

North Carolina Medicaid Bulletin

An Information Service of the Division of Medical Assistance

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

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A New Children's Health Insurance Program Began
October 1, 1998

NC Health Choice for Children

5,990 children enrolled statewide during the first month!

- * fee-for-service indemnity program
- * providers do not need to enroll to be eligible
- * use State Health Plan Blue Cross/Blue Shield of North Carolina claim forms

Benefits and provider reimbursement are the equivalent of the NC Teachers' and State Employees' Comprehensive Major Medical Plan, plus Vision, Hearing, and Dental benefits are 100 % UCR.

See page 3 for more information.

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

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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:

Thursday, December 24, 1998	Christmas
Friday, December 25, 1998	Christmas
Friday, January 1, 1999	New Years Day
Monday, January 18, 1999	Martin Luther King, Jr. Birthday

EDS

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

Attention: Physicians and Hospitals

Cochlear Implantation

Effective with date of service September 1, 1998, North Carolina Medicaid covers Cochlear Implant Devices (and Aural Rehabilitation following cochlear implants) for prelinguistically and postlinguistically deafened children two to 21 years of age. There is no prior approval; however, records are subject to review.

CPT codes for HCFA-1500 form billing are:

69930	Cochlear device implantation, with or without mastoidectomy
92510	Aural rehabilitation following cochlear implant (includes evaluation of aural rehabilitation status and hearing, therapeutic services) with or without speech processor programming.

Coverage of cochlear implants requires that patients meet all of the following criteria:

- Two to 21 years of age
- Diagnosis of bilateral severe-to-profound sensorineural hearing impairment with limited benefit from appropriate hearing (or vibrotactile) aids. Bilateral profound sensorineural deafness must be demonstrated by the inability to improve on age appropriate closed-set word identification tasks with amplification
- Cognitive ability to use auditory clues and a willingness to undergo an extended program of rehabilitation
- Freedom from middle ear infection, an accessible cochlear lumen that is structurally suited to implantation, and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system
- No contraindications to surgery

Only devices that are FDA approved can be used for Cochlear Implantation.

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

NC Health Choice for Children Provider Guides

OVERVIEW: NC Health Choice for Children is a new health insurance program at low or no cost for children of working families who make too much money to qualify for Medicaid and too little to afford individual or employer-sponsored health insurance coverage.

PROVIDER PARTICIPATION: NC Health Choice for Children is a fee-for-service/indemnity insurance program. No special provider enrollment is required. A Blue Cross/ Blue Shield of North Carolina provider number is necessary for payment to be made promptly.

CLAIMS FILING: To file a claim, providers use the same forms they use for the Blue Cross/Blue Shield of North Carolina claims. Providers should file the claim themselves rather than asking patients to file. Payments will not be made to patients, only to providers.

REIMBURSEMENT: Physician reimbursement is based on UCR as determined by the Blue Cross/Blue Shield of North Carolina CostWise Program. Hospitals will be paid based on DRG contracting arrangements with the Teachers' and State Employees' Comprehensive Major Medical Plan. Providers are prohibited from balance billing for covered charges. Payment will usually be made within 30 days of filing.

WHO IS ELIGIBLE: There are two criteria for program eligibility:

- (1) children must be uninsured and
- (2) family income must be less than twice the federal poverty level:
 - \$21,700 for a family of two
 - \$27,300 for a family of three
 - \$32,900 for a family of four
 - \$38,500 for a family of five

HOW CAN FAMILIES APPLY: Families can apply for the program by mail using a simple two-page form available through local Social Services and Public Health offices or by calling 1-800-367-2229. Some families will be required to pay an annual enrollment fee of \$50 for one child or \$100 for two or more children to the county social service department. These are families whose income falls between 150% and 200% of the federal poverty level that is above:

- \$16,275 for a family of two
- \$20,475 for a family of three
- \$24,675 for a family of four
- \$28,875 for a family of five

NC Health Choice for Children Provider Guides, continued

FINANCIAL PARTICIPATION: Families with incomes above 150% of the federal poverty level must also pay a small copayment to the provider:

- \$5 per office visit, except for preventive health visits
- \$6 per prescription drug
- \$20 for nonemergency visits to the emergency room

Families below 150% of poverty pay no enrollment fee or copayment. The health information card will list \$0 for their copayments on the face of the card.

