



December 2007 Medicaid Bulletin

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Providers are responsible for informing their billing agency of information in this bulletin CPT codes, descriptors, and other data only are copyright 2006 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.

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National Provider Identifier

Attention: All Providers

Importance of One to One Enumeration (Reprint from September 2007 Bulletin)

N.C. Medicaid strongly recommends that providers obtain an NPI for each Medicaid Provider Number in use today. Providers should mirror their Medicaid enrollment when enumerating. The only exception is for sole proprietors, who are only able to obtain one individual (Type I) NPI. When NPI is implemented, claims will continue to process through the current MMIS system. Therefore, N.C. Medicaid has designed a mapping solution to crosswalk the NPI to the Medicaid Provider Number used today. Ideally, each NPI will only crosswalk to one Medicaid Provider Number, otherwise known as a “one to one” match. If the NPI crosswalks to multiple Medicaid Provider Numbers, the NPI will have a “one to many” match. If a “one to many” match occurs, the mapping solution will determine the appropriate Medicaid Provider Number by taking the claim through a series of steps. Information such as Zip + 4 and taxonomy will play important roles in determining the appropriate Medicaid Provider Number. If the mapping solution cannot narrow down to one Medicaid Provider Number, impacted claims may require additional research in order to process, and payment could be delayed.

To request additional NPIs, providers should complete an application by visiting the NPPES website: <https://nppes.cms.hhs.gov>.

NPI - Get It! Share It! Use It! Getting one is free - Not having one can be costly!

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



National Provider Identifier

Attention: All Providers

National Provider Identifier Seminars

NPI seminars will be held during the month of February 2008. Seminars are intended to educate providers on NPI guidelines.

The seminar sites and dates will be announced in the January 2008 General Bulletin, <http://www.ncdhhs.gov/dma/prov.htm>. Pre-registration will be required. Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

NPI - Get It! Share It! Use It! Getting one is free - Not having one can be costly!

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

Attention: All Providers

2008 CPT Update

Effective, with Date of Service, January 1, 2008, rates for the 2008 CPT codes will be revised in accordance with the NC State Plan.

Revised fee schedule will be available on the Division of Medical Assistance (DMA) Web site at <http://www.ncdhhs.gov/dma/fee/fee.htm>. Providers must bill their usual and customary charges.

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

Attention: All Providers

North Carolina Behavioral Pharmacy Management Project

The North Carolina Division of Medical Assistance continues to be engaged in a project to provide information about the behavioral medication utilization of Medicaid recipients. The project, launched in 2005, utilizes a product called Behavioral Pharmacy Management (BPM) developed by Comprehensive NeuroScienc, Inc. (CNS). CNS is an independent company with experience in evidence-based guidelines and consensus-based standards for behavioral medication prescribing. The central purpose of the project is to insure Medicaid recipients receive the best possible care.

Each month prescribers of pharmacy claims that trigger quality improvement and safety indicators are mailed informational packets that include information based on best practice prescribing guidelines. The information serves as an alert to prescribing practices that may represent high risk to patients and/or to situations which may affect continuity and coordination of care. The intent of all information is to educate and inform.

The next level of intervention currently underway for the project is peer to peer consultation. Prescribers who do not follow best practice guidelines over extended periods of time will be targeted for consultation. Prest and Associates, an independent review organization and board certified by the American Board of Psychiatry and Neurology, will provide the telephone consultative services. Prest psychiatrists are specialists in psychopharmacology and nationally recognized prescription standards. Physicians contacted for consultation are encouraged to respond.

Pharmacy and Ancillary Services
DMA, 919-855-4300

Attention: CAP/MR-DD Service Providers, Enhanced Mental Health Services Providers, Local Management Entities and Residential Child Care Treatment Facilities

Updated Records Management and Documentation Manual

An update to the [*Records Management and Documentation Manual for Providers of Publicly-Funded MH/DD/SAS, CAP-MR/DD Services and Local Management Entities*](#) (APSM 45-2) is now available on the Providers page of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services Web site, <http://www.ncdhhs.gov/mhddsas/providers.htm>. (Scroll down to and click on Manuals to see a listing of titles.)

