Number 11 *November 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

In This Issue…… *Page #*

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

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

Attention: All Providers

CPT Anesthesia Codes

As published in the September 2003 general Medicaid bulletin, effective with dates of service October 1, 2003, providers must bill anesthesia services using CPT anesthesia codes (00100 through 01999) instead of CPT surgical codes.

Effective September 30, 2003, the YA modifier was end-dated to comply with the implementation of national standard codes mandated by the Health Insurance Portability and Accountability Act (HIPAA). General anesthesia is not billed with modifiers. When billing for general anesthesia, do not append the YA modifier to the CPT anesthesia code. However, when billing for monitored anesthesia, continue to append the QS modifier to the CPT anesthesia code.

Note: For dates of service prior to October 1, 2003, bill using surgical CPT codes and either modifier YA or QS plus time.

Auditing of CPT anesthesia services follows the Correct Coding Initiative (CCI). Additional information concerning specific coding requirements will be published in upcoming general Medicaid bulletins.

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

Attention: All Providers

Anesthesia Billing for Labor and Delivery

Effective with dates of service October 1, 2003, anesthesia services must be billed with CPT anesthesia codes. For dates of service prior to October 1, 2003, surgical CPT codes appended with either the YA or QS modifier should be billed.

Use the following chart as a guide for services performed on or after dates of service October 1, 2003. For dates of service prior to October 1, 2003 refer to the July 2002 general Medicaid bulletin.

Service Description	Procedure Code	Remarks	Billing Unit
Vaginal delivery only under epidural	01967		1 unit (flat rate)
Delivery only under general	01960 **or** 01961	Vaginal delivery C-section delivery	1 unit (flat rate) 1 unit (flat rate)
Sterilization only under general or epidural	00840 **or** 00851	For sterilization use diagnosis code V252	1 min=1 unit (time)
Delivery under epidural, sterilization under general or epidural	01967 **and** 01968 **plus** 00840 **or** 00851	C-section delivery with add-on code For sterilization use diagnosis code V252	1 unit (flat rate) 1 unit (flat rate) 1 min=1 unit
	01967 **and** 00840 **or** 00851	Vaginal delivery For sterilization use diagnosis code V252	1 unit (flat rate) 1 min.=1 unit (time)

Billing Chart, continued

Service Description	Procedure Code	Remarks	Billing Unit
Delivery under general, sterilization under general or epidural	01960 **and** 00840 **or** 00851	Vaginal delivery For sterilization use diagnosis code V252	1 unit (flat rate) 1 min=1 unit
	01961 **and** 00840 **or** 00851	C-section delivery For sterilization use diagnosis V252	1 unit (flat rate) 1 min=1 unit (time)
C-section hysterectomy after labor under epidural or spinal anesthesia	01967 **and** 01969	C-section hysterectomy with add-on code	1 unit (flat rate) 1 unit (flat rate)
C-section delivery following intrathecal block (62311 is included in 01961)	01961		1 unit (flat rate)

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

Attention: All Providers

Supplemental Security Income Medicaid Recipients with Incorrect Medicare Indicators

All Supplemental Security Income (SSI) recipients in North Carolina are automatically eligible for Medicaid benefits. These individuals are not required to apply for Medicaid benefits at the county department of social services. Their Medicaid eligibility records are created from the Social Security Administration's SSI data files.

Incorrect Medicare information may appear on an SSI Medicaid recipient's Medicaid identification (MID) cards due to inaccurate data in the Social Security Administration's SSI files. If a recipient's MID card indicates Medicare coverage, providers can verify Medicare coverage by asking to see the recipient's Medicare card. Hospitals may also verify Medicare benefits through an online inquiry to the Medicare Common Working File (CWF). If it is determined that a Medicaid recipient is covered by Medicare, providers must file claims for Medicare covered services to Medicare before filing claims to Medicaid.

If a recipient's MID card indicates Medicare coverage but the recipient does not have a Medicare card and the recipient is under the age of 65, the Medicare indicators on the MID card are probably incorrect. Claims for Medicaid covered services other than inpatient hospital services (filed on the UB-92 claim form) are not affected by the incorrect Medicare indicators and can be filed directly to Medicaid.

Because a claim for inpatient hospital services will deny if an incorrect Medicare indicator appears on the MID card, the claim must be processed separately. Providers must submit the claim on paper with a copy of the CWF, if applicable, to the DMA Claims Analysis Unit at the address listed below.

Claims Analysis Unit
DMA
2501 Mail Service Center
Raleigh, NC 27699-2501

Claims Analysis Unit
DMA, 919-857-4018

Attention: All Providers

Medicaid Credit Balance Reporting

All providers participating in the Medicaid program are required to submit a quarterly **Credit Balance Report** to the Division of Medical Assistance (DMA), Third Party Recovery Section. Providers are to report any **OUTSTANDING** credits owed to Medicaid that have not been reported previously on a Medicaid Credit Balance Report. (Hospital and nursing facility providers continue to be required to submit a report every calendar quarter even if a zero ($0.00) credit balance exists.) The report is to be submitted no later than 30 days following the end of the calendar quarter (March 31, June 30, September 30, and December 31).

The Medicaid Credit Balance Report is used to monitor and recover "credit balances" owed to the Medicaid program. A credit balance results from an improper or excess payment made to a provider. For example, refunds must be made to Medicaid if a provider is paid twice for the same service (e.g., by Medicaid and a medical insurance policy; by Medicare and Medicaid; by Medicaid and a liability insurance policy) if the patient liability was not reported in the billing process; or when computer or billing errors occur.

