment height. |
| 48 | Distance P.D. | Enter distance pupillary distance. |
| 49 | Near P.D. | Enter near pupillary distance. |
| 50 | Manufacturer/Lens Name | Enter contact lens manufacturer and lens name. |
| 51 | Lens Type | Enter contact lens type: (i.e. daily wear, RGP, etc.) |
| 52 | Invoice Cost | Enter manufacturer's invoice cost of contact lenses. |
| 53 | Reason for CL request | Check reason for contact lenses request, if "*Other", attach letter of medical necessity/justification. |
| 54 | Special Instructions for Mediciad Contractor/Laboratory | Enter special instructions for lab. (example: note different signs, etc.) |
| 55 | Initial Fitting Optician/Technician | Print Name |
| 56 | Initial Fitting Optician/Technician | Signature and Fitting Date |
| 57 | Phone Number | Enter provider's area code and phone number. |
| 58 | Submission Date | Enter date prior approval form is submitted. |
| 59 | Provider Address | Print or stamp provider's address. |
| 60 | Provider Number | Enter provider's 7 digit Medicaid number. |
| 61 | Caller's Initials | Print initials of person notifying recipient to pick up visual aids. |
| 62 | Date | Enter date(s) recipient is notified. |
| 63 | Method | Enter method used to notify recipient: (i.e. phone, mail, etc.) |
| 64 | Inspected by | Print name of person performing inspection of Medicaid glasses. |
| 65 | Date Inspected | Enter date glasses were inspected. |
| 66 | Dispensed by | Print name of dispenser. |
| 67 | Date Dispensed | Dispenser to enter dispense date. |
| 68 | Recipient Name | Printed name of person picking up glasses- if other than recipient. |
| 69 | Signature | Signature of person picking up glasses (recipient if over 18, parent or guardian if recipient is under 18) |
| 70 | If recipient is under 18… | Print relationship to recipient (parent, guardian, etc.) |
| 71 | Date | Recipient, Parent/Guardian should enter date glasses are received. |

## Attention: Personal Care Services and Personal Care Services-Plus Providers

## Personal Care Services Provider Training Session II

The Carolinas Centers for Medical Excellence (CCME), formerly Medical Review of North Carolina (MRNC), under contract with the Division of Medical Assistance (DMA), will continue quarterly Personal Care Services (PCS) training sessions statewide.

The training will be for registered nurses, agency administrators, and agency owners. A complete agenda will be finalized and posted in the November N.C. general Medicaid bulletin. Please choose the training session that is most convenient for you from among those listed below.

December 1, 2006
Charlotte
Hilton Charlotte Executive Park
5624 Westpark Drive
Charlotte NC 28217
704-527-8000
http://www.hilton.com/en/hi/hotels/index.jhtml;jsessionid=O0HUORJ5IHTNKCSGBIXM22QKIYFCVUUC?ctyhocn=CLTEPHF

December 4, 2006
Winston-Salem
Benton Convention Center
301West Fifth Street
Winston-Salem NC 27101
336-727-2976
http://www.cityofws.org/default.aspx?mod=Article&id=1474

December 5, 2006
Cary
Embassy Suites/RTP
201 Harrison Oaks Boulevard
Cary NC 27513
919-677-1840
http://embassysuites.hilton.com/en/es/hotels/index.jhtml;jsessionid=KU23WDKZTA00KCSGBI1MVCQKIYFC5UUC?ctyhocn=RDUAPES

December 7, 2006
Wilmington/Wrightsville Beach
Shell Island Resort
2700 North Lumina Avenue
Wrightsville Beach NC 28480
910-256-8696
http://www.shellisland.com

December 8, 2006
New Bern
Sheraton Hotel
One Bicentennial Park
New Bern NC 28560
252-638-3585

http://www.starwoodhotels.com/sheraton/property/overview/index.html?propertyID=18 (Note: the Sheraton Web site gives this address as 100 Middle Street.)

Pre-registration is required. Space is limited to the first 200 participants at each site. To register online, go to http://www.mrnc.org/mrnc_web/mrnc/medicaid.aspx?ID=Registration and follow the instructions for registration. A computer-generated confirmation number will confirm your registration.

To register via fax, complete the attached registration form and fax it to the attention of Jennifer Manning at 919-380-9457. A member of the PCS team will call you with a confirmation number.

Registration began Tuesday, September 5, 2006, for all sites and will close Friday, November 17, 2006. If you need to cancel at any time, please contact Jennifer Manning at 919-380-9860, x2018.
Check-in for each session begins at 8:30 a.m.; the trainings are scheduled from 9:00 a.m. to 4:00 p.m. Lunch will be on your own.

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

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## Attention: ICF-MR Providers

## ICF-MR Provider Assessment Database

The Division of Medical Assistance (DMA) provider assessment database will go live on October 1, 2006. The purpose of the provider assessment database is to enhance the providers' ability to correctly complete their monthly assessment sheets via the Internet.

By utilizing the available technology, providers will be able to file monthly assessments that are currently due and manage historical transactions by viewing completed assessments from prior months for all facilities within their management company.

If you would like to obtain additional information regarding your facility utilizing the assessment database, please contact Mishawn Davis or Stacey Crute at (919)855-4200.

**Rate Setting**
**DMA, 919-855-4200**

## NCLeads Update

Information related to the implementation of the new Medicaid Management Information System, *NCLeads*, can be found online at http://ncleads.dhhs.state.nc.us. Please refer to this web site for information, updates, and contact information related to the *NCLeads* system.

Provider Relations
Office of MMIS Services
919-647-8315

## Proposed Clinical Coverage Policies

In accordance with Session Law 2005-276, proposed new or amended Medicaid clinical coverage policies are available for review and comment on DMA's Web site at http://www.ncdhhs.gov/dma/prov.htm. To submit a comment related to a policy, refer to the instructions on the website. Providers without Internet access can submit written comments to the address listed below.

Gina Rutherford
Division of Medical Assistance
Clinical 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.

### 2006 Checkwrite Schedule

| | | |
|---|---|---|
| October | 10/06/06 | 10/10/06 |
| | 10/13/06 | 10/17/06 |
| | 10/20/06 | 10/26/06 |
| November | 11/03/06 | 11/07/06 |
| | 11/09/06 | 11/14/06 |
| | 11/17/06 | 11/21/06 |
| December | 12/01/06 | 12/05/06 |
| | 12/08/06 | 12/12/06 |
| | 12/15/06 | 12/21/06 |

*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.*

Mark T. Benton, Senior Deputy Director
and Chief Operating Officer
Division of Medical Assistance
Department of Health and Human Services

Cheryll Collier
Executive Director
EDS