Attention: Mecklenburg County Providers

Health Maintenance Organization Update

Effective October 1, 2001, The Wellness Plan of North Carolina, Inc. is no longer serving as a Health Maintenance Organization (HMO) to Medicaid recipients in Mecklenburg County.

Southcare/Coventry Health Care of the Carolinas, Inc. and United HealthCare of North Carolina, Inc. will remain as HMO providers in this county. Additionally, Metrolina (formerly C.W. Williams), a Federally Qualified Health Center (FQHC), will remain as another Medicaid option in Mecklenburg County.

Julia McCollum, Managed Care Section
DMA, 919-857-4022

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

Changes to Copayment for Brand Name Medicines

Effective October 1, 2001, there is a change for Medicaid recipients required to pay copayments for prescriptions. The copayment for **brand name drugs** is now $3.00. Copayment for **generic drugs** remains at $1.00.

Denise Rogers, Recipient and Provider Services
DMA, 919-857-4019

Attention: Emergency Department Physicians

After-Hours, Weekend Visits, and On-Call Services

The N.C. Medicaid program does not allow separate reimbursement for CPT procedure codes 99050, 99052, 99054, and 99058 for services provided in an emergency department. Medicaid defines normal hours as those hours when the emergency department is routinely open. Emergency rooms are open and services are available to recipients 24 hours a day, 7 days a week. The following CPT procedure codes must not be billed:

- **99050** Services requested after office hours in addition to basic service
- **99052** Services requested between 10:00 p.m. and 8:00 a.m. in addition to basic services
- **99054** Services requested on Sundays and holidays in addition to basic service
- **99058** Office services provided on an emergency basis

EDS, 1-800-688-6696 or 919-851-8888
Attention: Anesthesiologists, Certified Registered Nurse Anesthetists, Hospitals

Separate Billing for Supervision of Certified Registered Nurse Anesthesiologists

The N.C. Medicaid program does not reimburse supervision of Certified Registered Nurse Anesthetists (CRNA) as a separate service. This policy applies to all CRNAs whether they are enrolled as:

- independent providers, or
- employed by a hospital, or
- employed through a physician’s office.

When a CRNA is employed by an anesthesiologist, the CRNA services are incident to the physician and should be billed under the physician provider number. No supervisory fee can be billed. When a CRNA is employed by the hospital, the CRNA services should be billed on the HCFA-1500 claim form using the hospital's professional number. No supervisory fee can be billed. There is also no supervisory fee should a physician supervise a CRNA by phone after normal business hours.

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

Attention: Physicians and Other Practitioners

Medicaid Fee Schedule

Effective with date of service September 1, 2001, the North Carolina Medicaid Fee Schedule shall be based on ninety-five percent (95%) of the Medicare Fee Schedule Resource Based Relative Value System (RBRVS) in effect on the date of service.

EDS, 1-800-688-6696 or 919-851-8888
Attention: All Providers

Fee Schedules and Reimbursement Plans

Fee Schedule Request Form
There is no charge for fee schedules or reimbursement plans requested from the Division of Medical Assistance (DMA). However, all requests for publications must be made on the Fee Schedule Request form and mailed to:

Division of Medical Assistance
Financial Operations – Fee Schedules
2509 Mail Service Center
Raleigh, NC  27699-2509

Or, fax your request to DMA’s Financial Operations section at 919-715-0896.

NOTE: PHONE REQUESTS ARE NOT ACCEPTED

Advanced Practice Psychiatric Clinical Nurse Specialist  
Advanced Practice Psychiatric Nurse Practitioner  
After Care Surgery Period  
Ambulatory Surgery Center  
Anesthesia Base Units  
Community Alternatives Program  
Dental  
Durable Medical Equipment  
Health Department  
Home Health  
Home Infusion Therapy  
Hospital Reimbursement Plan  
ICF/MR Reimbursement Plan  
Laboratory  
Licensed Clinical Social Worker  
Licensed Psychologist  
Nurse Midwife  
Nursing Facility Reimbursement Plan  
Optical and Visual Aids  
Orthotics and Prosthetics  
Physician Fees (includes x-ray)  
Portable X-ray

Requestor: ___________________________ Provider Type: ___________________________
Address: ________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Technical Contact: ______________________ Phone: ____________________________
**Request for Diskettes**

Some fee schedules, the after-care surgery schedule, and the anesthesia base units schedule are also available on diskette or by e-mail. **NOTE:** To reduce costs, where available, schedules will be sent by e-mail.