For the purpose of completing the report, a Medicaid Credit Balance is the amount determined to be refundable to the Medicaid program. When a provider receives an improper or excess payment for a claim it is reflected in their accounting records (patient accounts receivable) as a "credit." However, credit balances include money due Medicaid regardless of its classification in a provider's accounting records. If a provider maintains a credit balance account for a stipulated period (e.g., 90 days) and then transfers the account or writes it off to a holding account, this does not relieve the provider of its liability to the Medicaid program. The provider is responsible for identifying and repaying all monies owed the Medicaid program.

The Medicaid Credit Balance Report requires specific information on each credit balance on a claim-by-claim basis. This form provides space for 15 claims but may be reproduced as many times as necessary to accommodate all the credit balances being reported. Specific instructions for completing the report are on the reverse side of the reporting form.

Submitting the Medicaid Credit Balance Report does not result in the credit balances automatically being reimbursed to the Medicaid program. If submitting a check is the preferred form of satisfying the credit balances, the check should be made payable to EDS and sent to EDS with the required documentation for a refund payment. If an adjustment is to be made to satisfy the credit balance, an adjustment form must be completed and submitted to EDS with all the supporting documentation for processing.

Submit **Medicaid Credit Balance Report** to:	Submit **refund checks** to:	Submit **Medicaid Claim Adjustment Request** to:
Third Party Recovery Section Division of Medical Assistance 2508 Mail Service Center Raleigh, NC 27699-2508	EDS Refunds P.O. Box 300011 Raleigh, NC 27622-3011	EDS Adjustment Unit P.O. Box 300009 Raleigh, NC 27622-3009

Submit **ONLY** the completed Medicaid Credit Balance Report to the Division of Medical Assistance. **DO NOT** send refund checks or adjustment forms to the Division of Medical Assistance. **DO NOT** send the Credit Balance Reports to EDS.

Failure to submit a Medicaid Credit Balance Report will result in the withholding of Medicaid payments until the report is received.

A copy of the Medicaid Credit Balance Report form is available on page 7. Both the Medicaid Claim Adjustment Request form and the Medicaid Credit Balance Report form are also available on DMA's website at http://www.dhhs.state.nc.us/dma/forms.html

Marilyn Vail, Third Party Recovery Section
DMA, 919-733-6294

MEDICAID CREDIT BALANCE REPORT

PROVIDER NAME: _____ CONTACT PERSON: _____

PROVIDER NUMBER:_____ TELEPHONE NUMBER: (_____)_____

QUARTER ENDING: (Circle one) 3/31 6/30 9/30 12/31 YEAR:_____

(1) RECIPIENT'S NAME	(2) MEDICAID NUMBER	(3) FROM DATE OF SERVICE	(4) TO DATE OF SERVICE	(5) DATE MEDICAID PAID	(6) MEDICAID ICN	(7) AMOUNT OF CREDIT BALANCE	(8) REASON FOR CREDIT BALANCE
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							

Circle one: Refund Adjustment

Return form to: Third Party Recovery
DMA
2508 Mail Service Center
Raleigh, NC 27699-2508

Revised 9/03

(See back of form for instructions)

Instructions for Completing Medicaid Credit Balance Report

Complete the "Medicaid Credit Balance Report" as follows:

- Full name of facility as it appears on the Medicaid Records
- The facility's **Medicaid** provider number. If the facility has more than one provider number, use a separate sheet for each number. **DO NOT MIX**
- Circle the date of quarter end
- Enter year
- The name and telephone number of the person completing the report. This is needed in the event DMA has any questions regarding some item in the report

Complete the data fields for each Medicaid credit balance by providing the following information:

Column 1 - The last name and first name of the Medicaid recipient (e.g., Doe, Jane)

Column 2 - The individual Medicaid identification (MID) number

Column 3 - The month, day, and year of beginning service (e.g., 12/05/03)

Column 4 - The month, day, and year of ending service (e.g., 12/10/03)

Column 5 - The R/A date of Medicaid payment (not your posting date)

Column 6 - The Medicaid ICN (claim) number

Column 7 - The amount of the credit balance (not the amount your facility billed or the amount Medicaid paid)

Column 8 - The reason for the credit balance by entering: "81" if it is a result of a Medicare payment; "83" if it is the result of a health insurance payment; "84" if it is the result of a casualty insurance/attorney payment or "00" if it is for another reason. Please explain "00" credit balances on the back of the form.

After this report is completed, total column 7 and mail to **Third Party Recovery, DMA, 2508 Mail Service Center, Raleigh, NC 27699-2508**.

Attention: All Providers

Medical Coverage Policies

During the month of October 2003, the following medical coverage polices were amended and are now available online at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm.

- A1 – Special Services: After Hours
- 5 – Durable Medical Equipment
- 8F – Outpatient Specialized Therapies
- 8G – Independent Practitioners
- 8H – Local Education Agencies
- 8J – Children's Development Service Agencies

Medical coverage policies extracted from 22A NCAC 22O are also available on this web page.

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

Attention: All Providers

Remittance and Status Report Changes

It was announced in the August 2003 general Medicaid bulletin that changes would be made to the Remittance and Status Report (RA). These changes were delayed until December 1, 2003.

Effective December 1, 2003, the RA will be revised to include a new field labeled "DIFF." This field denotes the difference between the Medicaid projected payment (a calculation of the difference between the Medicaid allowable and the Medicare payment) and the actual Medicaid payment when Medicaid pays the Medicare coinsurance and deductible. Initially, this field will only be used by providers filing UB-92 outpatient hospital Medicare primary claims.

The "DEDUCTIBLE" and the "PAT LIAB" fields will be shortened to "DED" and "PT LIB." There will be no changes to the information that is currently recorded in these fields.

Refer to the example on page 10.

