JANUARY 2005 Medicaid Bulletin

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Attention: All Providers

Ambulatory Visits and Diagnosis Code V829

Diagnosis code V82.9 should only be billed to indicate the recipient is being treated for an illness that is eminently life threatening and, as such, the recipient should be exempted from the legislated 24 ambulatory visit limit. Ambulatory visits include Evaluation and Management services such as office visits, hospital visits, and consultations. If a claim does not include one of these types of visits, diagnosis code V82.9 should **not** appear on the claim. Claims that include diagnosis code V82.9 without including an ambulatory visit code **will be returned** to the provider for correction.

The following paragraphs detail the requirements for appropriate use of diagnosis code V82.9.

The primary diagnosis code listed on the claim must be the specific ICD-9-CM diagnosis code that describes the reason for the encounter and the secondary diagnosis code must be listed as V82.9. When a provider submits a claim with diagnosis code V82.9, a medical review is performed to determine if additional documentation is required to support the exemption. Claims for visits that exceed the 24-visit limit and do not list V82.9 as the secondary diagnosis will deny.

Ambulatory medical visits are limited to 24 visits per year beginning July 1 of each year through June 30 of the next year. These include any one or a combination of visits to the following: physicians, clinics, hospital outpatient other than emergency room, optometrists, chiropractors, and podiatrists. Once this limit has been reached, claims will deny with EOB 525, "Exceeds legislative limits for provider visits for fiscal year." Providers may bill the patient the usual and customary charge for the visit.

Exemptions to the 24-visit limit include:

1. End stage renal disease.

2. Chemotherapy and/or radiation therapy for malignancy.

3. Acute sickle cell disease, hemophilia or other blood clotting disorders.

4. Services rendered to recipients under age 21.

5. Prenatal services.

6. Dental services.

7. Physician inpatient visits to patients in intermediate care facilities or skilled nursing facilities.

8. Mental Health Center services are exempt because the services are subject to independent utilization review.

9. Recipients receiving Community Alternatives Program (CAP) services.

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

Attention: All Providers

CAP/Choice – A Pilot Program of Consumer Directed Care

Effective January 1, 2005, a new waiver program entitled CAP/Choice will be piloted in two counties: Cabarrus and Duplin. CAP/Choice is an alternative to the existing traditional home and community-based services waiver program, Community Alternatives Program for Disabled Adults (CAP/DA). CAP/Choice is a program of consumer-designated care for elderly and disabled adults who wish to remain at home and have increased control over their services and supports. CAP/Choice allows recipients (consumers) who prefer, to select their individual workers, more fully direct their care, and have more flexibility in tailoring plans of care to their home care requirements.

Two new CAP indicator codes have been created for this new program: ID (intermediate level of care) and SD (skilled level of care). They appear on the Medicaid identification card of a recipient in either **Cabarrus** or **Duplin** counties who is enrolled in the CAP/Choice program.

The same exemptions that apply to the established CAP/DA program, such as no copayments and no limits on prescriptions apply to the CAP/Choice program.

Tracy Colvard, CAP Consultant
DMA, 919-855-4360

Attention: All Providers

Code Changes for Radiopharmaceuticals

Effective with date of service January 1, 2005, CPT code 78990, provision of diagnostic radiopharmaceutical(s), was discontinued by the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA).

Providers billing for the provision of diagnostic radiopharmaceuticals using this generic code with an invoice now need to bill one of the following appropriate HCPCS codes:

CODE	DESCRIPTION	TESTS
A9503	Supply of radiopharmaceutical diagnostic imaging agent, Technetium Tc 99m medronate, up to 30 millicurie	Bone/Joint Imaging
A9510	Supply of radiopharmaceutical diagnostic imaging agent, Technetium Tc 99m disofenin, per vial	Hepatobiliary Scan
A9512	Supply of radiopharmaceutical diagnostic imaging agent, Technetium Tc 99m pertechnetate, per mci	MUGA Scan, Thyroid Imaging
A9513	Supply of radiopharmaceutical diagnostic imaging agent, Technetium Tc 99m mebrofenin, per mci	Hepatobiliary Scan, Gallbladder Ejection Fraction
A9514	Supply of radiopharmaceutical diagnostic imaging agent, Technetium Tc 99m pyrophosphate, per mci	Avid Infarct Imaging
A9516	Supply of radiopharmaceutical diagnostic imaging agent, I-123 sodium iodide capsule, per 100 uci	Thyroid Scan, Thyroid Uptake
A9520	Supply of radiopharmaceutical diagnostic imaging agent, Technetium Tc 99m sulfur colloid, per mci	Liver, Spleen or GI Bleed Scan
A9521	Supply of radiopharmaceutical diagnostic imaging agent, Technetium Tc 99m exametazine, per dose	Cerebral Perfusion
A9528	Supply of radiopharmaceutical diagnostic imaging agent, I-131 sodium iodide capsule, per millicurie	Thyroid Uptake, Thyroid Scan
Q3005	Supply of radiopharmaceutical diagnostic imaging agent, Technetium Tc 99m mertiatide, per millicurie	Renal Scan
Q3009	Supply of radiopharmaceutical diagnostic imaging agent, Technetium Tc 99m oxidronate, per millicurie	Bone Scan
Q3010	Supply of radiopharmaceutical diagnostic imaging agent, Technetium Tc 99m – labeled red blood cells, per millicurie	MUGA Scan

The invoice must be attached to the CMS-1500 claim form and include the:

- Name of the patient
- Patient’s Medicaid Identification number

- Name of the agent
- Dose administered
- Cost per dose

Claims submitted without this information on the invoice will be denied. Reimbursement is based on the actual invoice price of the agent only (less the shipping and handling).