DMA stipulates that the information provided is to be used only for internal analysis. **Providers are expected to bill their usual and customary rate.**

Please complete the information below with each request:

Requestor: __________________________  E-mail Address: __________________________
Address: __________________________________________________________________________

Phone: ________________________________

**Type of File (circle one):**

- Text File
- Excel Spreadsheet
- E-mail
- Diskette

**Format (circle one):**

- Text File
- Excel Spreadsheet
- E-mail
- Diskette

**Type of Schedule (check):**

- Advanced Practice Psychiatric Clinical Nurse Specialist
- Advanced Practice Psychiatric Nurse Practitioner
- After Care Surgery Period
- Ambulatory Surgery Center
- Anesthesia Base Units
- Dental
- Health Department
- Laboratory
- Licensed Clinical Social Worker
- Licensed Psychologist
- Nurse Midwife
- Optical and Visual Aids
- Physician Fees (includes x-ray)
- Portable X-ray

Mail the request to:

Division of Medical Assistance
Financial Operations – Fee Schedules
2509 Mail Service Center
Raleigh, NC 27699-2509

Or, fax your request to DMA’s Financial Operations section at 919-715-0896.
Attention: All Providers

Circumcision Policy for Newborns

Effective with date of service November 1, 2001, the N.C. Medicaid program will no longer cover routine newborn circumcisions. Medically necessary circumcisions will continue to be covered for all male recipients.

The American Academy of Pediatrics (AAP) policy on circumcision states that the benefits are not significant enough for the AAP to recommend circumcision as a routine procedure.

Physicians who perform routine circumcisions must follow the guidelines set forth in the North Carolina Administrative Code at 10 NCAC 26K.0106 concerning billing recipients for this noncovered service. Medicaid must not be billed for noncovered services.

Hospital claims must list all expenses related to routine newborn circumcisions as noncovered services and must not bill the family.

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

Attention: All Providers

Billing Nerve Conduction Studies

The N.C. Medicaid program reimburses for nerve conduction studies when they are medically necessary. Current procedural terminology codes 95900, 95903, and 95904 refer to testing performed using standard electro-diagnostic equipment. These devices must be capable of recording amplitude, duration, and response configuration as well as latency and sensory nerve action potential amplitude. Reimbursement for examinations using portable hand-held devices is included in the office visit and cannot be billed separately.

Procedure codes 95900 and 95903 cannot be billed for testing of the same nerve on the same day. Procedure code 95903 with F-wave study includes the services of a test without F-wave study. When one nerve is tested without F-wave study and a different nerve is tested with an F-wave study, bill both 95900 and 95903.

One unit of service represents all studies performed on a single nerve, including latency, velocity, amplitude, and response with antidromic or orthodromic stimulation. The medical record must clearly document the medical necessity and identify each type of test performed.

The clinical efficacy and applicability of Current Perception Threshold testing in diagnosing or managing a disease has not been established. Therefore, Current Perception Threshold testing is not covered by Medicaid and will not be reimbursed.

EDS, 1-800-688-6696 or 1-919-851-8888
Attention: All Providers

Response Time for Provider Inquiries

Due to budget constraints for the July 2001/2002 fiscal year, the Division of Medical Assistance (DMA) is experiencing a shortage in staff. As a result, providers may experience delays when contacting DMA with issues that require a response. DMA appreciates your patience and understanding during this temporary inconvenience.

To ensure that issues are handled effectively when calling Medicaid, refer to the following list for the contact source and telephone number related to your question.