Please refer to the Outline of Changes Memo as well as the manual itself. This manual will become effective Jan. 1, 2008, as explained in the New Implementation Date memo.

The standards identified in this manual apply to MH/DD/SAS services provided to consumers by agencies or individuals who are 1) endorsed by a Local Management Entity (LME) as a Community Intervention Service Agency for direct Medicaid enrollment, 2) providing services through a contract with an LME, or 3) providing CAP/MR-DD services.

All MH/DD/SAS services covered by Medicaid are **also** subject to the clinical coverage policies published by the Division of Medical Assistance and posted on <http://www.ncdhhs.gov/dma/mp/mpindex.htm>.

Behavioral Health Services
DMA, 919-855-4290

Attention: Dental Providers

2008 Dental Update

Effective with date of service beginning Jan. 1, 2008, dental rates will be revised based on the 2007 National Dental Advisory Service (NDAS).

The 2008 Dental fee schedule will be available January 1, 2008 on the Division of Medical Assistance (DMA) Web site at <http://www.ncdhhs.gov/dma/fee/fee.htm>. Providers should continue to bill their usual and customary charges.

Contact: DMA – Financial Management
(919) 855-4200
Or EDS – Provider Services
800-688-6696

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

Attention: Durable Medical Equipment Providers

Oxygen Supplies and Equipment Clinical Coverage Policy

Attention: Durable Medical Equipment Providers

Effective with date of service January 1, 2008, new/revised clinical coverage policies for Oxygen and Oxygen supplies and equipment will be in effect. It should be noted that there are several significant changes in the new clinical coverage policies from the old policy.

Please reference the new clinical coverage policy for the changes.

Refer to the [Clinical Coverage Policy #5A, Durable Medical Equipment](#) on DMA's web site www.ncdhhs.gov/dma for more coverage details.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: Enhanced Mental Health and Substance Abuse Service Providers

Community Support Services – Billing (Reprint from November 2007 Bulletin)

The General Assembly enacted Session Law 2007-323, Section 10.49 (ee) that requires an additional modifier to identify units of service provided by the Qualified Professional (QP) and Non-Qualified Professional (non-QP) staff persons for Community Support services. This is effective with date of service December 1, 2007. Community Intervention Services (CIS) providers billing for community support will be required to bill a secondary modifier on the claim submission for:

- H0036 HA – Community Support Child
- H0036 HB – Community Support Adult
- H0036 HQ – Community Support Group

The identified modifiers for use are as follows:

- Modifier U3 will be used as a secondary modifier to identify a service rendered by a Qualified Professional (QP)
- Modifier U4 will be used as a secondary modifier to identify a service rendered by a non-Qualified Professional (non QP)

Each submission will require the total of the two modifiers to be processed for payment.

Primary modifiers HA, HB, or HQ must be placed in the first modifier field on the corresponding claim detail line.

Secondary modifiers U3 or U4 must be placed in the second modifier field on the corresponding claim detail line.

CMS-1500 Claim Examples:

These examples are for illustration purposes only. Actual codes billed should reflect who rendered the services.

24. A.	DATE(S) OF SERVICE			B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES			E.	F.	G.	H.	I.	J.
	From	To		PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)			DIAGNOSIS POINTER	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #
	MM	DD	YY	MM	DD	YY	CPT/HCPCS	MODIFIER						
1	12	01	07	12	01	07	11	H0036	HA	U3				
											256.40	20	1D	55555B
													NPI	NPI Number
1	12	01	07	12	01	07	11	H0036	HA	U4				
											256.40	20	1D	55555B
													NPI	NPI Number

Note: No rounding is allowed for billable services, only round down when time does not reach a complete 15 minutes per individual staff rendering the service.

**Behavioral Health Services
DMA, 919-855-4290**

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

HCPCS Code Additions for Home Health Medical Supplies

Effective with dates of service September 1, 2007, the following medical supply codes are being added to the home health fee schedule. The code additions resulted from a review of items billed using the miscellaneous supply code T1999. Providers are reminded to limit the use of code T1999 to the billing of supplies that meet the criteria for home health medical supplies but with no applicable HCPCS code on the Home Health Fee Schedule. The reason for the use of the miscellaneous supply code should be documented and available upon request. The criteria for T1999 use can be found in the Home Health Policy in section 3.6.2. The policy is posted on the DMA website, <http://www.ncdhhs.gov/dma/cc/3A.pdf>.

