



# 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: [www.dhhs.state.nc.us/dma](http://www.dhhs.state.nc.us/dma)

Attention: All Providers

## Holiday Observance

The Division of Medical Assistance and EDS will be closed on Monday, November 12, 2001 in observance of Veteran's Day, and on Thursday, November 22, 2001 and Friday, November 23, 2001 in observance of Thanksgiving.

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

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

**Attention: All Providers**

**B**illing Professional Component for Fluoroscopy, CPT Code 76000

Retroactive to January 1, 2001, the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) removed the Relative Value Units on modifier 26 for CPT code 76000, fluoroscopy. To bill the professional component, use CPT code 76000 without a modifier. The description of the code indicates that the code is for the physician services, i.e., the professional component. The description does not include the technical component. Therefore, billing CPT code 76000 without a modifier signifies that the physician service (professional component) is being billed.

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**Attention: All Providers**

**H**IV Resistance Testing

Genotype and phenotype HIV resistance testing – CPT codes 87901, 87903, and 87904 – include several components based on information from the Department of Health and Human Services, Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration).

Component codes 83890, 83894, 83898, 83902, 83912, 87252, and 87253 cannot be billed on the same date of service as CPT test codes 87901, 87903 or 87904.

Comprehensive Test	Component Codes			
87901, 87903 or 87904	83890	83898	83912	87253
	83894	83902	87252	

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

**Attention: All Local Education Agencies, Head Start Programs, and Independent Practitioners**

**D**ocumentation of Medical Necessity as Indicated by Written Physician’s Order Prior to Initiation of Assessment and Treatment Services

The following statement is provided to clarify the Division of Medical Assistance’s policy on physician’s orders for Local Education Agencies (LEA), Head Start Programs, and Independent Practitioner (IP) Services.

It is mandatory that a written and dated physician’s order, including the physician’s handwritten signature, be obtained and available for inspection within the Medicaid recipient’s record. The written order must be obtained prior to the commencement of all assessment and treatment services rendered by qualified providers seeking to bill Medicaid under the LEA, Head Start, and IP Health Related Services programs for children under 21 years of age.

**Note:** The *Health Related Services Provided in Public School* and the *Health Related Services for Children Under 21 Years of Age Provided by Independent Practitioner (IP) Providers* manuals are being revised. Providers will be notified when the revised manuals are available.

**Jency L. Abrams R.N., BSN, M.S.**  
**Independent Practitioner (IP) Services**  
**DMA, 919-855-4051**

## Attention: All Providers

# Reaching Compliance with HIPAA Privacy Regulations

Congress addressed the increasing use of electronic technology within the health care industry by enacting the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The law includes provisions for the simplification of administrative and financial health care transactions by standardizing the electronic exchange of information between health care plans (payers), clearinghouses, and providers. HIPAA went a step further by introducing regulations to protect patient rights and to guard against the misuse or disclosure of their health records. The HIPAA privacy rule became effective on April 14, 2001, and all health care payers, clearinghouses, and providers are required to comply with the provisions of the rule by April 14, 2003.

The privacy rule establishes accountability and responsibility for the use or disclosure of any **protected health information (PHI)** for the purposes of **treatment, payment or health care operations (TPO)**. This includes all medical records and health information used or disclosed in any form, whether electronic, written or oral.

Providers are required to obtain a patient's consent before using or disclosing protected health information (PHI) for treatment, payment or health care operations (TPO). The consent form must be written in simple language and inform the patient that PHI may be used or disclosed for TPO. The consent form must also state the patient's right to review a provider's written notice of privacy practices and inform the patient of the right to review, restrict, and revoke consent. All consent forms must be dated and signed by the patient and retained by the provider for a minimum of six years.

If a patient refuses to sign a consent form, providers may choose not to treat the patient. It is important to note that prior consent is not required in an emergency, where treatment is required by law or where a substantial communication barrier exists. Additionally, health care providers who are indirectly involved in the treatment of a patient are not required to obtain the patient's consent. For example, a laboratory that is running tests at the request of a physician as part of the patient's treatment does not require prior consent from the patient.

While it is necessary for physicians to have full access to a patient's medical records in order to provide treatment, disclosure of health information for purposes other than other treatment, payment or health care operations (TPO) must be limited to the minimum amount of information that is necessary to accomplish the intended purpose. What constitutes the minimum is determined by the provider. Providers must develop criteria to determine minimum necessity, and then document the policies and procedures for enforcing the standards. Reasonable safeguards must be in place to protect confidential information.

Exceptions to the requirements for minimum disclosure standards include using or disclosing health information to protect public health, to conduct medical research or to improve the quality of consumer health care. Use and disclosure of protected health information (PHI) required to comply with HIPAA regulations for electronic transactions are also allowed, as are those uses and disclosures that are required by other laws or under the rule for enforcement purposes. This includes disclosure of PHI to health oversight agencies for activities authorized by law including audit, investigation, and civil, criminal or administrative proceedings.