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

Attention: All Providers

Corrected 1099 Requests – Action Required by March 1, 2005

Providers receiving Medicaid payments of more than $600 annually receive a 1099 MISC tax form from EDS. The 1099 MISC tax form is generated as required by IRS guidelines. It will be mailed to each provider no later than January 31, 2005. The 1099 MISC tax form will reflect the tax information on file with Medicaid as of the last Medicaid checkwrite cycle date, December 22, 2004.

If the tax name or tax identification number on the annual 1099 MISC you receive is **incorrect**, a correction to the 1099 MISC must be requested. This ensures that accurate tax information is on file with Medicaid and sent to the IRS annually. When the IRS receives incorrect information on your 1099 MISC, it may require backup withholding in the amount of **28 percent of future Medicaid payments**. The IRS could require EDS to initiate and continue this withholding to obtain correct tax data.

A correction to the original 1099 MISC must be **submitted to EDS by March 1, 2005** and must be accompanied by the following documentation:

- a copy of the original 1099 MISC
- a signed and completed IRS W-9 form clearly indicating the correct tax identification number and tax name. (Additional instructions for completing the W-9 form can be obtained at www.irs.gov under the link "Forms and Pubs.")

Fax both documents to 919-816-3186-Attention: Corrected 1099 Request - Financial

Or

Mail both documents to:

EDS
Attention: Corrected 1099 Request - Financial
4905 Waters Edge Drive
Raleigh, NC 27606

A copy of the corrected 1099 MISC will be mailed to you for your records. All corrected 1099 MISC requests will be reported to the IRS. In some cases, additional information may be required to ensure that the tax information on file with Medicaid is accurate. Providers will be notified by mail of any additional action that may be required to complete the correction to their tax information.

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

Attention: All Providers

Clinical Coverage Policies

The following new or amended clinical coverage policies are now available on the Division of Medical Assistance's website:

- **4A** – Dental Services
- **8C** – Outpatient Behavioral Health Services Provided by Direct Enrolled Providers
- **10B** – Independent Practitioners
- **10C** – Local Education Agencies

These policies supersede previously published policies and procedures. Providers may contact EDS at 1-800-688-6696 or 919-851-8888 with billing questions.

Gina Rutherford, Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

Updated EOB Code Crosswalk to HIPAA Standard Codes

The list of standard national codes used on the Electronic Remittance Advice (ERA) has been cross-walked to EOB codes as an informational aid to adjudicated claims

listed on the RA. An updated version of the list is available on the Division of Medical Assistance's HIPAA web page.

With the implementation of standards for electronic transactions mandated by the Health Insurance Portability and Accountability Act (HIPAA), providers now have the option to receive an ERA in addition to the paper version of the Remittance and Status Report (RA).

The EOB codes that providers currently receive on a paper RA are not used on the ERA. Because the EOB codes on the paper RA provide a greater level of detail on claim denials, all providers will continue to receive the paper version of the RA, even if they choose to receive the ERA transaction. The list is current as of the date of publication. Providers will be notified of changes to the list through the general Medicaid bulletin.

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

Attention: All Providers

CPT Code Update 2005

The Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA) have added new and deleted current CPT codes effective with date of service January 1, 2005. New CPT codes are covered by the N.C. Medicaid program effective with date of service January 1, 2005. Claims with codes deleted for 2005 will deny with dates of service on or after January 1, 2005. CMS has rescinded the 90-day grace period allowed for previous years.

The following table lists the new CPT codes that may be billed with date of service January 1, 2005:

00561	11004	11005	11006	11008	19296	19297	19298	31545	31546	31620
31636	31637	31638	32019	34803	36475	36476	36478	36479	36818	37215
37216	43644	45391	45392	46947	50391	57267	57283	58565	58956	63295
66711	76077	76510	78811	78812	78813	78814	78815	78816	79005	79101
79445	82045	82656	83009	84163	84166	86064	86335	86379	86587	88184
88185	88187	88188	88189	88360	88367	88368	91034	91037	91038	91040
91120	92620	92621	92625	93745	93890	93892	93893	95978	95979	97597

97598

The following table lists CPT codes that were **end-dated** effective December 31, 2004:

35161	35162	35582	50559	50578	50959	50978	52347	78810	78990	79000
79001	79020	79030	79035	79100	79400	79420	79900	88180	91032	91033
92589	97601	97780	97781							

The following table lists the new 2005 CPT codes that are **not covered pending further review**:

27412	27415	29866	29867	29868	32855	32856	33933	33944	44137	44715
44720	44721	47143	47144	47145	47146	47147	48551	48552	50323	50325
50327	50328	50329	58356	63050	63051	83630	87807	90465	90466	90467
90468	95298	95929								

The following table lists the new 2005 CPT codes that are **not covered**:

43257	43645	43845	52402	76820	76821	90656	91035	94452	94453	97605
97606	97810	97811	97813	97814						

The following table lists CPT codes that were previously non-covered services. These codes are **covered** services effective with date of service January 1, 2005:

20982	22532	22533	22534	36415	37765	37766	52327

Additional information will be published in future general Medicaid bulletins as necessary.