Updates to the Home Health Fee Schedule, with an effective date of service September 1, 2007 have been posted to the DMA website <http://www.ncdhhs.gov/dma/fee/hh.pdf>. Providers are reminded that the rates listed on the fee schedule are the maximum allowable reimbursement for the individual code. Claims submitted for payment should reflect the providers usual and customary rate.

ADDITIONS TO HOME HEALTH CARE MEDICAL SUPPLIES

HCPCS CODE	Description	Unit	Maximum Allowable
A4362	Skin barrier; solid, 4 x 4 or equivalent; each	each	\$ 3.46
A4367	Ostomy belt, each	each	\$ 6.25
A4388	Ostomy pouch, drainable, with extended wear barrier attached, (1 piece), each	each	\$ 4.36
A4394	Ostomy deodorant, with or without lubricant, for use in ostomy pouch, per fluid ounce	fl. Oz.	\$ 2.58
A4399	Ostomy irrigation supply; cone/catheter, including brush	each	\$ 12.15
A4404	Ostomy rings	each	\$ 1.44
A4408	Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, with built-in convexity, larger than 4 x 4 inches, each	each	\$ 9.87
A4409	Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, 4 x 4 inches or smaller, each	each	\$ 6.22
A4411	Ostomy skin barrier, solid 4x4 or equivalent, extended wear, with built-in convexity, each	each	\$ 5.10
A4414	Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, 4 x 4 inches or smaller, each	each	\$ 4.93
A4415	Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, larger than 4x4 inches, each	each	\$ 6.00
A4430	Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece), each	each	\$ 8.52
A4432	Ostomy pouch, urinary; for use on barrier with non-locking flange, with faucet-type tap with valve (2 piece), each	each	\$ 3.59
A4461	Surgical dressing holder, nonreusable, each	each	\$ 3.29
A5055	Stoma cap	each	\$ 1.26
A6211	Foam dressing, wound cover, pad size more than 48 sq. In. Without adhesive border	each	\$ 29.37
A6261	Wound filler, gel paste, per fl.oz, NOC	fl. Oz.	\$ 28.48
A6262	Wound filler, dry form, per gm, NOC	1 gm	\$ 0.58

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

Attention: Physicians, Nurse Practitioners, Nurse Midwives, Federally Qualified Health Centers, Rural Health Centers, Health Departments and Certified Dialysis Providers

National Drug Code Implementation December 28, 2007

Effective with date of service December 28, 2007, the North Carolina Division of Medical Assistance will require that claims for all drugs administered in a physician office or clinic, or by certified dialysis providers, include the National Drug Code (NDC). All providers affected by this change must implement a process to record and maintain the NDC(s) and quantity(ies) of the drug(s) administered to the recipient.

Billing software programs need to be modified to include the required NDC-related fields. Please refer to the HIPAA Implementation Guides (on the Washington Publishing's website at <http://www.wpc-edi.com/>) for information regarding the placement of NDC information on an 837 transaction and share it with your vendors and/or clearinghouse.

Detailed billing instructions can be found in the October 2007 special bulletin, [*National Drug Code Implementation, December 28, 2007: Billing for Drugs Through the Physician's Drug Program.*](#)

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

Attention: Physicians, Nurse Midwives, Nurse Practitioners, Federally Qualified Health Centers and Rural Health Centers

Revision to “Change in Reimbursement Rates for Injectable Immunization Administration Codes” (Oct. 2007)

Effective with date of service Jan. 1, 2007, the reimbursement rates for the following CPT codes were adjusted: 90465, 90466, 90471 and 90472. The definitions of these codes are as follows.

CPT code	Definitions
90465	Immunization administration younger than 8 years of age (includes percutaneous, intradermal, subcutaneous, or intramuscular injections) when the physician counsels the patient/family; first injection (single or combination vaccine/toxoid), per day
90466*	Each additional injection (single or combination vaccine/toxoid), per day (List separately in addition to code for primary procedure)
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)
90472*	Each additional injection (single or combination vaccine/toxoid), per day (List separately in addition to code for primary procedure)

*Providers may now submit claims for these codes with multiple quantity units.