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

NORTH CAROLINA MEDICAID
REMITTANCE AND STATUS REPORT

RECIPIENT, JOE
123 ANY STREET
ANY CITY, NC 12345

PROVIDER NUMBER **3400000** REPORT SEQ. NUMBER DATE **12/09/03** PAGE **2**

NAME / RECIPIENT ID	SERVICE DATE FROM	SERVICE DATE TO	DAYS OR UNITS	PROCEDURE/ACCOMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMOUNT	EXPLA-NATION CODES
Paid Claims												
Outpatient												
RECIPIENT JOE A	**CO=92**	**RCC=**	**CLAIM NUMBER= 252002001001001NCXIX**									
900000000k						**MED REC= 123456**				**ATTN PROV= 0.8000**		**8926**
NCXIX	**10162002**	**10162002**	**2 B**	**250 PHARMACY-GEN**	**78 00**	**00**	**78 00**	**38 68**	**39 32**	**3932**	**00**	**8926**
NCXIX	**10162002**	**10162002**	**1 B**	**341 NUCLEAR MEDICINE**	**576 00**	**00**	**576 00**	**285 69**	**290 31**	**20110**	**89 21**	**8926**
DED= .00	*PT LIB= .00*	*CO*	*PAY= .00*	*TPL= 88.01*	*DIFF= 152.41*	*654 00*	*0*	*65400*	*324 37*	*329 63*	*24042*	*89 21*
ORIGINAL BILLED AMOUNT= 654.00				*ORIGINAL DETAIL COUNT = 2*			*TOTAL FINANCIAL PAYERS= 1*					

Attention: Hospitals

Change to Medicare Part B Pricing Policy

It was announced in the August 2003 general Medicaid bulletin that system changes were being made to the payment methodology for hospital outpatient claims. On September 22, 2003, a letter was sent from the Division of Medical Assistance (DMA) to Patient Financial Services Directors announcing that these changes had been delayed. This delay has resulted in continued incorrect payments for outpatient services (including hospitals that modified their billing system to accommodate the change). The claims processing system is being modified to accommodate the revised payment methodology effective December 1, 2003, and will follow the guidelines published in the August 2003 general Medicaid bulletin.

Effective December 1, 2003, claims filed to Medicaid when Medicare Part B has made a payment, must have the sum of both the coinsurance and the deductible in form locator 55, estimated amount due. Medicaid will begin reimbursing providers the lesser of the coinsurance and deductible or the difference between the Medicaid allowable and the Medicare payment. This change only applies to dates of service after October 1, 2002. For additional information about billing claims when Medicare Part B is primary, providers should refer to the September 2002 Draft Special Bulletin VI (revised November 14, 2002), *Medicare Part B Billing Guidelines*.

Below is a sample section of the UB-92:

50 Payer	**51 Provider No**	**52 Rel Info**	**53 Asg Ben**	**54 Prior Payments**	**55 Est. Amount Due**	**56**
M0000	34XXXX			$50.00		
DNC00	34XXXXX				$100.00	

Example:
Medicare payment = $50
Medicare coinsurance = $75
Medicare deductible = $25
Contractual adjustment = $10

In the above example, the payment from Medicare Part B was $50.00, as indicated in form locator 54. The coinsurance plus the deductible was $100.00, as indicated in form locator 55.

These claims can be filed electronically. Do not add the contractual adjustment to the payment listed in form locator 54.

Update on Medicare Part B Verification of Potential Overpayments

The September 22 letter sent to Patient Financial Services Directors included three reports identifying claims where Medicare Part B was primary. The deadlines indicated in the letter for the required reports on overpayments have been extended. Refer to the following table for the revised due dates.

Report Name	Period Covered	Due Date
Report # 1	October 1, 2002 – March 31, 2003	March 31, 2004
Report # 2	April 1, 2003 – June 30, 2003	May 31, 2004
Report # 3	July 1, 2003 – August 31, 2003	July 30, 2004
Report # 4	September 1, 2003 – November 30, 2003	September 30, 2004

A letter explaining the revised dates will be forthcoming. Report # 4 (covering the period September 2003 through November 2003) was not included in the September 22 letter. Report # 4 will be included in the forthcoming letter.

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

Attention: Area Mental Health Centers, Developmental Evaluation Centers, Health Departments, Home Health Providers, Hospital Outpatient Clinics, Independent Practitioners, and Physician Services

Outpatient Specialized Therapies Prior Approval Process

Below are some reminders to assist with the flow of the prior approval (PA) process:

- A prior approval request form MUST be completed for each therapy service requested.
- If you fax a PA request to Medical Review of North Carolina (MRNC) and do not receive a response within five days, call MRNC at 1-800-228-3365.
- The signed treatment plan may be used as the physician's order. However, PA cannot be issued for services rendered prior to the date that the physician signed the treatment plan. If the treatment plan is written for September 9, 2003 through March 8, 2004 and the physician did not sign the treatment plan until October 1, 2003, services rendered on September 9 through September 30 will not be authorized. PA can only be requested for dates of service for October 1, 2003 and after. However, MRNC must receive the request by October 1, 2003.
- The same provider number that is used on the PA request submitted to MRNC must be used on the claim submitted for reimbursement to EDS. Providers who bill with a group provider number must use the same group number on the PA request. Providers who bill with an individual provider number must use the same individual provider number on the PA request.
- Only home health agencies and hospitals request PA in visits. Therefore, one visit equals one unit. All other providers request PA according to how the CPT code is billed. The billing unit for all of the CPT procedure codes for Speech Therapy (ST) and Respiratory Therapy (RT) is an event. One event equals one unit.

  Example: Both CPT code 92501 and 92526 will be billed for ST that will occur during the same therapy session. Thus, providers must request PA for two units and bill for two units.
- MRNC is not responsible for ensuring that the correct billing provider number, the correct number of billing units, and the correct dates of service are used on the PA requests.
- It is the provider's responsibility to request PA for additional units of service before the approved units of service end or before the PA period expires.
- If two providers (for example, a school and an independent practitioner) are providing services to the same recipient there must be coordination of services. Services should not be provided on the same day.