**Phone Numbers**

<table>
<thead>
<tr>
<th>Topic/Reason For Call</th>
<th>Call</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident Related Issues</td>
<td>DMA Third Party Recovery</td>
<td>1-919-733-6294</td>
</tr>
<tr>
<td>Advance Directives</td>
<td>DMA Medical Policy Section</td>
<td>1-919-857-4020</td>
</tr>
<tr>
<td>Automatic Deposits</td>
<td>EDS Finance Unit</td>
<td>1-800-688-6696 or 1-919-851-8888</td>
</tr>
<tr>
<td>Baby Love</td>
<td>DMA Baby Love Coordinator</td>
<td>1-919-857-4020</td>
</tr>
<tr>
<td>Billing Issues</td>
<td>EDS Provider Services</td>
<td>1-800-688-6696 or 1-919-851-8888</td>
</tr>
<tr>
<td>CAP Retroactive Requests</td>
<td>DMA Community Care</td>
<td>1-919-857-4021</td>
</tr>
<tr>
<td>Carolina ACCESS Enrollment Verification</td>
<td>AVR System</td>
<td>1-800-723-4337</td>
</tr>
<tr>
<td>Carolina ACCESS (Other than Denials)</td>
<td>DMA Managed Care Section</td>
<td>1-919-857-4022</td>
</tr>
<tr>
<td>ACCESS II Information</td>
<td>ACCESS II</td>
<td>1-919-715-7625</td>
</tr>
<tr>
<td>Carolina ACCESS Denials</td>
<td>EDS Provider Services</td>
<td>1-800-688-6696 or 1-919-851-8888</td>
</tr>
<tr>
<td>Checkwrite Information</td>
<td>AVR System</td>
<td>1-800-723-4337</td>
</tr>
<tr>
<td>Claims Status</td>
<td>AVR System</td>
<td>1-800-723-4337</td>
</tr>
<tr>
<td>Coverage Issues</td>
<td>EDS Provider Services</td>
<td>1-800-688-6696 or 1-919-851-8888</td>
</tr>
<tr>
<td>Denials (Other than Eligibility Denials)</td>
<td>EDS Provider Services</td>
<td>1-800-688-6696 or 1-919-851-8888</td>
</tr>
<tr>
<td>Drug Utilization Review</td>
<td>DMA Program Integrity</td>
<td>1-919-733-3590</td>
</tr>
<tr>
<td>Electronic Data Interchange (EDI)</td>
<td>EDS</td>
<td>1-800-688-6696 or 1-919-851-8888</td>
</tr>
<tr>
<td>Eligibility Information, Current Day</td>
<td>AVR System</td>
<td>1-800-723-4337</td>
</tr>
<tr>
<td>Eligibility Information, Date of Service over 12 Months</td>
<td>DMA Claims Unit</td>
<td>1-919-857-4018</td>
</tr>
<tr>
<td>Electronic Claims Submission</td>
<td>EDS Electronic Commerce Services (ECS) Unit</td>
<td>1-800-688-6696 or 1-919-851-8888</td>
</tr>
<tr>
<td>Eligibility Denials</td>
<td>DMA Claims Analysis</td>
<td>1-919-857-4018</td>
</tr>
<tr>
<td>Fee Schedules</td>
<td>DMA Financial Operations</td>
<td>1-919-857-4015</td>
</tr>
<tr>
<td>Forms (Information and Orders)</td>
<td>EDS Provider Services</td>
<td>1-800-688-6696</td>
</tr>
<tr>
<td>Fraud and Program Abuse</td>
<td>DMA Program Integrity</td>
<td>1-919-733-6681</td>
</tr>
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### Phone Numbers, continued

<table>
<thead>
<tr>
<th>Topic/Reason For Call</th>
<th>Call</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Connection (Mecklenburg County Managed Care)</td>
<td>DMA Managed Care Section</td>
<td>1-919-857-4022</td>
</tr>
<tr>
<td>Health Care Connection, Local</td>
<td>Health Benefits Advisors</td>
<td>1-704-373-2273</td>
</tr>
<tr>
<td>Health Check</td>
<td>DMA Managed Care Section</td>
<td>1-919-857-4022</td>
</tr>
<tr>
<td>Health Insurance Payment Program (HIPP)</td>
<td>DMA Third Party Recovery</td>
<td>1-919-733-6294</td>
</tr>
<tr>
<td>HMO Risk Contracting, including Health Care Connection</td>
<td>DMA Managed Care Section</td>
<td>1-919-857-4022</td>
</tr>
<tr>
<td>HMO Enrollment Verification</td>
<td>AVR System</td>
<td>1-800-723-4337</td>
</tr>
<tr>
<td>Medical Policy Questions</td>
<td>EDS Provider Services</td>
<td>1-800-688-6696 or 1-919-851-8888</td>
</tr>
<tr>
<td>Medicare Crossovers</td>
<td>EDS Provider Enrollment</td>
<td>1-800-688-6696 or 1-919-851-8888</td>
</tr>
<tr>
<td>Preadmission Screening and Annual Resident Review (PASARR)</td>
<td>First Health of Tennessee (FH)</td>
<td>1-800-639-6514</td>
</tr>
<tr>
<td>Preadmission Review for Inpatient Psychiatric Admissions</td>
<td>First Health of Tennessee (FH)</td>
<td>1-800-770-3084</td>
</tr>
<tr>
<td>Prior Approval</td>
<td>EDS Prior Approval Unit</td>
<td>1-800-688-6696 or 1-919-851-8888</td>
</tr>
<tr>
<td>Private Insurance (Denials)</td>
<td>DMA Third Party Recovery</td>
<td>1-919-733-6294</td>
</tr>
<tr>
<td>Procedure Code Pricing</td>
<td>AVR System</td>
<td>1-800-723-4337</td>
</tr>
<tr>
<td>Provider Enrollment – Managed Care</td>
<td>DMA Managed Care Section</td>
<td>1-919-857-4022</td>
</tr>
<tr>
<td>Provider Enrollment – MQB</td>
<td>EDS Provider Enrollment</td>
<td>1-800-688-6696 or 919-851-8888</td>
</tr>
<tr>
<td>Provider Enrollment – All Other Providers</td>
<td>DMA Provider Services</td>
<td>1-919-857-4017</td>
</tr>
<tr>
<td>Rate Setting and Reimbursement</td>
<td>DMA Financial Operations</td>
<td>1-919-857-4015</td>
</tr>
<tr>
<td>Recipient Questions (Number for recipients to call)</td>
<td>DHHS Care Line</td>
<td>1-800-662-7030</td>
</tr>
<tr>
<td>Third Party Insurance Code Book</td>
<td>DMA Third Party Recovery Section</td>
<td>1-919-733-6294</td>
</tr>
<tr>
<td></td>
<td>Fax: 1-919-715-4725</td>
<td></td>
</tr>
</tbody>
</table>