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

Attention: All Providers

Basic Medicaid Billing Seminar Schedule

Basic Medicaid Billing seminars are scheduled for February 2005. Seminars are intended for providers who are new to the NC Medicaid program. Topics to be discussed will include, but are not limited to, provider enrollment requirements, billing instructions, eligibility issues, and Managed Care. Persons inexperienced in billing N.C. Medicaid are encouraged to attend.

The seminars are scheduled at the locations listed below. **Preregistration 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.

Providers may register for the Basic Medicaid Billing seminars by completing and submitting the registration form available on the next page or by registering online. Please indicate the session you plan to attend on the registration form the session you plan to attend. 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 must print the PDF version of the Basic Medicaid Billing Guide formally known as General Medicaid Billing/Carolina ACCESS Policies and Procedure Guide May 2004 and bring it to the seminar. This guide will be available on DMA's website after January 31, 2005.

Wednesday, February 9, 2005
Greenville Hilton
207 SW Greenville Boulevard
Greenville, NC

Tuesday, February 15, 2005
Jane S. McKimmon Center
1101 Gorman Street
Raleigh, NC

Wednesday, February 16, 2005
Coast Line Convention Center
501 Nutt Street
Wilmington, NC

Wednesday, February 23, 2005
Blue Ridge Community College
Bo Thomas Auditorium
College Drive
Flat Rock, NC

Directions to the Basic Medicaid Billing Seminars

Greenville Hilton – Greenville, North Carolina
Take US 64 east to US 264 east. Follow 264 east to Greenville. Once you enter Greenville, turn right on 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 at 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 at the corner of Gorman Street and Western Boulevard.

Coast Line Convention Center – Wilmington, North Carolina
Take I-40 east to Wilmington. Take the US 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.

Blue Ridge Community College, Bo Thomas Auditorium – Flat Rock, North Carolina
Take I-40 to Asheville. Travel east on I-26 to exit 53, Upward Rd. Turn right and end of ramp. At second light, turn right onto S. Allen Drive. Turn left at sign onto College Drive. First building on right is the Sink Building. Bo Thomas Auditorium is on the left side of the Sink Building.

Return registration form to:

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

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

Attention: Licensed Psychologists, Licensed Clinical Social Workers, Certified Clinical Nurse Specialists in Psychiatric Mental Health Advanced Practice, Nurse Practitioners Certified as Clinical Nurse Specialists in Psychiatric Mental Health Advanced Practice, Licensed Psychological Associates, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Clinical Addictions Specialists, and Certified Clinical Supervisors

Seminar Schedule for the Expansion of Provider Types for Outpatient Behavioral Health Services

Seminars for the Expansion of Provider Types for Outpatient Behavioral Health Services are scheduled for January 2005. This seminar will focus on the expansion of access to services for Medicaid eligible recipients by increasing the provider community and the age group that they serve.

The seminars will begin at 9:00 a.m. and end at 12:00 p.m. Providers are encouraged to arrive by 8:30 a.m. to complete registration. Unregistered providers are welcome to attend if space is available. No food or drinks will be provided.

Providers may register for the seminars by completing and submitting the registration form below or by registering online.

The January 2005 Special Bulletin I, *Outpatient Behavioral Health Services Provided by Direct Enrolled Providers*, and the General Medicaid Billing/Carolina ACCESS Policies and Procedure Guide May 2004 will be used as the primary training document for the seminar. Please print **both** bulletins and bring them to the seminar.

Tuesday, January 11th, 2005
9:00 a.m. to 12:00 noon
Holiday Inn
1450 Tunnel Road,
Asheville, NC

Wednesday, January 12th, 2005
9:00 a.m. to 12:00 noon
Park Inn
Gateway Conference Center
909 Hwy 70 SW
Hickory, NC

Thursday, January 13th, 2005
9:00 a.m. to 12:00 noon
Greenville Hilton
207 Greenville Blvd., SW
Greenville, NC

Friday, January 14th, 2005
9:00 a.m. to 12:00 noon
Jane S. McKimmon Center
1101 Gorman Street
Raleigh, NC

Directions to Seminars the Expansion of Provider Types for Outpatient Behavioral Health Services

Holiday Inn Tunnel Road – Asheville, North Carolina

Traveling East on I-40
Take I-40 East to Exit 55 and turn left. At the light, turn right. HTL Drive is on the left.

Traveling West on I-40
Take I-40 West to Exit 55 and turn right. At the light, turn right. HTL Drive is on the left.