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

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

HCPCS Code Changes for Home Health Supplies

Effective with date of service November 1, 2003, the following codes were **deleted** from the Home Health and Private Duty Nursing fee schedules.

HCPCS Code	Description
A6198	Alginate or other fiber gelling dressing, wound cover, pad size more than 48 sq. in.
A6218	Gauze, non-impregnated, non-sterile, pad size more than 48 sq. in. w/o adhesive border, each dressing
A6224	Gauze, impregnated, other than water or normal saline, pad size more than 48 sq. in., without adhesive border, each dressing
A6236	Hydrocolloid dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing
A6253	Specialty absorptive dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing
A6259	Transparent film, more than 48 sq. in., each dressing
A6404	Gauze, non-impregnated, sterile, pad size more than 48 sq. in., without adhesive border, each dressing

The following codes will be **end-dated** on November 30, 2003:

HCPCS Code	Description
W4617	Fleet enema
W4640	IV administration set (tubing, clamp)
W4651	Blood glucose test strips, each (visual strips – not for use with blood glucose monitor
W4663	Needle, sterile, filter
W4740	IV infusion start kit (sterile drape, tourniquet, 2x2's tape, alcohol/iodine wipe, dressing)
W4741	Venipuncture kit (butterfly needle, tourniquet, 2x2's, tape, alcohol swabs, iodine prep)
W4742	Cotton-tip applicators, sterile

Medicaid covers medical supplies meeting the criteria listed in Section 5.1.6 of the *N.C. Medicaid Community Care Manual* (http://www.dhhs.state.nc.us/dma/cc). A physician's order in itself does not make an item "medically necessary" in the context of Medicaid coverage. The order allows the item to be billed if it meets Medicaid criteria.

When using the miscellaneous supply code to bill for items not listed on the Home Health and Private Duty Nursing fee schedule, follow the instructions in Section 5.1.6. and bill the usual and customary rate.

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

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

Rate Increase for Ostomy Supplies

In an effort to help facilitate recipient access to care, the N.C. Medicaid program increased the maximum reimbursement rates for the following ostomy supplies effective with date of service November 1, 2003.

HCPCS Code	Description	Billing Unit	Old Reimbursement Rate	New Reimbursement Rate
A4364	Adhesive for ostomy or catheter	ounce	$ 2.55	$ 5.97
A4369	Ostomy skin barrier, liq per oz	ounce	2.47	3.96
A4371	Ostomy skin barrier, powder, per oz	ounce	3.73	6.93
A4397	Irrigation supply; sleeve each	each	4.17	5.93
A4405	Ostomy skin barrier, non pectin paste	ounce	3.50	4.25
A4406	Ostomy skin barrier, pectin paste	ounce	3.50	6.30
A4407	Ostomy skin barrier w. flange 4x4	each	4.92	8.82
A4410	Ostomy skin barrier w. flange	each	4.92	9.04
A4455	Adhesive remover or solvent	ounce	1.24	3.84
A5051	Pouch, closed w/barrier 1 piece	each	2.29	2.75
A5061	Pouch, drainable w/barrier 1 piece	each	2.77	4.22
A5062	Pouch, drainable w/ barrier 1 piece	each	2.27	2.50
A5063	Pouch, drainable; for use on barrier 2 piece	each	2.28	3.07
A5071	Pouch, urinary; w/barrier 1 piece	each	4.44	4.79
A5073	Pouch, urinary; for use on barrier w. flange	each	3.25	3.65
A5119	Skin Barrier wipes; box of 50	50/box	10.36	11.94
A5121	Skin barrier, solid 6x6 (WAFER)	each	7.62	8.97
A5126	Adhesive disc or foam pad	each	1.15	1.64

Providers must bill their usual and customary charge.

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

Attention: Durable Medical Equipment Providers

HCPCS Code Changes for Durable Medical Equipment

The following HCPCS codes were changed effective with date of service November 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	
W4724 W4725	K0549*	Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, any type side rails, with mattress	5 years	Rental: New Purchase: Used Purchase:	$ 436.14 6,341.28 4,003.74
W4727 W4728 W4729	K0549*	Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, any type side rails, with mattress	5 years	Rental: New Purchase: Used Purchase:	436.14 6,341.28 4,003.74
	K0550*	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress	5 years	Rental: New Purchase: Used Purchase:	767.43 7,694.23 5,801.80
W4679 W4680 W4681 W4682 W4683	E0168	Commode chair, extra wide and/or heavy duty, stationary or mobile, with or without arms, any type, each	3 years	Rental: New Purchase: Used Purchase:	60.02 600.20 450.15
W4684	E0167	Pail or pan for use with commode chair	1 year	New Purchase:	6.29
W4692 W4693	E0148	Walker, heavy duty, without wheels, rigid or folding, any type, each	3 years	New Purchase: Used Purchase:	140.25 114.64
W4694	E0149	Walker, heavy duty, wheeled, rigid or folding, any type, each	3 years	New Purchase: Used Purchase:	227.09 170.32

*Codes K0549 and K0550 require prior approval. Otherwise, the new codes do not require prior approval. However, as 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

End-Dated Codes W9934 and W4046

HCPCS procedure codes W9934, pediatric enteral formulae, and W4046, disposable electrodes, were end-dated and deleted from the DME Fee Schedule effective with date of service October 31, 2003. This action was taken due to non-usage of the codes.

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

Attention: Health Check Providers

Vision and Hearing Assessments for Health Check Screenings

Hearing and vision assessments must be provided during a Health Check screening at age-appropriate intervals. The Health Check program follows the Recommendations for Preventive Pediatric Health Care from the American Academy of Pediatrics for hearing and vision assessment requirements as well as for all the other screening components. The Recommendations may be accessed online at http://www.aap.org/policy/re9939.html.

