North Carolina Medicaid Bulletin

An Information Service of the Division of Medical Assistance

Published by EDS, fiscal agent for the North Carolina Medicaid Program

Number 11 *November 1998*

Attention: All Providers

Holiday Observance

The Division of Medical Assistance (DMA) and EDS will be closed on the following dates for the observance of holidays:

Wednesday, November 11, 1998	Veterans Day
Thursday, November 26, 1998	Thanksgiving
Friday, November 27, 1998	Thanksgiving
Thursday, December 24, 1998	Christmas
Friday, December 25, 1998	Christmas
Friday, January 1, 1999	New Years Day

Attention: All Providers

Year 2000 Update

North Carolina's Medicaid Management Information System (MMIS) is internally Year 2000 compliant. Providers should be aware that certain claim data elements will be expanded to accommodate century information. Providers should communicate with their programmers and/or software vendors regarding required changes. For specific claim types and formatting changes, please refer to the March 1998 special bulletin entitled Year 2000 Changes.

Providers will be notified in the North Carolina Medicaid Bulletin of specific dates on which claims can be submitted in Year 2000 specification. A transition period during which Year 2000 and "old" format are both acceptable is planned.

Year 2000 compliant claims will be accepted starting with the end of the first quarter calendar year 1999; a specific effective date will be reported in a subsequent bulletin along with specific claims format changes.

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

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

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Attention: All Providers

Modifiers

The Division of Medical Assistance (DMA) and our Fiscal Agent, EDS, are in the process of implementing Modifiers for physician and practitioner claims submitted on the HCFA-1500 claim form. The implementation date is scheduled for claims processed on and after June 25, 1999. Processing the claims utilizing modifiers will enable Medicaid to adopt many of Medicare's policies, allow providers to bill uniformly between carriers, and eliminate many unnecessary claims processing delays. Providers should alert their vendors that changes will be forthcoming.

The Medicaid providers that will be required to bill modifiers are:

- Ambulatory Surgical Centers
- Birthing Centers
- Certified Registered Nurse Anesthetist
- Chiropractors
- Independent Labs
- Independent Nurse Midwifes
- Independent Nurse Practitioners
- Optometrists
- Physician Services in Federally Qualified Health Centers
- Physician Services in Rural Health Clinics
- Physician Specialties (All)
- Planned Parenthood (non M.D.)
- Podiatrists
- Portable X-Rays

Modifiers are two-digit codes that are appended to a five digit CPT (Physicians Current Procedural Terminology), HCPCs code (Health Care Common Procedure Coding System) or State Created Code. The two-digit modifier may be either numeric, alpha, or alphanumeric and are intended to convey specific information regarding the procedure or service to which it is appended. Modifiers will be implemented in order to aid in the pricing of a procedure, to allow more detailed/accurate information to allow enhanced processing, or simply to convey information.

The modifiers to be implemented were selected from the three levels of HCPCS.

- Level I modifiers are two digit, numeric, CPT modifiers, (EX. -22)
- Level II modifiers are two digit alpha, or alpha numeric, HCPCS modifiers, (ex. -SG, -T4)
- Level III modifiers are two digit, alpha or alphanumeric local modifiers assigned by individual carriers.

Future bulletins will address policy issues, educational information, and the specific modifiers implemented. DMA and EDS are planning informative and educational workshops for all providers prior to the implementation date.

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

Attention: All Providers

Tax Identification Information

Alert - Tax update requested

North Carolina Medicaid must have proper tax information for all providers. This will ensure correct issuance of 1099 MISC forms each year and also ensure the correct tax information is provided to the IRS. If inappropriate information is given or is on file, this can result in IRS mandatory 31% withholding of payments made by Medicaid. Be sure the individual responsible for maintenance of tax information in your organization receives the following information.