"Consent" is required for the use or disclosure of protected health information (PHI) for treatment, payment or health care operations (TPO). However, the use or disclosure of health information for purposes unrelated to TPO requires written "authorization" from a patient. While providers may deny treatment if a patient refuses to sign a consent form, treatment cannot be withheld if a patient refuses to sign an authorization form. In general, a written authorization gives permission to the provider to use specific health information for a specific purpose. An authorization is time-limited and must include an expiration date. For example, a physician would need authorization from a patient to release their name and address to a wholesale medical equipment supplier.

Health care plans, providers, and clearinghouses should begin assessing their organizations now to determine what actions are necessary to comply with HIPAA privacy regulations by April 13, 2003. An individual in their organization should be designated as the privacy officer or a committee should be appointed to learn the requirements of the privacy rule, ensure that privacy procedures are adopted, and train employees to understand the procedures.

All providers should draft a written notice of information practices and begin obtaining consent from their patients now. Policies and procedures should also be developed to allow patients to examine, copy, and request corrections to their health records. Ensure that patient records containing protected health information (PHI) are accessible only to those who need them.

Review who has access to protected health information (PHI) within your organization and document the procedure for transmitting information. Implement measures to account for disclosure of information for purposes other than treatment, payment or health care operations (TPO). Review all third party services – both contracted and informal arrangements – to ensure that PHI is not being accessed or disclosed without your knowledge or consent.

The U.S. Department of Health and Human Services' Office for Civil Rights (OCR) is responsible for the implementation and enforcement of the HIPAA privacy regulations. Compliance information and assistance is available from OCR on their website at <http://www.hhs.gov/ocr/hipaa/> or by contacting your provider association.

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

## Attention: Personal Care Service Providers

### Daily Limitation on Personal Care Services in the Home

Effective with date of service January 1, 2002, Personal Care Services (PCS) will be limited to 14 units (3.5 hours) per day for each recipient.

Adjustments to the plan of care must be made for all cases exceeding the 14 unit per day maximum. Obtain the physician signature for the change in hours according to established guidelines listed in section 6.8 on page 6-15 of the *N.C. Medicaid Community Care Manual*. The 320 unit (80 hour) monthly maximum allowable remains unchanged.

All claims beginning with dates of service January 1, 2002 must be filed according to this new limitation.

This change does not apply to Adult Care Home PCS Providers.

**Adelle Kingsberry, Medical Policy Section  
DMA, 919-857-4021**

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

### Conversion of Home Health Supply Codes to Standardized National Codes

Congress has mandated that all payer sources comply with guidelines of the Health Insurance Portability and Accountability Act (HIPAA). This includes using standardized national codes for services that are common to all carriers. The deadline for implementation is October 16, 2002. As codes are end-dated and new codes are added, providers will be notified in the general Medicaid bulletin.

Some of the codes currently used will be replaced by multiple codes, and some will be deleted and replaced with existing codes. Read each description carefully to ensure that the correct size, quantity or preparation is billed. For example, the current code for ostomy skin barrier is A4363. The new code will be A4369, A4370 or A4371 depending on whether a liquid, paste or powder skin barrier is used.

Current codes shown below will be end-dated effective with date of service December 31, 2001, with the new codes becoming effective with date of service January 1, 2002.

<b>Home Health Supplies</b>			
<b>Current Code</b>	<b>New Code</b>	<b>New Description</b>	<b>Maximum Rate/Unit</b>
		<b>Catheter Supplies</b>	
W4648	A4320	Irrigation tray with bulb or piston syringe, any purpose	4.62
W4614	A4334	Urinary catheter anchoring device, leg strap, each	5.04
W4612	A4351	Intermittent urinary catheter, straight tip, each	1.57
		<b>Dressing Supplies</b>	
W4607	A6222	Gauze, impregnated, other than water or normal saline, pad size 16 sq. in. or less, without adhesive border, each dressing	2.18
W4608	A6223	Gauze, impregnated, other than water or normal saline, pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing	2.47
W4608	A6224	Gauze, impregnated, other than water or normal saline, pad size more than 48 sq. in., without adhesive border, each dressing	3.69
W4605	A6234	Hydrocolloid dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing	6.68
W4606	A6235	Hydrocolloid dressing, wound cover, pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing	17.19
W4606	A6236	Hydrocolloid dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing	27.83
W4604	A6251	Specialty absorptive dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing	2.03
W4606	A6252	Specialty absorptive dressing, wound cover, pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing	3.32
W4606	A6253	Specialty absorptive dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing	6.48
W4607	A6257	Transparent film, 16 sq. in. or less, each dressing	1.56
W4608	A6258	Transparent film, more than 16 sq. in., but less than or equal to 48 sq. in., each dressing	4.39