Park Inn Gateway Conference Center – Hickory, North Carolina

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

Greenville Hilton – Greenville, North Carolina

Take Highway 264 east to Greenville. Turn right onto Allen Road in Greenville. Travel approximately 2 miles. Allen Road becomes Greenville Boulevard/Alternate

264. Follow Greenville Boulevard for 2½ miles to the Hilton Greenville, which is located on the right.

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

Traveling West on I-40
Take I-40 West to Exit 295 and turn right onto Gorman Street. Travel approximately one mile. The McKimmon Center is located on the right at the corner of Gorman Street and Western Boulevard.

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

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

Attention: All Providers

Modifier Additions for 2005

The Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA) have added modifiers for 2005. At this time, the N.C .Medicaid program does not require providers to submit claims using these modifiers. Crossover claims will not deny if the modifiers are placed on the claim. However, straight Medicaid claims will deny if the modifiers are listed on the claim. Providers will be notified in a future general Medicaid bulletin if the use of these modifiers becomes a requirement for straight Medicaid claims.

CMS Modifiers

AE	AF	AG	AK	AR	CD	CE	CF
CG	KC	KD	KF	RD	SW	SY	

AMA Modifiers for Use with Laboratory Procedures

Neoplasia (solid tumor)

OA	OB	OC	OD	OE	OF	OG	OH
OI	OJ	OK	OL	OM	IZ		

Neoplasia (lymphoid/hematopetic)

2A	2B	2C	2D	2E	2F	2G	2H
2I	2J	2K	2Z				

Non-neoplastic hematology/coagulation

3A	3B	3C	3D	3E	3F	3G	3H
3I	3J	3Z					

Histocompatibility/blood typing

4A	4B	4C	4D	4E	4F	4G	4H
4Z							

Neurologic, non-neoplastic

5A	5B	5C	5D	5E	5F	5G	5H
5I	5J	5K	5L	5M	5N	5O	5Z

Muscular, non-neoplastic

6A	6B	6C	6D	6Z

Metabolic, other

7A	7B	7C	7D	7E	7Z

Metabolic, transport

8A	8Z

Metabolic-pharmacogenetics

9A	9L

Dysmorphology

9M 9N 9O 9P 9Q 9Z

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

Attention: All Providers

New Health Plan Announcement

The Division of Medical Assistance, (DMA) is working with Piedmont Behavioral Healthcare to implement a new health plan for public mental health, developmental disabilities, and substance abuse services, (MH/DD/SA) in their five county catchment area. The targeted effective date for the program to become operational is April 2005, the Approval from the Centers for Medicare and Medicaid Services (CMS) was received in October 2004, making this effective planning date possible.

The counties in which the program will operate are Cabarrus, Davidson, Rowan, Stanly and Union. Piedmont Behavioral Healthcare will function as a prepaid inpatient health plan (PHIP) managing and paying for all Medicaid MH/DD/SA services. This also includes the intermediate care facilities for the mentally retarded, (ICF-MR) care and inpatient psychiatric hospitalizations.

As a prepaid health plan, Piedmont Behavioral Healthcare will develop a comprehensive provider network by contracting with individual providers of MH/DD/SA services. The statewide Community Alternatives Program for Persons with Mental Retardation or Developmental Disabilities (CAP-MR/DD) will not operate in the Piedmont area. A program similar to CAP-MR/DD called Innovations will be a part of the Piedmont plan and will only be available to those Medicaid recipients in the five-county Piedmont catchment area.

When this plan goes into effect, Medicaid will not pay individual providers of MH/DD/SA services on a fee-for-service basis. Medicaid will pay Piedmont a monthly fee for all covered Medicaid populations in the catchment area and Piedmont will in turn pay individual providers for authorized services.

Note: Except for emergency services, all providers must obtain approval/authorization from Piedmont to qualify for reimbursement for MH/DD/SA services. In addition, Carolina ACCESS primary care providers will no longer provide referral authorization for these services.

Additional details and any changes to the anticipated implementation date will be provided in future general Medicaid bulletins. Information about provider training will be published in the February 2005 general Medicaid bulletin.

Marie Britt, RN,C Behavioral Health Section, Clinical Policy Section
DMA, 919-855-4290

Attention: All Providers

NCLeads Update

Information related to the implementation of the new Medicaid Management Information System, *NCLeads*, scheduled for implementation in mid 2006 can be found online at http://ncleads.dhhs.state.nc.us. Please refer to this website for information, updates, and contact information related to the *NCLeads* system.

Thomas Liverman, Provider Relations
Office of MMIS Services
919-647-8315

Attention: All Dental Providers Including Health Department Dental Clinics

ADA Code Updates

Effective with date of service January 1, 2005, the following dental procedure codes have been added for the N.C. Medicaid Dental Program. These additions are a result of the CDT (Current Dental Terminology) 2005 ADA code updates.

CDT 2005 Code	Description	Reimbursement Rate
D2932	Prefabricated resin crown • limited to recipients under age 21 • limited to primary and permanent anterior teeth	$181.77
D2934	Prefabricated esthetic coated stainless steel crown – primary tooth • limited to recipients under age 21	$163.01

	• limited to primary anterior teeth	
D7111	Extraction, coronal remnants – deciduous tooth	$45.99
D7283	Placement of device to facilitate eruption of impacted tooth	$35.00
	• report the surgical exposure separately using D7280 (surgical access of an unerupted tooth)	
D7288	Brush biopsy – transepithelial sample collection	$113.30
D7963	Frenuloplasty	$258.37
	• prior approval required	

The following procedure codes were end-dated effective with date of service December 31, 2004.