Objective hearing assessments using electronic equipment (i.e., audiometer) must be performed at each periodic screening beginning at age 4. Hearing assessments are billed with CPT code 92551 or 92552 and the EP modifier. Subjective assessments (i.e., rattling coins in a cup) may be performed at interperiodic visits.

Objective vision assessments (i.e., Snellen chart), must be performed at each periodic visit beginning at age 3. Vision assessments are billed with CPT code 99173 or 99172 and the EP modifier. Subjective assessments (i.e., tracking) may be performed at interperiodic visits.

Claims that deny because a hearing or vision assessment could not be performed during a periodic visit due to a condition such as deafness or blindness, may be resubmitted through the adjustment process with supporting medical record documentation attached.

For additional information on the Health Check screening components and billing requirements, refer to the April 2003 Special Bulletin I, *Health Check Billing Guide 2003* on DMA's website at http://www.dhhs.state.nc.us/dma/bulletin.htm.

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

Attention: Personal Care Services Providers

Implementation of Personal Care Services-Plus

Effective with date of service November 1, 2003, the Division of Medical Assistance (DMA) implemented the new Personal Care Services-Plus (PCS-Plus) program. PCS-Plus is an enhancement to the Personal Care Services (PCS) program and was developed for PCS recipients whose needs exceed the 3.5-hour daily limit or 60-hour monthly limit for PCS. PCS-Plus allows for up to 20 additional hours of PCS each month for qualifying individuals. In addition, there are no daily hourly limits for recipients approved for PCS-Plus.

Note: The total number of PCS and PCS-Plus hours cannot exceed 80 hours per month.

PCS-Plus Criteria

To qualify for PCS-Plus, a recipient must be eligible for PCS, require additional time for the in-home aide to perform delegated tasks, and meet one of the following three criteria for medical necessity. The recipient must, at a minimum:

1. Require extensive assistance in four or more activities of daily living (ADLs);
2. Require extensive assistance in three or more ADLs **and** need the in-home aide to perform at least one task at the Nurse Aide II level; or
3. Require extensive assistance in three or more ADLs **and** have a medical or cognitive impairment that requires extended time to perform needed in-home aide tasks.

The recipient's assessment must include documentation that supports the PCS-Plus criteria. PCS agencies may use the Optional Nursing Assessment Worksheet for PCS-Plus (DMA-3000-B) to document the recipient's qualification for PCS-Plus. A copy of the DMA-3000-B is available on page 19 or on DMA's website at http://www.dhhs.state.nc.us/dma/forms.htm.

If the hours listed under item 32 on the Plan of Care (DMA-3000) should change due to a request for PCS-Plus, the PCS agency's registered nurse (RN) must note the change in the recipient's clinical record. No additional physician authorization or revisions to the DMA-3000 are required. However, requests for additional hours under PCS-Plus must be reviewed and approved by DMA.

How to Initiate PCS-Plus Services

PCS agencies must obtain prior approval (PA) from DMA before initiating PCS-Plus services. PCS agencies may request PA for up to a 180-day period. To obtain PA for PCS-Plus, the agency must take the following steps:

1. When a referral is made to the PCS agency for PCS-Plus or when the PCS agency identifies a recipient in need of PCS-Plus, the PCS agency's RN evaluates the recipient's medical and functional need for PCS-Plus and documents the findings on the PCS-Plus Request form (DMA-3000-A). A copy of the PCS-Plus Request Form is available on page 20 or on DMA's website at http://www.dhhs.state.nc.us/dma/forms.htm.
2. If the recipient is not currently receiving PCS, the PCS agency's RN must follow DMA's procedure for completing the DMA-3000 and obtaining the physician's authorization for PCS. Once the physician's authorization has been obtained, the PCS agency's RN can proceed with the request for PCS-Plus.
3. Completed PCS-Plus Request forms (DMA-3000-A) must be faxed to the DMA PCS-Plus Nurse Consultant at 919-715-2628.

4. The DMA Nurse Consultant reviews the PCS-Plus Request form (DMA-3000-A) to determine if the recipient qualifies for PCS-Plus. DMA will contact the PCS agency by phone if additional information is needed to make a determination.

5. If the DMA Nurse Consultant determines that the recipient does not meet the criteria for PCS-Plus, the PCS agency will be notified of the denial by e-mail or fax within three workdays. The PCS agency must notify the recipient of the denial. The PCS agency may request a reconsideration review if additional information to support the recipient's need for PCS-Plus can be provided to DMA.

6. If the DMA Nurse Consultant determines that the recipient does meet the criteria for PCS-Plus, the PCS agency will be notified of the approval by e-mail or fax within three workdays. The approval specifies the number of approved PCS hours per month and the effective dates of PCS-Plus coverage (PCS-Plus authorization period). The agency must notify the recipient of the approval.

7. At least one week before the PCS-Plus authorization expires, the agency must re-evaluate a recipient for PCS-Plus eligibility and submit a new PCS-Plus Request form (DMA-3000-A) to DMA for approval. PCS-Plus cannot be authorized for more than 180 days for each request.

PCS-Plus Billing Instructions

PCS agencies bill for approved PCS-Plus services using the same procedure that is used to bill for regular PCS (Refer to Section 14 of the *N.C. Medicaid Community Care Manual*). Claims must be submitted to EDS on a UB-92 claim form using revenue code RC599. Claims submitted for PCS-Plus services that have not been prior approved will deny.

Provider Seminars on PCS-Plus

Seminars for the new PCS-Plus program are scheduled for December 2003 and will focus on coverage criteria, initiating service, and billing instructions. Refer to page 24 for the seminar schedule and registration information.