WHAT'S COVERED: The program offers the NC Teachers' and State Employees' Comprehensive Major Medical Plan dependent coverage benefits, plus dental, vision and hearing benefits, and seamless coverage for special needs. The Blue Cross/Blue Shield of North Carolina is the claims processor for the program.

MEMBER IDENTIFICATION (ID) CARD: Each child will receive a NC Health Choice for Children member identification (ID) card from the Blue Cross/Blue Shield of North Carolina that shows any copayments due and the expiration date of the coverage. Once a child has been deemed eligible for the program, the child remains eligible for one year.

APPLICATION FORMS: Local health and social services departments are responsible for identification and enrollment of eligible children. Providers are encouraged to make applications available in their offices and to offer assistance to families in completing applications. Providers willing to participate in these outreach efforts should contact their local health or social services departments.

WHERE TO CALL FOR MORE INFORMATION:

Question	Contact
Billing or covered services, contact the provider line	1-800-422-4658
Patient enrollment	1-800-367-2229
Mental health; drug/alcohol treatment & pre-certification	1-800-753-3224
Prior approvals	1-800-422-1582
Pre-admission certification	1-800-672-7897
Electronic claim filing	1-919-756-3514
NC Health Choice for Children with Special Needs	1-800-737-3028

Attention: All Physicians

Policy and Procedure for Exempting Medicaid Recipients from the Dispensing Limitation of Six Prescriptions Per Month

The North Carolina General Assembly established a limitation of SIX prescriptions per recipient per month in 1982. Exemption from this limitation is authorized by the Department of Health and Human Services “when the life of the patient would be threatened without additional care”. Therefore, patients being treated for one of the conditions listed below can be exempt from the dispensing limitation if that action is deemed necessary by the primary prescribing physician.

End-stage renal disease	End-stage lung disease
Chemotherapy and radiation therapy for malignancy	Unstable diabetes
Acute sickle cell disease	Terminal stage any illness, or life threatening any illness
Hemophilia	

Physicians can request exemption from the dispensing limitation for those Medicaid patients who qualify by completing and signing DMA form 3098 and then sending the form to the pharmacy of record for the recipient. The form must be updated every six months if the recipient still qualifies for the exemption. This form negates the requirement that physicians have to write the diagnosis on every prescription for the purpose of exempting recipients from the dispensing limitation. However, the diagnosis written on the prescription would be helpful to the pharmacist in counseling patients.

The physician may mail or fax the form to the pharmacy of record for the patient or ask the patient to give the form to the pharmacist when he/she gets the prescriptions filled.

In compliance with Medicaid rules, pharmacists are required to retain these forms on file for five years. To bill the Medicaid Program for more than six prescriptions per month, Pharmacists must have this form in their possession.

A copy of DMA form 3098 is included in this bulletin and may be reproduced. Pharmacies can also provide physicians with copies of this form. Physicians may also obtain a copy of the form by contacting EDS.

There are two categories of recipients who are exempt from the dispensing limitation of six prescriptions per month because of participation in a specific program:

- Recipients who are participating in the Community Alternatives Program (CAP) and
- Recipients who are less than 21 years of age are exempt under guidelines established through the Healthy Children and Teens Program.

The physician does not need to complete a form to exempt these recipients from the dispensing limitation because the program information is incorporated into the eligibility files.

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



NORTH CAROLINA MEDICAID PHARMACY PROGRAM

Six Prescription Limit Override Form

North Carolina Medicaid Recipients are allowed only six prescriptions per month unless they have one of the diagnoses below. If the attending physician determines that a recipient is eligible for the override, he/she must check all diagnoses that apply, complete the rest of the form and sign in his own handwriting.