How to verify tax information

The last page of your Medicaid Remittance and Status (RA) report indicates the provider tax name and number (FEIN) Medicaid has on file. Refer to the Medicaid RA throughout the year for each provider number to ensure we have the proper information. The tax information needed for a group practice is as follows: (1) Group tax name and group tax number; (2) Attending Medicaid provider numbers in group. If you do not have a Medicaid RA, call Provider Services 919-851-8888 or 1-800-688-6696 to verify the tax information on file for each provider number.

Providers should complete a special W-9 (see next page) for all provider numbers with **incorrect** information on file. Instructions for completing the special W-9 are listed below.

- Fill in the North Carolina Medicaid Provider Name Block (**this must be completed**)
- Fill in the North Carolina Medicaid Provider Number (**this must be completed**)
- Part I Correction field - Indicate your tax identification number exactly as the IRS has on file for you and/or your business. Do not put your Social Security Number unless you are an individual or sole proprietor
- Part II Correction field - Indicate your tax name exactly as the IRS has on file for you and/or business
- Part III - Indicate the appropriate type of organization for your tax identification number. Please note, if you are using your Social Security Number as your tax identification number, you must select individual/sole proprietor as type of organization
- Part IV - An authorized person **MUST** sign and date this form, otherwise it will be returned as incomplete and your tax data ***will not*** be updated

Send completed and signed forms by 12/11/98 to:

EDS 4905 Waters Edge Drive Raleigh NC 27606	**OR**	FAX to (919) 851-4014
Attention: Provider Enrollment		Attention: Provider Enrollment

Change of ownership

Contact DMA Provider Enrollment at 919-857-4017 to report all changes in business ownership. If necessary, a new Medicaid provider number will be assigned and Provider Enrollment will ensure the correct tax information is on file for Medicaid payments. If you ***do not contact*** DMA and ***continue to use a provider number*** with incorrect tax data, you could ***become liable for taxes*** on income not received by your business. DMA will assume no responsibility for penalties assessed by the IRS or for misrouted payments prior to written receipt of notification of ownership changes.

Group practice changes

When a physician leaves or a physician is added to a group practice, contact DMA Provider Enrollment to update Medicaid enrollment and tax information. Remember, without notifying DMA Provider Enrollment, the wrong tax information could remain on file and your business could become liable for taxes on Medicaid payments you did not receive.

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

Special W-9

Complete all four parts below and return to EDS. Incomplete forms will be returned to you for proper completion.

Provider Name: [ ] Provider Number: [ ]

Part I. Provider Taxpayer Identification Number:

Your tax identification number should be reflected below exactly as the IRS has on file for you and/or your business. Please verify the number on file (per the last page of your most recent RA) and update as necessary in the correction fields listed below:

Correction Field (please write clearly in black ink):

[ ]
Employer Identification Number/Taxpayer Identification Number

[ ]
Social Security Number **If you do not have an employer ID then indicate social security number if you are an individual or sole proprietor only

Part II. Provider Tax Name:

Your tax name should be reflected below exactly as the IRS has on file for you and/or your business. Individuals and sole proprietors must use their proper personal names as their tax name. Please verify the name on file (per the last page of your most recent RA) and update as necessary in the correction fields listed below:

Correction Field: [ ]

Part III. Type of Organization - Indicate below:

____ Corporation/Professional Association _______ Individual/Sole Proprietor _______ Partnership

____ Other: _________________________ _______ Government: ___________________________________

Part IV. Certification

Certification - Under the penalties of perjury, I certify that the information provided on this form is true, correct, and complete.

____

Signature Title Date

EDS Office Use Only

Date Received: ________________ Name Control: _____________________ Date Entered: _________________

Attention: Hospices and Hospitals

Billing Reminder for Hospice Patients

This article is a billing reminder for hospices and hospitals. The Quality Assurance Section has found that these providers are billing in error.

When a hospice patient's hospitalization is for palliative care for the terminal illness, the hospice should bill the general inpatient rate (RC 656) since hospice care, not hospital care, is being provided. The hospice reimburses the hospital according to the terms of their contract.