Rosalie Wachsmuth, Community Care Services
DMA, 919-857-4021

North Carolina Division of Medical Assistance
Optional Nursing Assessment Worksheet for PCS-Plus

Medicaid Recipient Name:	**Date of Assessment:**
Assessment Completed by:	**Agency Name:**

The DMA-3000 provides a general evaluation of the client's medical and functional health (ADL/IADL) needs. This Optional Nursing Assessment Worksheet documents medical/nursing needs that may qualify the client for PCS-Plus services. Please note observations that document the client's condition specific to the criteria. A provider agency may choose to use its own forms in lieu of the Optional Nursing Assessment Worksheet to document the client's qualification for PCS-Plus. Forms used in lieu of the Optional Nursing Assessment Worksheet must clearly document assessment observations that specify individual client needs in identified PCS-Plus criteria.

Category	Description (Observation: specify)	Diagnosis (medical & nursing indicators)
Cognitive/Perceptual Orientation, memory, judgment, sensory deficits, developmental, emotional status, behavioral, seizures, pain, vision, hearing		
Nutrition/Metabolic Diet, type and method (oral, enteral, parenteral), appetite, eating problems, swallowing, weight changes, skin integrity **NA II Task:_____**		**NA II Task:_____**
Elimination (Bowel/bladder) Digestive problems, constipation, use of laxatives/enemas, continence (frequency) and continence management, catheter (type and frequency), ostomy (type/care) **NA II Task:_____**		**NA II Task:_____**
Activity/Exercise Activity, ambulary status/assistance, assistive devices, bed mobility, paralysis, weakness, history of falls, pain, musculoskeletal		
Respiratory COPD, respiratory status, use of O_2 (type/method/frequency), dyspnea, SOB, history of asthma, TB,		**NA II Task:_____**
Cardiovascular Heart disease, pacemaker, blood pressure, pain		
Medications/Medical Treatment/ Monitoring		

FORM DMA 3000-B 11/01/03

North Carolina Division of Medical Assistance (DMA)
PERSONAL CARE SERVICES-PLUS (PCS-PLUS) REQUEST FORM

1. ☐ **PCS-Plus Initial Request** ☐ **PCS-Plus Reauthorization Request**

Date of Request: _____ Request Submitted by: _____
Total Number of PCS Hours/Month Requested: _____ **hours/month**
Duration of PCS-Plus Request*: _____ **days** From: _____ To: _____
**PCS-Plus authorizations cannot exceed 180 days. To request an extension, submit a new PCS-Plus Request Form at least one week before the PCS-Plus authorization expires.*

DMA Prior Approval
Authorization for _____hours/month*
**Cannot exceed a total of 80 hours/month.*
Effective from: _____ to: _____
Date Request Reviewed: _____
RN Signature: _____

2. **Provider Agency Information**

Agency Name: _____ Provider Number: _____ Phone: _____ Fax: _____
Address: _____ Email: _____

3. **Medicaid Recipient Information**

Last Name: _____ First Name: _____ Middle Name: _____
Address: _____
Phone Number: _____ Medicaid ID # (MID): _____ Date of Birth: _____
Currently on PCS? ☐ Yes ☐ No**If no, agency RN must follow DMA procedures for PCS assessment and obtaining MD approval.*
Physician Name: _____ Phone Number: _____ Date Contacted: _____

4. **Specify Primary and Secondary Diagnosis (if applicable):** _____

If a medical or cognitive condition is being used to qualify for PCS-Plus, the assessment must document at least one of the following (check all that apply):

- ☐ Presence of continuous and/or substantial pain interfering with individual's activity or movement
- ☐ Dyspneic or noticeably short of breath with minimal exertion during ADL performance and requires continuous use of oxygen
- ☐ Due to cognitive functioning, individual requires extensive assistance in routine situations. Individual is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- ☐ Bowel incontinence more often than once daily ☐ Urinary incontinence during the day and night

5. **List Current Medications**

6. **Limitations in Activities of Daily Living (ADLs)**

Rate the individual's ADL Self-Performance and ADL Support Provided using the scores below

A. ADL Self-Performance Scores

0. INDEPENDENT: No help or oversight needed
1. SUPERVISION: Oversight, encouragement or cueing needed
2. LIMITED ASSISTANCE: Individual highly involved in activity; receives help in guided maneuvering of limbs or other non-weight bearing assistance
3. EXTENSIVE ASSISTANCE: While individual performs part of activity, help of the following type(s) are needed: *weight-bearing support OR full performance of activity by another.*
4. FULL DEPENDENCE: Full performance of activity by another.

B. ADL Support Provided Scores

0. No setup or physical help from staff 1. Setup help only 2. One person physical assist 3. Two+persons physical assist

			ADL Self-Performance	ADL Support Provided
a	**Bed Mobility**	Moving to and from lying position, turning side-to-side and position body while in bed.		
b	**Transfer**	Moving to and between surfaces: bed, chair, wheelchair, standing position. (Exclude to/from bath/toilet)		
c	**Ambulation**	Note assistive equipment (walker, cane, wheelchair); self-sufficiency once in chair. **Assistive Equip:** _____		
d	**Eating**	Taking in food by any method, including tube feedings. **Therapeutic Diet:** _____		
e	**Toilet Use**	Using the toilet (commode, bedpan, urinal); transferring on/off toilet, cleaning self after toilet use, changing pads/diapers, managing any special devise required (ostomy or catheter), and adjusting clothes.		
f	**Bathing**	Taking full-body bath/shower, sponge bath, transferring in/out of tub/shower. (Exclude washing back/hair)		
g	**Dressing**	Laying out clothes, retrieving clothes from closet, putting clothes on and taking clothes off.		
h	**Personal Hygiene**	Combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands, and perineum. (Exclude baths and showers)		
i	**Self-Monitoring**	Self-monitoring of pre-poured medications, glucometers, etc.		