## Home Health Supplies, continued

Current Code	New Code	New Description	Maximum Rate/Unit
W4608	A6259	Transparent film, more than 48 sq. in., each dressing	11.17
A4202	A6264	Gauze, non-elastic, non-sterile, all types, per linear yard	.50
W4603	A6402	Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	.12
W4603	A6403	Gauze, non-impregnated, sterile, pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing	.44
W4603	A6404	Gauze, non-impregnated, sterile, pad size more than 48 sq. in., without adhesive border, each dressing	.46
A4202	A6406	Gauze, non-elastic, sterile, all types, per linear yard	.82
		<b>Intravenous Therapy and Parenteral Supplies</b>	
W4667	A4206	Syringe with needle, sterile, 1 cc, each ( <i>or smaller</i> )	.34
W4662	A4215	Needle only, sterile, any size, each	.14
		<b>Miscellaneous Supplies</b>	
W4639	A4554	Disposable underpads, all sizes	.55
		<b>Ostomy Supplies</b>	
A4363	A4369	Ostomy skin barrier, liquid (spray, brush, etc.), per oz.	2.47
A4363	A4370	Ostomy skin barrier, paste, per oz.	3.50
A4363	A4371	Ostomy skin barrier, powder, per oz.	3.73
		<b>Skin Care (Decubitus) Supplies</b>	
W4633	E0199	Dry pressure pad for mattress, standard mattress length and width	27.83
		<b>Solutions</b>	
W4615	A4246	Betadine or pHisoHex solution, per pint	5.59

Providers must bill their usual and customary charges.

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

## Attention: Nursing Facility Providers

### Utilization Review

Effective November 1, 2001, there will be a change regarding the Utilization Review Committee (URC) reports submitted to the Medical Policy Section at the Division of Medical Assistance (DMA).

Each Medicaid resident reviewed by the URC must be listed on the FL12 as usual. However, only the white copy of the FL2 for **residents with recommended level of care changes** should be mailed with the URC packet to DMA.

The FL2 for residents who do not have recommended level of care changes should not be mailed to DMA.

All other parts of the Utilization Review process will remain the same and Medicaid residents must continue to be reviewed as scheduled.

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

## Attention: All Providers

### Billing Agents

Federal regulation 42CFR447.10(f) addresses the use of a billing service or an accounting firm by enrolled Medicaid providers. An agent can be used to file claims and receive payment on behalf of the provider if the agent's compensation for this service is:

1. related to the cost of processing the billing
2. not related on a percentage or other basis to the amount that is billed or collected
3. not dependent upon the collection of the payment

Providers using business or billing agents are reminded of the above conditions and are urged to review their contracts or agreements. If these conditions are not met, Medicaid payments are considered improper and will be recovered.

**Darlene Cagle, Provider Services**  
**DMA, 919-857-4017**

## Attention: Carolina ACCESS Providers

### Carolina ACCESS Override Requests

Effective immediately, Carolina ACCESS (CA) providers must contact the EDS Managed Care Unit at 1-800-688-6696 or 919-816-3049 to request a CA override. CA providers were notified in the September 2001 general Medicaid bulletin that due to budget constraints, funding for the Managed Care Representatives (MCR) had been eliminated and the override function had been assigned to the regional Managed Care Consultants. This was a temporary solution initiated during the transition period of reassigning MCR functions that were critical to CA. The Division of Medical Assistance has now contracted with EDS Provider Services to manage CA overrides.

EDS is authorized to issue overrides when extenuating circumstances beyond control of the responsible parties affect access to medical care. Overrides may be issued when:

1. a county department of social services (DSS) incorrectly links a recipient to a primary care provider (PCP);
2. an enrollee is placed in foster care and the placement impedes access to the PCP;
3. a recipient transfers to another county and the distance to the PCP exceeds time/distance standards;
4. a Medicaid identification (MID) card does not have correct information due to an eligibility system error;
5. there are extenuating circumstances that impede access to care. These will be reviewed case by case.

Overrides will not be issued solely due to provider error to verify CA enrollment, recipient error, provider disenrollment, or because a patient has not established with the PCP after the 90-day enrollment period. PCPs are contractually required either to provide services or authorize another provider to see the patient until the county DSS changes the CA status. Therefore, it is very important for providers to continue to verify Medicaid eligibility and the CA PCP for the date of service before service is rendered. Verify by viewing the current month's MID card or through the Automated Voice Response (AVR) system at 1-800-723-4337.

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

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### Checkwrite Schedule

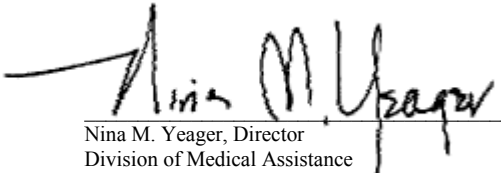
November 6, 2001	December 11, 2001
November 14, 2001	December 18, 2001
November 20, 2001	December 28, 2001
November 29, 2001	


### Electronic Cut-Off Schedule

November 2, 2001	December 7, 2001
November 9, 2001	December 14, 2001
November 16, 2001	December 21, 2001
November 21, 2001	

*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.*

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

  
Ricky Pope  
Executive Director  
EDS



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