Procedure Code	Description
D2970	Temporary crown (fractured tooth)
D2933	Prefabricated stainless steel crown with resin window

The following procedure codes descriptions were revised effective with date of service January 1, 2005.

Procedure Code	Description
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant
D4341	Periodontal scaling and root planing – four or more teeth per quadrant
D7286	Biopsy of oral tissue - soft
D7490	Radical resection of maxilla or mandible
D7955	Repair of maxillofacial soft and/or hard tissue defect

With the addition of procedure code D7283 (placement of device to facilitate eruption of impacted tooth), reimbursement for procedure code D7280 (surgical access of an unerupted tooth) has been revised to pay for the surgical exposure only. Effective January 1, 2005, procedure code D7280 reimburses $165.00.

In addition, procedure code D2931 (prefabricated stainless steel crown – permanent tooth) is now allowed for premolars and first and second molars for recipients under age 21 effective with date of service January 1, 2005.

Providers are reminded to bill their usual and customary charges rather than the Medicaid rate. For coverage criteria and additional billing guidelines, please refer to Clinical Coverage Policy 4A, Dental Services.

Darlene Baker, Dental Policy Analyst
DMA, 919-855-4280

Attention: Dental Providers (Including Health Department Dental Clinics)

2002 American Dental Association (ADA) Claim Form

The Division of Medical Assistance (DMA) and EDS have updated the Medicaid claims processing system to accept the 2002 ADA claim form. Providers were given a three-month transition period, October 1, 2004 through December 31, 2004, that both the 1999 and 2002 forms were accepted. Effective January 1, 2005, only the 2002 ADA claim form is accepted. Claim forms can be ordered directly from the ADA. Listed below are the web address, toll-free telephone number, and mailing address.

1-800-947-4746

American Dental Association
Attn: Salable Materials Office
211 E. Chicago Avenue
Chicago, IL 60611

The claim form is available as a single or two-part form. The single form must be used when submitting claims for payment. The two-part form must be used when requesting prior approval. The original is returned to the provider and serves as the prior approval/claim copy. The second page is retained by EDS.

For specific information regarding required fields for prior approval requests or claims for payment, refer to Clinical Policy #4A, Dental Services, which has been updated to include the 2002 ADA claim form.

Quadrant and Arch Indicators Entered on the 2002 ADA Claim Form

During the three month transition period, October 1, 2004 through December 31, 2004, DMA received a request from the provider community to allow the quadrant or arch indicator to be entered in field 25 (Area of Oral Cavity). As a result of this request, procedures that require a quadrant or arch indicator can be entered in Field 25

(Area of Oral Cavity) or Field 27 (Tooth Number(s) or Letter(s)) effective January 1, 2005. For specific information regarding procedure codes that require a quadrant or arch indicator, refer to Clinical Policy #4A, Dental Services.

Darlene Baker, Dental Policy Analyst
DMA, 919-855-4282

Attention: Personal Care Services Providers

Handling PCS-Plus Transfers

During the past year of PCS-Plus implementation, DMA has received numerous questions from PCS providers on how to handle PCS-Plus clients who transfer from one agency to another. In these situations, **DMA requires the PCS provider to submit a new PCS-Plus Request form for the PCS-Plus client who transfers to the agency** even though the client already had PCS-Plus approval with the previous agency. DMA will issue PCS-Plus prior approval for the client at the new agency, if the client meets PCS-Plus criteria.

PCS-Plus approvals are not transferable between agencies since all PCS-Plus prior approvals are linked to an individual Medicaid recipient and an agency-specific PCS provider number. The agency should treat the PCS-Plus client as a new referral by completing a new DMA-3000 and submitting a new PCS-Plus Request Form to DMA for prior approval. If an agency does not submit a new PCS-Plus Request form for a client who had PCS-Plus prior approval with another agency, the agency accepting the transfer will not be reimbursed for PCS-Plus services if they provide PCS-Plus. In this case, the PCS-Plus claim will be denied by EDS. To prevent this from occurring, the agency must obtain PCS-Plus prior approval from DMA before initiating PCS-Plus services. However, the agency can initiate regular PCS according to Medicaid guidelines.

Also, DMA requests that PCS providers notify DMA PCS-Plus staff via fax at (919) 715-2628 when a PCS-Plus client transfers from one agency to another. The fax coversheet should list the following:

1. Client first and last name
2. Client Medicaid Identification number
3. The name of the previous agency
4. The last date of service with the previous agency
5. The name of the new agency

6. The new date of service with the new agency
7. If you are requesting prior approval for PCS-Plus, include the PCS-Plus Request form with the fax.

If DMA does not receive this information, then the new PCS provider may experience delayed Medicaid payments for the client due to problems with the client's PCS-Plus prior approval.