7. **Nurse Aide II Tasks (specify below)**

8. **Nurse Assessor Certification**

I certify that the above information reflects this Medicaid recipient's condition and that I contacted the attending physician on (specify date) _____ to obtain authorization for PCS.
Print Name: _____ Signature: _____ Date: _____

Form DMA 3000-A 11/01/03

Attention: Pharmacists and Prescribers

Levitra

Effective with date of service August 19, 2003, Levitra was added to the list of drugs for impotency covered by N.C. Medicaid. There is a limit of two units per month. The physician must document in his/her own handwriting "erectile dysfunction" on the face of the prescription. Impotence drugs for males 25 years of age and older do not require prior approval. For males under 25 years of age, the physician (or designee) must obtain prior approval from the Division of Medical Assistance. Documentation for medical necessity must be sent to the following address:

N.C. Division of Medical Assistance
Attention: Pharmacy Section
2501 Mail Service Center
Raleigh, NC 27699-2501
Fax: 919-733-2796

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

Attention: Area Mental Health Centers and Residential Child Care Treatment Providers for Levels II through IV

Area Mental Health and Residential Child Care Treatment Seminar Schedule

Area Mental Health and Residential Child Care Treatment seminars are scheduled for December 2003. Seminars are intended for providers of mental health services to enrollees at area mental health centers or residential child care treatment facilities. The seminars will consist of two service-specific sessions and will focus on the claim filing process, obtaining authorization, and Y code conversions to standard national codes as mandated by the Health Insurance Portability and Accountability Act (HIPAA).

The Area Mental Health and Residential Child Care Treatment seminars are scheduled at the locations listed on page 22. Due to limited seating, **preregistration is required** and limited to two staff members per office. Unregistered providers are welcome to attend if space is available. Providers may register for the Area Mental Health and Residential Child Care Treatment seminars by completing and submitting the registration form on page 23 or by registering online at http://www.dhhs.state.nc.us/dma/provsem.htm. Please indicate on the registration form the session(s) you plan to attend.

The morning session on Area Mental Health begins at 9:30 a.m. and ends at 12:00 noon. Providers are encouraged to arrive by 9:15 a.m. to complete registration. The afternoon session on Residential Child Care Treatment begins at 1:00 p.m. and ends at 3:30 p.m. Providers are encouraged to arrive by 12:45 p.m. to complete registration. Lunch will not be provided.

Providers must access and print the PDF version of the November 2003 Special Bulletin IV, *HIPAA Code Conversions* from DMA's website at http://www.dhhs.state.nc.us/dma/bulletin.htm and bring it to the seminar.

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

Schedule for the Area Mental Health and Residential Child Care Treatment Seminars

Wednesday, December 3, 2003
Greenville Hilton
207 Greenville Boulevard SW
Greenville, NC

Friday, December 5, 2003
Jane S. McKimmon Center
1101 Gorman Street
Raleigh, NC

Wednesday, December 10, 2003
Park Inn Gateway Conference Center
909 US Highway 70 SW
Hickory, NC

Thursday, December 11, 2003
Bo Thomas Auditorium
Blue Ridge Community College
College Drive
Flat Rock, NC

Directions to the Area Mental Health and Residential Child Care Treatment Seminars

Blue Ridge Community College, Bo Thomas Auditorium – Flat Rock, North Carolina
Take I-40 to Asheville. Travel east on I-26 to exit 22. Turn right and then take the next right. Follow the signs to Blue Ridge Community College. Turn left at the large Blue Ridge Community College sign. The college is located on the right. Take the first right-hand turn into the parking lot for the Bo Thomas Auditorium.

Greenville Hilton – Greenville, North Carolina
Take US 64 east to US 264 east. Follow 264 east to Greenville. Once you enter Greenville, turn right onto Allen Road. After traveling approximately 2 miles, Allen Road becomes Greenville Boulevard/Alternate 264. Follow Greenville Boulevard for approximately 2½ miles. The Hilton Greenville is located on the right.

Jane S. McKimmon Center – Raleigh, North Carolina
Traveling East on I-40
Take exit 295 and turn left onto Gorman Street. Travel approximately one mile. The McKimmon Center is located on the right on the corner of Gorman Street and Western Boulevard.

Traveling West on I-40
Take exit 295 and turn right onto Gorman Street. Travel approximately one mile. The McKimmon Center is located on the right between Avent Ferry Road and Western Boulevard.

Park Inn Gateway Conference Center – Hickory, North Carolina
Take I-40 to exit 123. Follow signs to US 321 North. Take the first exit (Hickory exit) and follow the ramp to the stoplight. Turn right at the light onto US 70. The Gateway Conference Center is on the right.

Registration Form for the Area Mental Health and Residential Child Care Treatment Seminars

(cut and return registration form only)

Area Mental Health and Residential Child Care Treatment Seminars
(No Fee)

Provider Name _____ Provider Number _____

Address _____

City, Zip Code _____ County _____

Contact Person _____ E-mail Address _____

Telephone Number (____) _____ Fax Number (____) _____

1 or **2** (circle one) person(s) will attend the seminar at _____ on _____
(location) (date)

Check the box for the session(s) you will be attending

☐ Morning Session
(Area Mental Health)

☐ Afternoon Session
(Residential Child Care Treatment)

Return to: Provider Services
EDS
P.O. Box 300009
Raleigh, NC 27622

Attention: Personal Care Services Providers

Personal Care Services-Plus Program Seminar Schedule

On November 1, 2003, the N.C. Medicaid program implemented the new Personal Care Services-Plus (PCS-Plus) program. The program is designed to enhance the current Personal Care Services (PCS) program by providing up to 20 additional hours of PCS each month to eligible recipients. (Refer to page 17 for additional information.)