- Acute Sickle Cell Disease
- Hemophilia
- End Stage Lung Disease
- End Stage Renal Disease
- Unstable Diabetes
- Chemotherapy or Radiation Therapy for Malignancy
- Any Life Threatening Illness or Terminal Stage of Any Illness

Recipient's Name _____

Recipient's MID Number _____

Facility _____
(Fill out only if in nursing facility or adult care home)

Physician's Signature _____

Date _____

* THIS FORM MUST BE UPDATED EVERY SIX MONTHS IF THE RECIPIENT STILL QUALIFIES FOR THE SIX PRESCRIPTION OVERRIDE

* THIS IS THE ONLY ACCEPTED FORM AND MUST BE KEPT ON FILE IN THE PHARMACY AT ALL TIMES

THIS FORM MAY BE REPRODUCED

Attention: All Providers**Remittance Advice Changes**

The Division of Medical Assistance (DMA) will implement modifier processing 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. Tape and paper Remittance Advice and Status Reports (RAs) will reflect modifier processing beginning with the July 6, 1999 checkwrite. Changes to the RA are detailed below. Additional information about the modifier implementation will be disseminated in upcoming bulletin articles and provider workshops.

Paper RA changes:

An additional line will appear on the RA for each detail submitted with modifiers on the HCFA-1500 claim form. The modifier line will immediately follow the associated detail and contain all submitted modifiers. Claims processed for providers or services requiring modifier billing (with the exception of Health Check and crossovers) will not show the type of service on the detail. Contact the Provider Services Department at (919) 851-8888 or (800) 688-6696 with questions.

Tape RA changes:

Tape RAs will include detail modifiers and a new EOB description record. Modifiers submitted on the HCFA-1500 claim form will be included on the claim detail record. Claims processed for providers or services requiring modifier billing (with the exception of Health Check and crossovers) will not show the type of service on the detail. The new EOB description record(s) will provide a description of each EOB utilized throughout the RA. The following fields will be added to accomplish these changes:

Claim Detail Record (Not applicable to drug claims)

Field name	Position in Record	Length	Type	Format
TB Detail Modifier (occurs 10 times)				
TB Detail Modifier (1)	242-243	2	A/N	
TB Detail Modifier (2 - 10)	244-261			
Filler	262 - 341	80	A/ N	

EOB Description Record

Field name	Position in Record	Length	Type	Format
Tape RA Record ID	1-3	3	N	'260'
Filler	4-33	30	N	
Provider Number	34-41	8	A/N	
Filler	42-46	5	A/N	
Explanation of Benefits (EOB) Code	47-50	4	N	9(4)
EOB Description Line (1)	51-110	60	A/N	
EOB Description Line(2)	111-170	60	A/N	
EOB Description Line(3)	171-230	60	A/N	
Filler	231-341	111	A/N	

Providers using tape Remittance Advice (RA) have received information regarding changes to the tape RA format. Contact the EDS Electronic Commerce (ECS) Department with questions or requests for tape RA specifications.

EDS

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

Attention: All Providers

Year 2000 Update

In a March 1998 Special Bulletin we gave providers basic information about the NC Medicaid Management Information system Year 2000 or Y2K project. Layouts and specifications accommodating four digit years were described for various claim forms and the tape RA.

DMA has developed its final methodology for Y2K claims acquisition. The MMIS is currently internally Y2K capable. The effort now is to describe how and when providers will submit Y2K compliant claims. A summary of the plan for various methods of submitting claims to EDS follows. The chart at the end of this article identifies planning dates for submission of Y2K compliant claims. These dates are tentative and will be finalized when a final schedule is established. Providers will be notified of final dates.

DMA will accept claims in current non-Y2K compliant form until the end of transition periods for various methods of submission. This allows DMA to make decisions to accept non-compliant claims in those situations where the capability will best serve the provider community and DMA. This capability should give a high degree of comfort and flexibility to providers transitioning to Y2K compliant formats. However, all providers are reminded they will be required to make conversion to Y2K claims compliance. Details applicable to various submission forms appear below.

NECS Submitters

The current NECS software will be replaced by a windows like software to be re-named the *North Carolina Electronic Claims Submission (NCECS)* software. This software is compatible with a wide variety of computers. As an added feature, this software will output files or diskettes of claims not only Y2K compliant, but also in ANSI 837 format. The Health Insurance Portability and Accountability Act (HIPAA) legislation of 1996 will eventually require all electronic claims to be submitted in the ANSI 837 format sometime, probably, in the next few years. The NCECS software gives that capability. EDS will offer NCECS software training classes at times to be announced. EDS will send providers the new NCECS software in August 1999. Providers will have August to October of 1999 to implement the changes. It is expected claims in the new formats will arrive at EDS in the period August 1999 to February of 2000. NCECS providers will not require testing by EDS prior to claim acceptance. The software will be internally tested by EDS. Providers will simply key/data enter claims into the software.