Billing Instructions:

Providers who **previously billed** and were paid for **1 quantity unit** under 90466 EP and 90472 EP and need to be paid for additional units of those codes **may submit an electronic replacement claim or a paper adjustment request**. Electronic replacement claims are processed faster than paper adjustments. Replacement claims submitted electronically by 5:00 p.m. on the cut-off date are processed on the following checkwrite.

When filing a replacement claim, include Claim Resubmission Reason Indicator 7, the original ICN of the most recent previously processed claim, and corrected claim information. The claim associated with the original ICN will be recouped and the corrected claim will be processed in its place. If for any reason the corrected claim is denied, the previously processed claim will not be recouped.

When filing a paper adjustment, indicate the total units billed for each specific administration code for the date of service. For example, if 90466 EP was billed for 2 quantity units and only 1 quantity unit paid, the reason for adjustment should read, “Change units to 2 for code 90466 EP.”

Be sure to reference the most recent ICN on the adjustment request. For example, if the claim has been recently adjusted to allow additional payment due to a rate increase, the adjustment ICN rather than the original ICN should be used as the reference ICN on the adjustment request. Failure to indicate the appropriate reference ICN could result in delayed adjustment processing.

Replacement claims and paper adjustments can be processed only on paid claims. Providers who previously billed and were denied do not require adjustments; correct the errors indicated by the Explanation of Benefits code (EOB) and resubmit the claim.

Questions regarding these types of adjustments can be addressed by EDS Provider Services at 1-800-688-6696; select option 3 from the menu. Refer to the July 2007 Special Bulletin, *NCECSWeb Instruction Guide* (on the Division of Medical Assistance Web site at <http://www.ncdhhs.gov/dma/bulletin.htm#special>).

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

Attention: UB/837I Billers**M**edicaid Treatment of Private Insurance Plan Payments and Denials***Non-Compliance Denials***

Effective with date of service December 1, 1997, State and Federal third party liability (TPL) laws mandate that Medicaid not pay for services denied by private health plans due to noncompliance with those private plan requirements. Common noncompliance denials include:

- Non-participating provider
- Failure to obtain pre-approval
- Exceeds time filing deadline
- Service not provided in proper location
- Service not payable separately but is lumped with payment for other services, etc.

If the service would have been a covered service and payable by the private plan, but some requirement of the plan was not met, then Medicaid will not pay for this service.

The recipient and the provider both have responsibility for complying with private plan requirements. If the recipient did not inform the provider of the existence of the recipient's private plan, and the plan's requirements were not met because the provider was unaware of them, the provider may bill the recipient for those services if both the private plan and Medicaid deny payment due to noncompliance. Similarly, if a recipient fails to cooperate in any way in meeting any private plan requirement, the provider may bill the recipient for the service(s). Recipients are being informed of their responsibility and that they may be billed for services which do not comply with their private plans. However, if the recipient presents the private payer information, and the provider is aware that the provider is not a participating provider in that plan or cannot meet any other private plan requirement, the provider must inform the recipient of that fact and that the recipient will be responsible for payment.

When submitting claims to Medicaid with private insurance denials, the insurance company explanation of benefits (EOB) MUST be included with the claim, along with the explanation of any denial codes. If a claim is submitted with an insurance denial, and either the EOB or the denial code explanation is missing, the claim will be either returned to the provider as incomplete or denied for insufficient information.

Discounted Fee-For-Service Payments

The Medicaid program makes payment to providers on behalf of the recipients for medical services rendered, but is not an “insurer.” As such, Medicaid is not responsible for any amount for which the recipient is not responsible. Therefore, a provider cannot bill Medicaid for any amount greater than what the provider agreed to accept from the recipient’s private plan. If the recipient is not responsible for payment, then Medicaid is not responsible for payment. The provider should bill only the amount which the provider has agreed to accept as payment in full from the private plan.

Policy states that the TPL Amount Paid PLUS the Contractual Adjustment must be added together and deducted from the allowed amount and pay the difference, if there was one.

Example: If the TPL Paid Amount is \$1,744.96; and Contractual Adj. \$233.95. The total TPL payment billed to Medicaid should \$1978.91. Medicaid would deduct \$1978.91 from the Medicaid allowed amount.