The Automated Voice Response (AVR) system (1-800-723-4337) can be used to inquire about:

<table>
<thead>
<tr>
<th>Recipient Eligibility</th>
<th>Hospice Participation</th>
<th>Hysterectomy Statement Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed Care Enrollment</td>
<td>Drug Coverage Information</td>
<td>Sterilization Consent Status</td>
</tr>
<tr>
<td>Prior Approval Information</td>
<td>Dental Benefit Limitations</td>
<td>Claim Status</td>
</tr>
<tr>
<td>Procedure Code Pricing</td>
<td>Refraction Benefit Limitations</td>
<td>Checkwrite Information</td>
</tr>
<tr>
<td>Modifier Information</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The Automated Attendant telephone line (1-800-688-6696 or 919-851-8888) can be used to access the EDS Provider Services unit, Prior Approval unit or the Electronic Commerce Services (ECS) unit.

<table>
<thead>
<tr>
<th>For Electronic Commerce Services “Press 1”</th>
<th>For Prior Approval “Press 2”</th>
<th>For Provider Services Press 3”</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you select ECS from the main menu, you will be prompted to: “Press 1 to reach an ECS Analyst”</td>
<td>If you select Prior Approval from the main menu, you will be prompted to: “Press 2 for Optical or Hearing Aid” “Press 3 for Long-Term Care, Surgery or Out-of-State” (Includes Psychiatric and Ambulance services) “Press 4 for Dental” “Press 5 for DME” “Press 9 for Enhanced Care, Therapeutic Leave or Hospice” (Includes High Risk Intervention providers)</td>
<td>If you select Provider Services from the main menu, you will be prompted to: “Press 6 if you are calling from a Physician’s Office or a County Health Department” (Includes Health Check, Eye Care, Chiropractor, Ambulatory Surgery, IP, Nurse Midwife, Nurse Practitioner, Radiologist, Podiatrist, Health-Related Services in Public Schools Providers, CRNA, Independent Diagnostic Testing Facilities, Independent Mental Health, and Anesthesiology providers) “Press 7 if you are calling from a Hospital or a Long-Term Care Facility” (Includes Mental Health, Psychiatric Residential Treatment Facilities Level II – IV, Hearing Aid, and Dialysis providers) “Press 8 if you are a Pharmacy, Dental, Health Care, Personal Care, DME or Domiciliary Care Facility” (Includes Ambulance, CAP, DSS/DHS, Hospice, Home Infusion Therapy, Private Duty Nursing, Rural Health, FQHC, Adult Care Homes, At-Risk Case Management, and HIV Case Management providers)</td>
</tr>
</tbody>
</table>

“For operator-assisted calls - stay on the line”

Once you select the appropriate unit, you will be connected to an individual to handle your call or placed in a queue for the first available agent. All calls placed in a queue are handled in the order in which they are received.
To ensure that correspondence and documents are processed in a timely manner, refer to the following list of mailing addresses for the Medicaid program.