David Hose, Facility and Community Care
DMA, 919 855-4369

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ttention: Personal Care Services (PCS) Providers

PCS Program Violations Subject to Recoupment

Recent DMA Program Integrity reviews have identified problems regarding the provision and billing of Medicaid Personal Care Services (PCS) for pediatric recipients. Based on medical records reviews and recipient home visits, a significant number of the pediatric recipients did not appear to meet the criteria for PCS coverage. When providing PCS to children, providers must follow Medicaid policies regarding medical necessity criteria and provision of services. Guidance on this subject is located in Chapter 6 (Personal Care Services) of the DMA Community Care Manual.

PCS provided to pediatric recipients must be needed due to the child's medical condition. In addition, the amount of time allocated to provide the services and the time of day the services are provided should be appropriate to meet the identified medically related unmet or inadequately met personal care needs.

Example: PCS can be appropriate to consider when a parent or guardian needs assistance in the morning with getting a severely mobility-impaired child ready for school. Normal self care tasks performed for young children ordinarily do not require the specialized care of a PCS aide. The PCS provider must differentiate medically based personal care needs from the parental caregiving responsibility.

Developmentally appropriate care tasks such as bathing and dressing a small child, supervision and occasional assistance with grooming and hygiene for a school age child, or diapering an infant are not covered under PCS. In addition, tasks such as tutoring and assistance with homework, basic after-school supervision, and transportation to and from school activities are not covered in the PCS program.

For pediatric recipients with Attention Deficit Hyperactivity Disorder (ADHD) or attention deficit disorder (ADD), PCS is not covered unless the medical condition prevents the patient from performing personal care tasks at an age-appropriate level.

Payments to PCS providers for services provided to children or adolescents whom Program Integrity determines did not meet the criteria for coverage will be recouped.

Carol Putnam, Home Care Review Section, Program Integrity
DMA, 919 647-8000

Attention: All Physicians, Chiropractors, Dentists, Osteopaths, Optometrists and Podiatrists

Provider Enrollment, Billing, and Coverage Information

Effective January 1, 2005, Medicaid provider enrollment of all instate and border area physician types will be handled by the N.C. Division of Medical Assistance (DMA). The Medicaid Provider Enrollment Application and Agreement for new enrollment is available on DMA's website.

Below is a list of important information for new providers:

Provider Enrollment Questions: Providers may contact DMA Provider Services at (919)855-4050 with questions about Medicaid enrollment

Carolina ACCESS: Providers who are interested in becoming a Carolina ACCESS PCP must also complete a Carolina ACCESS PCP Application for Participation. This is a separate application and may be found on DMA's website.

Billing and Program Information: The *General Medicaid Billing/Carolina ACCESS Policies and Procedures Guide* is available on DMA's website. This document provides an overview of the Medicaid program including claims filing instructions, eligibility verification, Managed Care, third party liability, prior approval requirements, contact information, etc.

Medicaid Bulletins: The monthly Medicaid bulletin is the primary method of notification to providers regarding changes in billing procedures and covered services. Information on provider seminars is also published in the bulletin. The Medicaid bulletin is available on DMA's Bulletin web page.

Clinical Coverage Policies: Clinical coverage and program information is available on DMA's Clinical Coverage Policies and Provider Manuals web page.

Change of Address or Status: To ensure prompt receipt of payments, providers must notify DMA immediately of address or status changes such as providers leaving or joining a group. For your protection, we will not forward your checks to an address that we do not have on file. To report changes in address and status complete the Medicaid Provider Change Form.

Carolina ACCESS: Carolina ACCESS providers must also complete the Carolina ACCESS Provider Information Change Form. For questions regarding this information you may contact DMA Provider Services at (919)855-4050.

Medicare Part B Crossovers: To allow Medicare Part B claims to cross over automatically to Medicaid for payment, providers must complete a Medicare Crossover Reference Request form. This form is located on page 20 of the August 2004 Medicare Part B Special Bulletin V on our Provider Forms web page. Contact EDS Provider Services at 1-800-688-6696 or (919)851-8888 with questions about Medicare Part B crossover claims.

Electronic Funds Transfer (EFT): EDS offers EFT as an alternative to paper checks. This service enables Medicaid payments to be automatically deposited into the provider's bank account. The EFT form is available on DMA's Provider Forms web page.

Electronic Claims Submission (ECS): ECS allows you to bill Medicaid claims electronically. Providers must complete an ECS Provider Agreement prior to submitting claims electronically. Providers are required to use software that complies with the transaction standards mandated by the Health Insurance Portability and Accountability Act (HIPAA). Contact EDS at 1-800-688-6696 or (919)851-8888 (option 1 from the menu) for additional information.

Additional information is available on DMA's Provider web page such as forms, checkwrite schedules, contact information etc.

Provider Services
DMA, 919-855-4050

Attention: Ambulatory Surgical Centers

CPT Code Update 2005 for Ambulatory Surgical Centers

Effective with date of service **January 1, 2005,** Ambulatory Surgical Centers may no longer receive reimbursement when billing the CPT codes listed in the table below. Claims submitted with deleted codes for dates of service on or after January 1, 2005 will deny.

CPT code	Description
50559	Renal endoscopy with insertion of radioactive substance
50978	Ureteral endoscopy with insertion of radioactive substance
50959	Ureteral endoscopy with insertion of radioactive substance

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

Attention: Durable Medical Equipment Providers

HCPCS Code Conversions for Orthotic Devices

In order to comply with the Centers for Medicare and Medicaid Services (CMS) HCPCS coding changes, the following code conversions are effective with date of service January 1, 2005.