Seminars for the new PCS-Plus program are scheduled for December 2003 and will focus on coverage criteria, initiating service, and billing instructions. **Preregistration for the seminars is required.** Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend if space is available. Lunch will not be provided at the seminars.

The seminars begin at 10:00 a.m. and end at 1:00 p.m. Providers are encouraged to arrive by 9:45 a.m. to complete registration. Providers may register for the seminars by completing and submitting the registration form on page 26 or by registering online at http://www/dhhs/state.nc.us/dma/provsem.htm. Please indicate on the registration form the session you plan to attend.

Providers must print the PDF version of the December 2003 Special Bulletin V, *Personal Care Services-Plus Program* from DMA's website at http://www.dhhs.state.nc.us/dma/bulletin.htm and bring it to the seminar. The Special Bulletin will be available online on December 1, 2003.

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

Schedule for the Personal Care Services-Plus Seminars

Tuesday, December 2, 2003
Auditorium
Martin Community College
1161 Kehukee Park Road
Williamston, NC

Thursday, December 4, 2003
Coast Line Convention Center
501 Nutt Street
Wilmington, NC

Tuesday, December 9, 2003
Andrews Conference Center
WakeMed
3000 New Bern Ave.
Raleigh, NC

Tuesday, December 16, 2003
Rotary Auditorium
Mitchell Community College
Statesville, NC

Directions to the Personal Care Services-Plus Program Seminars

Coast Line Convention Center – Wilmington
Take I-40 east to Wilmington. Take the Highway 17 exit. Turn left onto Market Street. Travel approximately 4 or 5 miles to Water Street. Turn right onto Water Street. The Coast Line Inn is located one block from the Hilton on Nutt Street behind the Railroad Museum.

Martin Community College – Williamston
Traveling East on US 64
Take US 64 east to exit 512 and turn right onto Prison Camp Road. Turn left onto Kehukee Park Road. Martin Community College is located on the right. The Auditorium is located in Building 2.

Traveling West on US 64
Take US 64 west into Williamston. Look for the McDonalds at the intersection of US 64 and NC 13/US 17 Bypass. Turn left onto NC 13/US 17 Bypass at this intersection. After passing the Comfort Inn on the right, US 64 becomes the Old Highway 64 Bypass. Travel approximately 2 to 3 miles. Turn left onto Kehukee Park Road. Martin Community College is located on the right. The Auditorium is located in Building 2.

Mitchell Community College Rotary Auditorium – Statesville
Traveling West on I-40
Take I-40 west to exit 115. Turn south onto Highway 115 (Center Street). Follow the green directional signs on Center Street for Mitchell Community College through downtown Statesville. Turn right at the second stop light in town onto W. Broad Street (at the square). Mitchell Community College is located at the end of W. Broad Street. The Rotary Auditorium is located in the Library Building.

Traveling South on I-77
Take I-77 to the Broad Street exit, near Signal Hill Mall. Turn right onto E. Broad Street. Follow the green directional signs on E. Broad Street for Mitchell Community College through downtown Statesville. E. Broad Street becomes W. Broad Street at the square. Mitchell Community College is located at the end of W. Broad Street. The Rotary Auditorium is located in the Library Building.

WakeMed Andrews Conference Center – Raleigh
Driving and Parking Directions
Take the I-440 Raleigh Beltline to exit 13A, New Bern Avenue.

Paid parking ($3.00 maximum per day) is available on the **top two levels** of parking deck P3. To reach the parking deck, turn left at the fourth stoplight on New Bern Avenue, and then turn left at the first stop sign. Parking for oversized vehicles is available in the overflow lot for parking deck P3. Handicapped accessible parking is available in parking lot P4, directly in front of the conference center.

To enter the Andrews Conference Center, follow the sidewalk toward New Bern Avenue past the Medical Office Building to entrance E2 of the William F. Andrews Center for Medical Education. A map of the WakeMed campus is available online at http://www.wakemed.org/maps/.

Illegally parked vehicles will be towed. Parking is **not** permitted at East Square Medical Plaza, Wake County Human Services or in parking lot P4 (except for handicapped accessible parking).

Registration Form for the Personal Care Services-Plus Program

(cut and return registration form only)

Personal Care Services-Plus Program
Seminar Registration
(No Fee)

Provider Name _____ Provider Number _____

Address _____

City, Zip Code _____ County _____

Contact Person _____ E-mail Address _____

Telephone Number (____) _____ Fax Number (____) _____

1 or **2** (circle one) person(s) will attend the seminar at _____ on _____
(location) (date)

Return to: Provider Services
EDS
P.O. Box 300009
Raleigh, NC 27622

Holiday Closing

The Division of Medical Assistance (DMA) and EDS will be closed on Tuesday, November 11, 2003 in observance of Veteran's Day and on Thursday, November 27, 2003 and Friday, November 28, 2003 in observance of Thanksgiving.

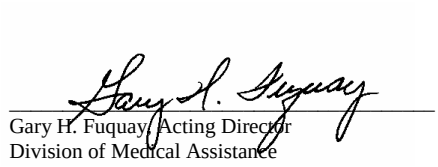
Checkwrite Schedule

November 4, 2003	December 9, 2003	January 13, 2004
November 12, 2003	December 16, 2003	January 22, 2004
November 18, 2003	December 29, 2003	January 27, 2004
November 26, 2003		

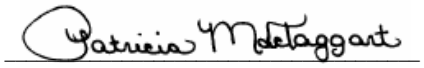
Electronic Cut-Off Schedule

October 31, 2003	December 5, 2003	January 9, 2004
November 7, 2003	December 12, 2003	January 16, 2004
November 14, 2003	December 19, 2003	January 23, 2004
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

e

Presorted Standard
U.S. POSTAGE
PAID
Raleigh, N.C.
Permit No. 1087

P.O. Box 300001
Raleigh, North Carolina 27622