**EDS Addresses**

<table>
<thead>
<tr>
<th>Category</th>
<th>EDS Address</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HCFA-1500 Claims</strong></td>
<td>EDS&lt;br&gt;PO Box 30968&lt;br&gt;Raleigh, NC 27622</td>
</tr>
<tr>
<td><strong>Prior Approval Requests</strong></td>
<td>EDS&lt;br&gt;PO Box 31188&lt;br&gt;Raleigh, NC 27622</td>
</tr>
<tr>
<td><strong>Pharmacy Claims</strong></td>
<td>EDS&lt;br&gt;PO Box 300001&lt;br&gt;Raleigh, NC 27622</td>
</tr>
<tr>
<td><strong>Drug Rebates</strong></td>
<td>EDS&lt;br&gt;PO Box 300002&lt;br&gt;Raleigh, NC 27622</td>
</tr>
<tr>
<td><strong>Adjustments</strong></td>
<td>EDS&lt;br&gt;PO Box 300009&lt;br&gt;Raleigh, NC 27622</td>
</tr>
<tr>
<td><strong>Medicare Crossovers</strong></td>
<td>EDS&lt;br&gt;PO Box 300011&lt;br&gt;Raleigh, NC 27622</td>
</tr>
<tr>
<td><strong>UB-92 Claims</strong></td>
<td>EDS&lt;br&gt;PO Box 300010&lt;br&gt;Raleigh, NC 27622</td>
</tr>
<tr>
<td><strong>All Other Claims</strong></td>
<td>EDS&lt;br&gt;PO Box 300011&lt;br&gt;Raleigh, NC 27622</td>
</tr>
<tr>
<td><strong>Returned Checks</strong></td>
<td>EDS&lt;br&gt;PO Box 300001&lt;br&gt;Raleigh, NC 27622</td>
</tr>
<tr>
<td><strong>Sterilization Consent Forms</strong></td>
<td>EDS&lt;br&gt;PO Box 300012&lt;br&gt;Raleigh, NC 27622</td>
</tr>
<tr>
<td><strong>Hysterectomy Statements</strong></td>
<td>EDS&lt;br&gt;PO Box 300012&lt;br&gt;Raleigh, NC 27622</td>
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<tr>
<td><strong>General Correspondence</strong></td>
<td>EDS&lt;br&gt;PO Box 300009&lt;br&gt;Raleigh, NC 27622</td>
</tr>
</tbody>
</table>

When sending Certified mail, UPS or Federal Express, send to: EDS<br>4905 Waters Edge Drive<br>Raleigh, NC 27606
## DMA Addresses

<table>
<thead>
<tr>
<th>Carolina ACCESS</th>
<th>Claims Analysis and Medicare Buy-in</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division of Medical Assistance</td>
<td>Division of Medical Assistance</td>
</tr>
<tr>
<td>2516 Mail Service Center</td>
<td>2519 Mail Service Center</td>
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<tr>
<td>Raleigh, NC  27699-2516</td>
<td>Raleigh, NC  27699-2519</td>
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</table>

<table>
<thead>
<tr>
<th>Community Care Program</th>
<th>Eligibility Unit</th>
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<tbody>
<tr>
<td>Division of Medical Assistance</td>
<td>Division of Medical Assistance</td>
</tr>
<tr>
<td>2502 Mail Service Center</td>
<td>2512 Mail Service Center</td>
</tr>
<tr>
<td>Raleigh, NC  27699-2502</td>
<td>Raleigh, NC  27699-2512</td>
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<table>
<thead>
<tr>
<th>Financial Operations</th>
<th>Managed Care</th>
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</thead>
<tbody>
<tr>
<td>Division of Medical Assistance</td>
<td>Division of Medical Assistance</td>
</tr>
<tr>
<td>2509 Mail Service Center</td>
<td>2516 Mail Service Center</td>
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<tr>
<td>Raleigh, NC  27699-2509</td>
<td>Raleigh, NC  27699-2516</td>
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</table>

<table>
<thead>
<tr>
<th>Medical Policy/Utilization Control</th>
<th>Program Integrity</th>
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</thead>
<tbody>
<tr>
<td>Division of Medical Assistance</td>
<td>Division of Medical Assistance</td>
</tr>
<tr>
<td>2511 Mail Service Center</td>
<td>2515 Mail Service Center</td>
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<tr>
<td>Raleigh, NC  27699-2511</td>
<td>Raleigh, NC  27699-2515</td>
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</table>