Old Code	New Code	Description	Maximum Reimbursement Rate
L0500	K0634	Lumbar orthosis, flexible, provides lumbar support, posterior extends from L1 to below L5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include pendulous abdomen design, shoulder straps, stays, prefabricated, includes fitting and adjustment	$44.60
	K0637	Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, pendulous abdomen design, prefabricated, includes fitting and adjustment	67.89
L0510	K0638*	Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs,	212.13

		includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, custom fabricated.	
L0515	K0635	Lumbar orthosis, sagittal control, with rigid posterior panel(s), posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment.	63.10
	K0639	Lumbar-sacral orthosis, sagittal control, with rigid posterior panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment	131.07
L0520	K0642*	Lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panel, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment.	232.10
	K0643*	Lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, custom fabricated.	311.22
L5300	L5301*	Below knee, molded socket, shin, SACH foot, endoskeletal system.	2205.98
	L5704	Custom shaped protective cover, below knee.	429.86
L5310	L5311*	Knee disarticulation (or through knee), molded socket, external knee joints, shin, SACH foot, endoskeletal system.	3157.72
	L5706	Custom shaped protective cover, knee disarticulation.	752.93
L5320	L5321*	Above knee, molded socket, open end, SACH foot, endoskeletal system, single axis knee.	3197.63
	L5705	Custom shaped protective cover, above knee	768.08

L5330	L5331*	Hip disarticulation (or through knee), molded socket, external knee joints, shin, SACH foot, endoskeletal system.	4074.43
	L5707	Custom shaped protective cover, hip disarticulation.	992.63
L5340	L5341*	Hemipelvectomy, Canadian type, molded socket, endoskeletal system, hip joint, single axis knee, SACH foot.	4241.50
	L5707	Custom shaped protective cover, hip disarticulation	992.63

Also in compliance with CMS, the descriptions have changed for the following codes effective with date of service January 1, 2005.

HCPCS Code	Description
L0430*	Spinal orthosis, anterior-posterior-lateral control, with interface material, custom fitted (Dewall posture protector only)
L1820	Knee orthosis, elastic with condylar pads and joints, with or without patellar control, prefabricated, includes fitting and adjustment
L2036*	Knee ankle foot orthosis, full plastic, double upright, free knee, with or without free motion ankle, custom fabricated
L2037*	Knee ankle foot orthosis, full plastic, single upright, free knee, with or without free motion ankle, custom fabricated
L2038*	Knee ankle foot orthosis, full plastic, without knee joint, multi-axis ankle, custom fabricated
L2320*	Addition to lower extremity, non-molded lacer, for custom fabricated orthosis only
L2330*	Addition to lower extremity, lacer molded to patient model, for custom fabricated orthosis only
L2800*	Addition to lower extremity orthosis, knee control, knee cap medial or lateral pull, for use with custom fabricated orthosis only
L4040*	Replace molded thigh lacer, for custom fabricated orthosis only
L4045	Replace non-molded thigh lacer, for custom fabricated orthosis only
L4050*	Replace molded calf lacer, for custom fabricated orthosis only
L4055	Replace non-molded calf lacer, for custom fabricated orthosis only
L6890*	Addition to upper extremity prosthesis, glove for terminal device, any material, prefabricated, includes fitting and adjustment
L6895*	Addition to upper extremity prosthesis, glove for terminal device, any material, custom fabricated

Note: HCPCS codes with an asterisk require prior approval.

The coverage criteria for these items have not changed. A Certificate of Medical Necessity and Prior Approval form must be completed for all items regardless of the

requirement for prior approval. Providers are reminded that these are maximum reimbursement rates. Rates have not changed for codes with only description revisions. You must bill your usual and customary rate for all DME. Refer to Clinical Coverage Policy #5, Durable Medical Equipment, Section 8.0 Billing for detailed billing guidelines.

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

Attention: UB-92 Billers

Maximum Number of Lines per Claim for Paper Submission of UB92's

The maximum number of lines that maybe processed on a UB-92 paper claim is 28 details, including the total. Outpatient UB-92 claims that require more than 28 details can be filed using the 837-I transaction set or the NCECS Web tool. If the outpatient claim is filed on a paper UB-92 claim form, providers should bill multiple claims with no more than 28 details on each claim. If Medicare or commercial insurance pays as the primary insurance, the Medicare and/or commercial insurance payment should be divided up between the claims.

Inpatient UB-92 claims that require more than 28 details can be filed using the 837-I transaction set or the NCECS Web tool or submitted on paper to EDS Providers Services with a Medicaid Resolution Inquiry.

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

Attention: Physicians, Nurse Practitioners

Abarelix, 100 mg (Plenaxis, J9999) - Billing Guidelines

Effective with date of service May 1, 2004, the N.C. Medicaid program covers abarelix, 100 mg (Plenaxis) for use in the Physician's Drug Program. The FDA indication for Plenaxis is the treatment of advanced prostate cancer. The FDA's recommended dosing schedule is 100 mg administered intramuscularly on day 1, 15, 29, and every 4 weeks thereafter. Treatment failure can be detected by measuring serum testosterone concentrations just prior to Plenaxis administration beginning on day 29 and every 8 weeks thereafter.