Tape Submitters

EDS will send specifications to providers in December 1998. Providers will have December 1998 to April 1999 to implement changes. EDS expects to receive claims in the new format in Feb-April 1999. All tape submitters must pass testing with EDS before Y2K compliant claims will be accepted. Providers are reminded to give as much notice as possible to vendors or data processing support staff so changes can be made smoothly and on time.

ECS Submitters

EDS will send specifications to providers in the January 1999 with providers having January 1999 to April 1999 to implement changes. All ECS submitters must pass testing with EDS before Y2K compliant claims will be accepted. Claims in new formats will begin arriving at EDS in the February to May 1999 period. Providers are reminded to give as much notice as possible to their vendors or data processing support staff so changes can be made smoothly and on time.

Paper Submitters

There will be no changes to paper claim forms. As space permits on forms, providers should enter a four digit year. Where the provider indicates only a two digit year, EDS' data entry staff will enter an appropriate four digit year. For example, "00" will be keyed as "2000", "99" will be keyed as "1999". We anticipate providers will send four digit year claims at anytime in the future. Plan to send a four digit year (form permitting) no later than June 1999.

ANSI 837 Submitters

Some providers will want to submit claims in ANSI 837 format as soon as EDS is capable of accepting them. The new NCECS software will configure claims in the 837 format. EDS will use translator software to accept any ANSI 837 compliant claim. EDS is expected to accept these claims between May and June 1999.

	Current Formats	NCECS	Tape	ECS/Vendors	Paper	ANSI 837
Providers Install		8/5/99-10/27/99	12/23/98-4/27/99	1/6/99-4/20/99		1/5/99-3/1/99
EDS Accepting Claims	until transition by DMA	8/19/99-2/2/00	2/3/99-4/30/99	2/3/99-5/16/99	6/9/99-6/15/99	5/1/99-6/1/99

EDS

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

Attention: HCFA-1500 Billers**Medicare/Medicaid Paper Claim Billing Reminder**

Paper Medicare/Medicaid claims must be billed accurately to assure correct payment. **Block 29 (Amount Paid) on paper HCFA-1500 claims must be completed only for other insurance payments. **DO NOT** enter the amount paid by Medicare or the difference of the Total Charge (Block 28) less the expected Medicaid reimbursement (sometimes shown in Block 30, Balance Due) in this field. Medicaid reimbursement for a paper crossover claim is calculated using the coinsurance and/or deductible information from the attached Medicare voucher. Any amount entered by the provider in Block 29 on the claim will be considered a third party insurance payment and will be deducted from the coinsurance/deductible due. **Corrections to the original claim payment, due to erroneous amounts in Block 29, will require an adjustment. To avoid filing adjustments, complete Block 29 as stated above.****

EDS

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

Attention: Hospice Providers**Hospice Rates**

Effective with date of service January 1, 1999, hospice rates are as follows:

		Routine Home Care	Continuous Home Care	Inpatient Respite Care	General Inpatient Care	Hospice Intermediate R & B	Hospice Skilled R & B
Metropolitan Statistical Area	SC	RC 651 Daily	RC 652 Hourly (1)	RC 655 Daily (2) (3) (4)	RC 656 Daily (3) (4)	RC 658 Daily (5)	RC 659 Daily (5)
Asheville	39	94.88	23.05	103.73	422.25	85.50	114.16
Burlington	40	91.87	22.32	101.14	409.78	85.50	114.16
Charlotte	41	96.43	23.43	105.04	428.63	85.50	114.16
Fayetteville	42	90.99	22.11	100.39	406.13	85.50	114.16
Greensboro/WS/HP	43	94.35	22.92	103.27	420.05	85.50	114.16
Hickory	44	91.18	22.15	100.55	406.91	85.50	114.16
Jacksonville	45	86.31	20.97	96.38	386.77	85.50	114.16
Raleigh/Durham	46	97.73	23.75	106.16	434.04	85.50	114.16
Wilmington	47	92.95	22.58	102.06	414.23	85.50	114.16
Rural	53	85.53	20.78	95.71	383.52	85.50	114.16

Note: Because providers are expected to bill their charges, no adjustments will be accepted.