<table>
<thead>
<tr>
<th>Provider Services</th>
<th>Third Party Recovery/Health Insurance</th>
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<tbody>
<tr>
<td>Division of Medical Assistance</td>
<td>Premium Payment Program</td>
</tr>
<tr>
<td>2506 Mail Service Center</td>
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<tr>
<td>Raleigh, NC  27699-2506</td>
<td>Division of Medical Assistance</td>
</tr>
<tr>
<td></td>
<td>2508 Mail Service Center</td>
</tr>
<tr>
<td></td>
<td>Raleigh, NC  27699-2508</td>
</tr>
</tbody>
</table>

If you do not know which DMA section or unit’s address to use, send correspondence to the following general address: *(Name of DMA employee)*

Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC  27699-2501

When sending Certified mail, UPS or Federal Express, send to: Division of Medical Assistance
1985 Umstead Drive
Raleigh, NC  27626

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**Jane S. Johnson, Claims Analysis Unit**
DMA, 919-857-4018
Attention: All Prescribers

Synagis Coverage

Synagis is reimbursable through the pharmacy program and not the physician’s program. It has been approved for prevention of RSV disease in children less than 24 months of age with bronchopulmonary dysplasia (BPD) or with a history of premature birth. The drug is administered once per month during the RSV season, which has been identified as being from October 2001 – March 2002 in our state.

Below is a list of guidelines that are approved by the American Academy of Pediatrics, which must be adhered to for drug coverage to be obtained.

- Synagis prophylaxis should be considered for infants and children younger than two years with BPD that are currently receiving or have received oxygen therapy within the six months prior to the anticipated RSV season.
- Infants with a gestational age of 28 weeks or less may benefit from prophylaxis until 12 months of age.
- Infants with a gestational age of 29 to 32 weeks may benefit from prophylaxis until 6 months of age.
- Infants with a gestational age of 32 to 35 weeks may benefit from prophylaxis until 6 months of age if they are also predisposed to at least two of the following risk factors: A number of young siblings, exposure to tobacco smoke in the home, child care center attendance, multiple births.
- Synagis has not been approved by the Food and Drug Administration (FDA) for patients with congenital heart disease and therefore, will not be covered by the Medicaid program for this condition alone, since Medicaid can only cover FDA approved indications.
- The physician is required to write in his own handwriting on the face of the prescription the weight and date of birth of the child. (Pharmacist will not be allowed to fill the prescription without this documentation.)
- Not every child under two years of age needs to be placed on Synagis. Only those at high risk or those who already have complicated respiratory problems should be considered. Decisions regarding each patient should be individualized.

Synagis will be reimbursable from October 1, 2001 to March 31, 2002 unless it is determined that the season has changed for our state. If it is determined, upon audit of physicians and pharmacist records, that the drug is being used outside the guidelines, the Medicaid program will consider a strict prior approval on all coverage of this drug.

EDS, 1-800-688-6696 or 919-851-8888
Attention:  Nursing Facility Providers

Change in Assigning Retroactive Prior Approval Level of Care on the FL2 Form

Effective with date of service October 1, 2001, the Division of Medical Assistance will implement a new prior approval procedure to allow the EDS Prior Approval Unit to assign more than one level of care on an individual FL2 form.

When EDS receives an FL2 retroactive level of care request with medical records, the record documentation may indicate more than one level of care for the retroactive request period. If more than one level of care is approved, EDS staff will document both the time-limited level of care and the most current level of care on the FL2 form. Once completed, EDS will forward the approved FL2 to the appropriate county department of social services (DSS). The county DSS will then forward a copy of the approved FL2 form to the appropriate nursing facility.

Example (see page 14):

On March 10, 2001, EDS receives medical records with an FL2 requesting approval for skilled level of care for Jimmy Doe beginning January 1, 2001. EDS determines that the medical record supports the criteria for skilled level of care beginning January 1, 2001 to February 12, 2001. The medical record documentation supports the intermediate level of care beginning February 13, 2001. EDS documents the following on the FL2:

Upper Right-Hand Corner:
- Service Review Number (SRN) – 2001001112345
- January 1 to February 12, 2001 – the time-limited skilled level of care
- MI – mail in request
- LH – initials of the nurse reviewer

Block 12:
- SRN – 2001044102055

Block 13:
- Approved – circled
- 2/13/01 – beginning approval date
- IC – intermediate level of care
- MI – mail in as the type of review
- LH – initials of the EDS nurse reviewer

Reminder: For the retroactive prior approval policy, refer to the January 2001 general Medicaid bulletin.