When a hospice patient's hospitalization is for a condition not related to the terminal illness, the hospice may bill Medicaid the routine home care rate (RC 651) during the admission to cover ongoing hospice care. Hospital care that is unrelated to the terminal illness is not waived during the hospice benefit. The hospital bills Medicaid according to Medicaid policies and procedures for hospital coverage.

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

Attention: All Providers

Additional Medicaid Fair Handbooks Still Available

Providers unable to attend the Medicaid Fair this past May still have an opportunity to purchase the handbook that was distributed. This year EDS published one large spiral-bound book that incorporated all the handouts and notes covered by the workshops. It still is an excellent resource with 408 pages of policies, procedures, and helpful billing information.

To obtain copies of the Medicaid Fair Handbook, send $20 per copy made payable to EDS. Please complete the form below and mail to the following address:

EDS
Sandi Campbell
Provider Relations
P.O. Box 300009
Raleigh, NC 27622

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

(Cut and return form below)

Name ____

Address ____

City/State ____ **Zip Code** ________________________

Please send ________ books.

Cost per book is **$20.00**

Total amount of check included: ______________

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Attention: Home Health Services Providers

Revisions to the Home Health Services MEDICARE-Medicaid Billing Chart

Effective with date of service November 1, 1998, three of the limitations on home health skilled nursing visits are amended. These limitations became effective in February 1998 as part of the revised MEDICARE-Medicaid Billing Chart. (See Medicaid Special Bulletin, Number VI, dated December 15, 1997.)

Items A.4, C.10, and C.12 have been revised to conform with language typically used in physician orders and state regulatory requirements. Language deleted has been lined through and the amendment underlined.

A.4. For observation and evaluation after a period with no significant changes in intervention. The patient's illness has reached a plateau. There is a chronic condition that is considered "stable" - no recent exacerbations, no recent changes in the medication or treatment regimen - yet there continues to be a documented medical necessity for intermittent skilled nursing visits. ~~Scheduled visits are limited to no more than one visit every 30 days.~~ Scheduled visits are limited to no more than one visit per calendar month. One PRN visit that is properly quantified and qualified on the physician's orders may be billed between scheduled visits.

Note: ~~When a need for intervention is identified, the patient becomes a Medicare patient.~~ When a need for intervention is identified, Medicare becomes the primary payor.

Example: Mr. Jones' condition has reached a plateau and the physician has ordered monthly skilled nursing visits for observation and evaluation. The first visit was on September 13. The second visit was on October 7. Another visit may not be scheduled until the month of November.

C.10. For prefilling medication dispensers ("mediplanners") and monitoring medication compliance after a period of time when the patient or caregiver has not been able to comprehend teaching and there is not a willing and able caregiver to do so. ~~Visits are limited to no more than one visit every seven days.~~ Visits are limited to no more than one visit per calendar week.

Example: Mrs. Lee lives in a neighboring county and has her "mediplanner" prefilled on Thursdays. While the home health nurse was visiting a new patient in Mrs. Lee's neighborhood the following Wednesday, she stopped by Mrs. Lee's to fill the "mediplanner". She may not make another visit for this purpose until the following week.

C.12. For prefilling insulin syringes if the patient does not have a qualifying Medicare home health service and there is not a willing and able caregiver to do so. ~~Visits limited to no more than one visit every seven days.~~ Visits are limited to no more than one visit per calendar week.

Example: Mr. Brown is insulin-dependent and has his syringes filled every week. Last week, the syringes were filled on Tuesday. The following Monday morning Mr. Brown called the office and complained of signs and symptoms of hypoglycemia. The nurse visited Mr. Brown to assess his condition and while there filled his syringes. The nurse may not make another visit to fill the syringes until the next week.