TPL Overrides and EOBs Generally

With respect to paper claims, if the provider received a payment from a private plan, the provider may continue to indicate such payment on the claim, and submit the claim without attaching the EOB. However, the provider must bill Medicaid only the amount for which the recipient is responsible, in accordance with the requirements outlined above. The contractual amount must be added to the third party payment amount and submitted in the Prior Payments field (FL-54) on the UB. Additionally, the provider must keep the EOB records on file for a period of six years pursuant to the Medicaid provider agreements and manuals. The Third Party Recovery (TPR) Section of DMA will conduct audits of provider records and billings, and providers will be required to provide copies of such EOBs. If no EOB is retained, Medicaid may recoup its payment made for the service(s). However, if the provider files a paper claim and receives a denial from a private plan, the EOB, with the denial code explanation, must be attached to the claim, as stated above. In extreme cases where the provider has tried repeatedly to obtain a private insurance EOB without success, the DMA form 2057, “Health Insurance Information Referral Form” may be used in lieu of an EOB.

When submitting claims electronically, if the provider received a payment from a private plan, the provider may continue to indicate the payment amount as traditionally done, complying with the limitations set out above regarding the billed amount. The contractual amount must be added to the third party payment amount and submitted in AMT Payer Prior Payment segment in Loop 2320 of the 837 for Institutional transaction. If the provider received a private plan denial, providers may use the following occurrence codes to override the TPL edits electronically (1) code 24 - Insurance Denied and Date; (2) code 25 - Benefits Terminated and Date; and (3) codes A3-C3 - Benefits Exhausted and Date. Occurrence code 24, “Insurance Denied” is defined to mean the following only: the private plan denied payment because this service is not a covered service by this private plan. This means that the service never would have been covered under any circumstance. This does not mean that the plan denied

payment for the service due to the provider's or recipient's noncompliance with that plan's requirements. As stated above with paper claims, the providers are required to retain the private plan EOBs for a period of three years, and the providers will be required to submit copies of such EOBs upon request by DMA.

All claims should be submitted to EDS for processing except the following:

- (1) Claims with a private plan denial for any denial other than
 - (a) applied to the deductible
 - (b) benefits exhausted
 - (c) not a covered service, as defined above
 - (d) pre-existing condition
 - (e) Medicare eligible with no private insurance (any denial meeting (1)(a)-(e) should be sent to EDS with a Medicaid Resolution Inquiry form attached, any other denial should be sent to TPR at DMA)
- (2) Claims with a DMA-2057 form

Claims for copayments due from the recipients having capitated plans, as discussed in the May 1996 Bulletin article referenced above should now be sent to EDS. Claims meeting the requirements in either (1) or (2) above only, should be submitted directly to the TPR Section at P.O. Box 29551, Raleigh, NC 27626-9551. If you have billed in error, use your current compliance policy. If you have any questions please contact DMA Program Integrity at 919-647-8000.

Please find this communication in the following locations:

- November 1997 Bulletin Article: <http://www.dhhs.state.nc.us/dma/bulletin/pdfbulletin/1197bulletin.pdf>
- Basic Medicaid Billing Guide, section 7-1: <http://www.dhhs.state.nc.us/dma/medbillcaguide.htm>
- Hospital Manual, section 8-3: <http://www.dhhs.state.nc.us/dma/hospita.htm>

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

Proposed Clinical Coverage Policies

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

Loretta Bohn
Division of Medical Assistance
Clinical Policy Section
2501 Mail Service Center
Raleigh NC 27699-2501

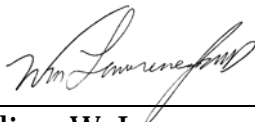
The initial comment period for each proposed policy is 45 days. An additional 15-day comment period will follow if a proposed policy is revised as a result of the initial comment period.

2007 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
December	11/29/07	12/04/07
	12/06/07	12/11/07
	12/13/07	12/20/07
January 2008	01/03/08	01/08/08
	01/10/08	01/15/08
	01/17/08	01/24/08

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.

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



William W. Lawrence, Jr., M.D.
Acting Director
Division of Medical Assistance
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Cheryll Collier
Executive Director
EDS