The ICD-9-CM diagnosis codes required when billing for Plenaxis are:

- **V58.1 – admission or encounter for chemotherapy**

AND

- **185 – Malignant Neoplasm of Prostate - Diagnosis code**

Providers must bill J9999, the unclassified drug code for antineoplastic agents, with an invoice attached to the CMS-1500 claim form. **An invoice must be submitted with each claim.** The paper invoice must indicate the recipient's name and Medicaid identification number, the name of the medication, the dosage given, the National Drug Code (NDC) number from the vial(s) used, the number of vials used, and the cost per dose. Providers must indicate the number of units given in block 24G on the CMS-1500 claim form. For Medicaid billing, one unit of coverage is 100 mg. The maximum reimbursement rate per unit is $885.38. Providers must bill their usual and customary charge. Add this drug to the list of injectable drugs published in the November 2004 general Medicaid bulletin.

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

Attention: Physicians and Nurse Practitioners

Pemetrexed (Alimta, J9999) - Billing Guidelines

Effective with date of service March 1, 2004, the N.C. Medicaid program covers pemetrexed (Alimta) for use in the Physician's Drug Program. Alimta is an antifolate antineoplactic agent. The FDA states that, in combination with cisplatin, it is indicated for the first-line treatment of patients with malignant pleural mesothelioma, whose disease is either unresectable or who are otherwise not candidates for curative surgery. The FDA indicates that the usual adult dose is 500 mg/m2 infused over 10 minutes on day 1 of each 21-day cycle.

The ICD-9-CM diagnosis codes required when billing for Alimta are:

- **V58.1 – admission or encounter for chemotherapy**

AND

- **162.0 – 162.9 – Malignant neoplasm or trachea, bronchus and lung, OR**
- **163.0 – 163.8 – Malignant neoplasm of pleura**

Providers must bill J9999, the unclassified drug code for antineoplastic agents, with an invoice attached to the CMS-1500 claim form. **An invoice must be submitted with each claim.** The paper invoice must indicate the recipient's name and Medicaid identification number, the name of the medication, the dosage given, the National Drug Code (NDC) number from the vial(s) used, the number of vials used, and the cost per dose. Providers must indicate the number of units given in block 24G on the CMS-1500 claim form. For Medicaid billing, one unit of coverage is 500 mg. The maximum reimbursement rate per unit is $2071.88. Providers must bill their usual and customary charge. Add this drug to the list of injectable drugs published in the November 2004 general Medicaid bulletin.

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

Attention: Independent Practitioners and Local Education Agencies

Code Changes

The following CPT procedure codes were changed effective with date of service January 1, 2005. Claims submitted with end-dated codes for dates of service after January 1, 2005 and after will deny.

End-Dated Code	New CPT Code	Description	Maximum Reimbursement Rate
92589	92620	Evaluation of central auditory function, with report; initial 60 minutes	$39.35
	92621	Evaluation of central auditory function, with report; each additional 15 minutes	$9.71

Note: CPT code 92621 cannot be billed separately; it must be billed in addition to 92620.

In addition to these changes, CPT procedure 97601 was end-dated on December 31, 2004. To bill for the removal of devitalized tissue, etc., providers must use code 97602.

Refer to Clinical Coverage Policy #10B, Independent Practitioners, and #10C, Local Education Agencies.

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

Attention: All Providers

2005 Revised Fees

Effective January 1, 2005, rates for the 2005 CPT codes were revised based on information from the Centers for Medicare and Medicaid Services (CMS) received as of December 17, 2004.

To allow for possible price changes, we suggest holding the January 2005 claims until January 15th, 2005, since systematic adjustments will NOT be made for claims that have processed for dates of service prior to final CMS corrections.

Providers may receive a current fee schedule by completing and submitting a copy of the Fee Schedule Request form as of February 1, 2005.

Providers must bill their usual and customary charges.

Aydlett Hunike, Financial Management
DMA, 919-855-4180

Proposed Clinical Coverage Policies

In accordance with Session Law 2003-284, proposed new or amended Medicaid clinical coverage policies are available for review and comment on DMA's website. 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.

Gina Rutherford
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.

Holiday Closing

The Division of Medical Assistance (DMA) and EDS will be closed on Friday, December 31, 2004 in observance of New Year's Day, and on Monday, January 17, 2005 in observance of Dr. Martin Luther King's birthday.

Checkwrite Schedule

January 6, 2005	February 8, 2005
January 11, 2005	February 15, 2005
January 19, 2005	February 24, 2005
January 27, 2005	March 8, 2005

Electronic Cut-Off Schedule

December 30, 2004	February 4, 2005
January 7, 2005	February 11, 2005
January 14, 2005	February 18, 2005
January 21, 2005	March 4, 2005

2005 Checkwrite Schedule

_____	_____
Gary H. Fuquay, Director	Cheryll Collier
Division of Medical Assitance	Executive Director
Department of Health and Human Services	EDS

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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.