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

Attention: Hospice Providers

Contracting with Physicians Reminder

The Balanced Budget Act (BBA) of 1997 includes a provision which amends the core hospice service requirement to allow hospices to contract for physician services. Effective August 5,1997, medical directors and physician members of the interdisciplinary group are no longer required to be employed by the hospice agency. Physicians may now be under contract with the hospice agency. Hospices are responsible for professional management of these services and must ensure that they are furnished in a safe and effective manner by qualified persons.

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

Attention: Hospices and Pharmacies

Billing Reminder for Hospice Patients

The Medicaid hospice benefit includes all medications related to the terminal illness. The Quality Assurance Section has found that pharmacies are billing for medications that are related to a patient's terminal illness and therefore, are included in the hospice benefit. Remember, any medications that are used primarily for pain relief and symptom control related to the terminal illness are included in the hospice benefit.

Hospice agencies should continue to place two hospice stickers on the patient's Medicaid card each month the patient receives hospice services. See 8.5 (step 6) of the Community Care Manual for an illustration. In addition, hospices need to remind patients and caregivers about what is included in the hospice benefit. The pharmacist should view the Medicaid card each month for possible hospice coverage. If the patient's medication(s) appear to be for pain relief or otherwise related to a terminal condition, ask the patient or caregiver about potential hospice coverage.

Example: A hospice patient with terminal cancer may require morphine for pain relief. Because the medication is related to the terminal illness, it is the responsibility of the hospice agency. The pharmacy may not bill Medicaid for the medication. The pharmacy and hospice agency may wish to enter into a contract for the pharmacy to provide the medication and bill the hospice.

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

Attention: Durable Medical Equipment (DME) Providers

Annual Revision of the Durable Medical Equipment Manual

This year, instead of receiving the annual revision of the Durable Medical Equipment Manual in November, DME providers can expect to receive a complete, reprinted manual in January. The reprint will incorporate the changes that have occurred since November 1997. EDS and DMA are issuing the reprint to help providers assure that they have current material.

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

Attention: Hospital Providers

Lower Level of Care and Swing Bed Rates

Effective with date of service October 1, 1998, the hospital lower level of care and swing bed rates per patient day are:

Level of Care	Rate
Skilled Nursing Care	$111.94
Intermediate Care	$84.92
Ventilator Dependent Care	$343.91

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

Attention: All Providers

Carolina ACCESS Emergency Room Policy Revision

Effective with date of service December 1, 1998, Carolina ACCESS is revising the hours during which the PCP may authorize treatment of non-emergent conditions in the emergency room. The PCP may authorize non-emergent care rendered in the emergency room only between the hours of 5:00 p.m. and 8:00 a.m., Monday through Friday, and 24 hours a day on Saturday and Sunday. DMA will no longer issue authorization (override) numbers for treatment of non-emergent conditions rendered in the emergency room during office hours, which are defined as 8:00 am to 5:00 p.m., Monday through Friday.

If the PCP does not have an appointment available to see a patient for a non-emergent condition upon request, a referral to a lesser level of care than the emergency room (i.e. another physician's office or urgent care center that accepts Medicaid) would be an acceptable option. The requirements for appointment availability for participating PCPs are described in the July 1996 Medicaid Bulletin.

Treatment of a "true emergency" as defined by ICD-9 codes is covered 24 hours a day, 7 days a week without authorization by the PCP. Medical screening exams (CPT code W9922) are also covered 24 hours a day, 7 days a week without authorization by the PCP.

If a hospital receives a claim denial for treatment of a patient with a non-emergent condition and there is sufficient documentation in the medical record to support the medical necessity of treatment in the emergency room, the claim and the medical record documentation may be submitted for reconsideration.

Reconsiderations may be mailed to:

Attention: Reconsideration
Managed Care Unit
Division of Medical Assistance
P.O. Box 29529
Raleigh, N.C. 27626-0529

The revised emergency room policy and "true emergency" diagnosis code list have been mailed to all primary care providers and hospitals. Additional copies of the policy may be obtained by contacting the Managed Care Unit at 1-800-228-8142 or 919-857-4022.