EDS, 1-800-688-6696 or 919-851-8888
FL-2 (86)
INSTRUCTIONS ON REVERSE SIDE
NORTH CAROLINA MEDICAID PROGRAM
LONG TERM CARE SERVICES

IDENTIFICATION

1. PATIENT'S LAST NAME: Doe
2. FIRST NAME: Jimmy
3. MIDDLE NAME: R
4. BIRTHDATE (M/D/Y): 01/01/100
5. SEX: M
6. FACILITY: Feel Good
7. ADDRESS: 456 Peaceful Lane
8. COUNTY AND MEDICAID NUMBER: 01-003002-0004
9. ATTENDING PHYSICIAN NAME AND ADDRESS: Dr. Brown
10. PROVIDER NUMBER: 1234-5678
11. HOMEDOMICILY
12. RECOMMENDED LEVEL OF CARE: DOMICILY
13. ADMISSION DATE (CURRENT LOCATION): January 1, 2001
14. PRIOR APPROVAL NUMBER: 200104102055
15. DATE APPROVED: 01/31/2001
16. DETAIL NUMBER: IC
17. DISCHARGE PLAN: HOME
18. MEDICAID NUMBER: 2001011235
19. DATES: 1/1/2001 TO 2/25/2001

15. ADMITTING DIAGNOSES - PRIMARY, SECONDARY, DATES OF ONSET
1. Ex. (E) Hip
2. HTN
3. GERD
4. CVA
5. Constipation

16. PATIENT INFORMATION

DIAGNOSTIC FINDINGS:

1. OASIS: 14
2. Coma: 0
3. Stroke: 0
4. CVA: 1
5. HTN: 1
6. GERD: 0
7. Diabetes: 0

LONG TERM CARE SERVICES:

1. HOSPITAL: 12345678
2. HOME: 98765432
3. DOMICILY: 12345678
4. REST HOME: 98765432
5. SNF: 12345678
6. ICF: 98765432
7. OTHER: 12345678

17. SPECIAL CARE FACTORS:

1. BLOOD PRESSURE: 120/80
2. DIABETIC URINE TESTING: Yes
3. PT (BY LICENSED PT): 5 X 3 Wks
4. RANGE OF MOTION EXERCISES: 3 X 2 Wks

18. MEDICATIONS - NAME & STRENGTHS, DOSAGE & ROUTE

1. HCTZ 25 mg TID
2. Celebrex 200 mg QD
3. Priosec 20 mg QD
4. Durisol 10 mg 3/day PRN Constipation
5. ASA 81 mg TID
6. Tylenol 325 mg 4 tabs 4x/day PRN for Pain

19. X-RAY AND LABORATORY FINDINGS - DATE:

20. ADDITIONAL INFORMATION:

MEDICARE'S SIGNATURE

374-124 (12-90)

EDS - DMA COPY

DATE: 5/9/01
Attention: All Providers

Cytogenetic Studies

Recently, the Division of Medical Assistance implemented diagnosis editing on CPT codes 88230 through 88239 and 88245 through 88291. For the diagnosis and treatment of the following conditions, one of the diagnoses listed must be on the claim in order for the claim to process:

Antepartum Condition or Complication
   659.43
   659.53
   659.63

Genetic Disorders in a Fetus
   758.0 through 758.9
   655.11 through 655.13
   655.21 through 655.24

Failure of Sexual Development
   259.0

Chronic Myelogenous Leukemia
   205.10 through 205.11
   205.80 through 205.81

Acute Leukemia Lymphoid, Myeloid, and Unclassified
   204.00 through 204.01
   204.90 through 204.91
   205.00 through 205.01
   208.00 through 208.01

Myelodysplasia
   238.7

Although medical records will not be required, documentation supporting the diagnosis billed must be maintained for a period of not less than five years.

EDS, 1-800-688-6696 or 919-851-8888
Attention: All Providers

Reporting Changes in Provider Status to Medicaid

Providers, including Managed Care providers (Carolina ACCESS, ACCESS II, ACCESS III, and HMO Risk Contracting), are required to report all changes in status to the N.C. Medicaid program. This includes changes of address, ownership, name, tax identification number, and addition or deletion of group members. Because failure to provide timely notice may prevent or delay payments to the provider, all changes should be sent to the Medicaid program within 30 calendar days.