Key to Hospice Rate Table:

SC = Specialty Code
RC = Revenue Code

1. A minimum of eight hours of Continuous Home Care must be provided.
2. There is a maximum of five consecutive days including the date of admission but not the date of discharge for Inpatient Respite Care. Bill for the sixth and any subsequent days at the routine home care rate.
3. Payments to a Hospice for inpatient care are limited in relation to all Medicaid payments to the agency for hospice care. During the 12 month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days, inpatient respite, and general inpatient, may not exceed 20 percent of the aggregate total number of days of hospice care provided during the same time period for all the hospice's Medicaid patients. Hospice care provided for patients with acquired immune deficiency syndrome (AIDS) is excluded in calculating the inpatient care limit. The Hospice refunds any overpayments to Medicaid.
4. Date of Discharge: For the day of discharge from an inpatient unit, the appropriate home care rate should be billed instead of the inpatient care rate unless the recipient dies as an inpatient. When the recipient is discharged as deceased, the inpatient rate (general or respite) is billed for the discharge date.

- 5. When a **Medicare/Medicaid** recipient is in a nursing facility, Medicare is billed for the routine or continuous home care, as appropriate, and Medicaid is billed for the appropriate long term care rate. When a **Medicaid only** hospice recipient is in a nursing facility, the Hospice may bill for the appropriate long term care (SNF/ICF) rate in addition to the home care rate provided in revenue code 651 or 652. See section 8.15.1, page 8-11, of the Medicaid Community Care Manual for details.

DMA is currently implementing policy to follow the same guidelines as Medicare.

- 1. Reimbursing based on the location of the recipient for RC651 and RC 652.
- 2. Adding 4 MSA areas.

Providers will be notified through the Medicaid Bulletin when these changes take place.

*Debbie Barnes, Financial Operations
DMA, 919-857-4165*

Attention: All Providers

Basic Medicaid Seminars

Basic Medicaid seminars intended for new Medicaid providers will be held February 1999. The January Medicaid Bulletin will have the registration form for the seminars and a list of site locations. Please suggest topics you would like addressed at the seminars. List topics and issues below and return to:

Provider Representative
EDS
P.O. Box 300009
Raleigh, NC 27622

If you would like to be contacted regarding this seminar, please list your name and phone number below:

Name _____ *Phone Number* _____

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Attention: Private Duty Nursing (PDN) Providers

Private Duty Nursing Seminars

Private Duty Nursing seminars will be held in February 1999. The January Medicaid Bulletin will have the registration form for the seminars and a list of site locations. Please suggest topics you would like addressed at the seminars. List topics and issues below and return to:

Provider Representative
EDS
P.O. Box 300009
Raleigh, NC 27622

If you would like to be contacted regarding this seminar, please list your name and phone number below:

Name _____ *Phone Number* _____

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Attention: Dialysis Providers (Including Physicians and Facilities)

Individual Visits

EDS is offering individual provider visits for all dialysis providers. If there are any questions regarding general Medicaid guidelines, policy changes, billing information, or claims follow-up procedures, please complete and return the form below. An EDS Provider Representative will contact you to schedule a visit.

(cut and return request form only)

Dialysis Provider Visit Request Form

(No Fee)

Provider Name _____ Provider Number _____

Address _____ Contact Person _____

City, Zip Code _____ County _____

Telephone Number _____ Date _____

List any specific concerns you would like us to address in the space provided below:

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

Checkwrite Schedule

December 8, 1998	January 5, 1999	February 2, 1999
December 15, 1998	January 12, 1999	February 9, 1999
December 23, 1998	January 21, 1999	February 18, 1999

Electronic Cut-Off Schedule *

December 4, 1998	December 31, 1998	January 29, 1999
December 11, 1998	January 8, 1999	February 5, 1999
December 18, 1998	January 15, 1999	February 12, 1999

* *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
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Department of Health and Human Services

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Bulk Rate
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