Please share this information with emergency room staff(doctors, nurses and receptionists), patient accounts/billing staff and others that need to become familiar with emergency room policy changes.

Managed Care Unit
1-800-228-8142 or 919-857-4022

Attention: All Providers

Billing for Multiple Endoscopies

Medicaid is aligning endoscopy policy with Medicare policy. Effective with date of service January 1, 1999, reimbursement for multiple endoscopies will be based on the following formula:

> **Medicaid will pay the full fee schedule price of the higher-valued endoscopy plus the difference between the next highest endoscopy and the base endoscopy.**

Example:

In the course of performing a laryngoscopy, diagnostic (31505), the physician performs a biopsy, (31510) and removes a lesion (31512). The value of 31510 plus 31512 both have the value of the diagnostic laryngoscopy built in.

Medicaid will pay the full fee schedule price of the higher valued endoscopy (31512) plus the difference between the next highest valued endoscopy (31510) and the base endoscopy (31505).

	Full fee schedule price of highest valued endoscopy (31512)	=	$119.31
+	Fee for next highest valued endoscopy (31510)	=	$76.55
-	Fee for base endoscopy (31505)	=	$32.18
=	Total Reimbursement for multiple endoscopies		$163.68

Base endoscopy codes and their related procedures

Base Code	Related Procedure
29815	29819-29823
29825-29826	
29830	29834-29838
29840	29843-29847
29860	29861-29863
29870	29871
29874-29877	
29879-29887	
31505	31510-31513
31525	31527-31530
31535	
31540	
31560	
31570	
31526	31531
31536	
31541	
31561	
31571	

Base Code	Related Procedure
31622	31625
31625-31631	
31635	
31640-31641	
31645	
43200	43202
43204-43205	
43215-43217	
43219-43220	
43226-43228	
43235	43239
43241	
43243-43247	
43249-43251	
43255	
43258-43259	
43260	43261-43265
43267-43269	
43271-43272	
44360	44361
44363-44366	
44369	
44372-44373	

Base Code	Related Procedure
44376	44377-44378
44388	44389-44394
45300	45303
45305	
45307	
45308	
45309	
45315	
45317	
45320-45321	
45330	45331-45334
45337-45339	
45378	45379-45380
45382-45385	
46600	46604
46606	
46608	
46610-46612	
46614-46615	
47552	47553-47556
50551	50555
50557	
50559	
50561	
50570	50572
50574-50576	
50578	
50580	
50951	50953
50955	
50957	
50959	
50961	

Base Code	Related Procedure
50970	50974
50976	
52000	52250
52260	
52265	
52270	
52275-52277	
52281	
52283	
52285	
52290	
52300	
52305	
52310	
52315	
52317-52318	
52282	
52005	52320
52325	
52327	
52330	
52332	
52334	
52335	52336-52339
56300	56301-56309
56311	
56343-56344	
56314	
56350	56351-56356
57452	57454
57460	

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

Attention: Adult Care Home Providers

Increase in Capitated Fee for Transportation

Effective with date of service October 1, 1998, the capitated fee for medically necessary non-emergency non-ambulance transportation for residents in Adult Care facilities has increased to $.53 cents per Medicaid resident per day. No adjustments will be made to previously filed claims.

Jackie Burnette, Financial Operations
DMA, 919-857-4015

Checkwrite Schedule

November 3, 1998	December 8, 1998	January 5, 1999
November 10, 1998	December 15, 1998	January 12, 1999
November 17, 1998	December 23, 1998	January 21, 1999
November 25, 1998		

Electronic Cut-Off Schedule *

October 30, 1998	December 4, 1998	December 31, 1998
November 6, 1998	December 11, 1998	January 8, 1999
November 13, 1998	December 18, 1998	January 15, 1999
November 20, 1998		

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

____
Paul R. Perruzzi, Director
Division of Medical Assistance
Department of Health and Human Services

____
James R. Clayton
Executive Director
EDS

EDS

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Raleigh, North Carolina 27622

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