The procedure for reporting changes to the Medicaid program is determined by the provider type. Physicians report changes to Medicaid through Blue Cross and Blue Shield of North Carolina. Other providers report changes to the Division of Medical Assistance (DMA) using the Notification of Change in Provider Status form. Managed Care providers must also report changes within their practice to DMA’s Managed Care Section. (Refer to the September 2001 general Medicaid bulletin for a copy of and information about the Carolina ACCESS Provider Information Change form.)

Revisions have been made to the Notification of Change in Provider Status form (see page 17). Providers are now required to submit a copy of their W9 for changes of ownership, name, and tax identification number.

The Notification of Change in Provider Status form, the Carolina ACCESS Provider Information Change form, and the W9 form are available from the DMA website at [http://www.dhhs.state.nc.us/dma](http://www.dhhs.state.nc.us/dma).

Darlene Cagle, Provider Services Unit
DMA, 919-857-4017
NOTIFICATION OF CHANGE IN PROVIDER STATUS

This form is intended for use by ALL PROVIDERS except as noted on the back of this form. This form is not intended for use by PHYSICIANS. Physicians must make changes through Blue Cross and Blue Shield of North Carolina.

Indicate the type of change you are submitting by placing an “X” in the appropriate box(es).

If you are requesting changes to a group, you must include the group name and number.

Return form to:
Provider Services, DMA, 2506 Mail Service Center, Raleigh, NC 27699-2506

Provider Name
Medicaid Provider Number
**REQUIRED**
Provider Site Address
Provider Billing Address
Phone Number (      ) (      )
Tax ID Number
Tax ID Name
Name of Individual Provider to be Deleted from Group
Provider Number for Individual Provider to be Deleted from Group
Contact Name
Contact Telephone Number (      )
Signature of Owner or Authorized Agent
Print Name and Title of Owner or Authorized Agent

October 2001
North Carolina Medicaid Bulletin
Report all changes to the Division of Medical Assistance using this form.

If you are enrolled as a Carolina ACCESS provider, you must also report changes to the Managed Care Section using the Carolina ACCESS Provider Information Change Form.

Ambulance Services
Certified Registered Nurse Anesthetists
Developmental Evaluation Centers
DSS Case Management
Federal Qualified Health Centers
Head Start Programs
Health Departments
Hearing Aid Dealers
HIV Case Management
Independent Diagnostic Treatment Facilities
Independent Practitioners
• Audiologists
• Occupational Therapists
• Physical Therapists
• Respiratory Therapists
• Speech Therapists
Licensed Clinical Social Workers
Licensed Psychologists
Mental Health Centers
Nurse Midwives
Nurse Practitioners
Optical Services
Out-of-State Hospitals
Planned Parenthood Programs
Psychiatric Clinical Nurse Specialist
Psychiatric Nurse Practitioners
Public School Health Programs
Residential Evaluation Centers
School Based Health Centers

Report all changes to the Division of Medical Assistance using this form. Include a copy of your new CLIA certificate.

Independent Free-Standing Laboratories

Report all changes to the Division of Medical Assistance using this form. Include a copy of your new accreditation from the Commission of Free-Standing Birthing Center.

Free-Standing Birthing Centers

Report all changes to the Division of Medical Assistance using this form. Include a copy of your new license.

Independent Free-Standing Laboratories

Report all changes to the Division of Medical Assistance using this form. The DMA Provider Services unit will contact you to obtain additional information as needed to complete your change request.

Community Alternative Program Services

Report all changes to the Division of Medical Assistance using this form.

Programs
Home Health Agencies
Hospice
Intermediate Care/Mental Retardation Facilities
Residential Child Care Facilities (Level II - IV)
Residential Treatment Facilities
Home Health Care
Migrant Health Centers
Licensing Professionals
Rehabilitation Therapists
Physical Therapists
Occupational Therapists
Audiologists
Attention: Physician and Physician Extenders Providing the Oral Screening Preventive Package under Codes W8002 and W8003

Oral Screening Preventive Package Update

A reminder to offices providing the oral screening preventive package: Medicaid will reimburse for a total of six oral screening preventive package visits per patient, from the time of tooth eruption UNTIL the third birthday. Services provided on or after the third birthday will NOT be reimbursed. These services can be provided at well child checkups, during a sick visit or at a separately scheduled visit.

Example of Oral Screening Preventive Package Visits:

<table>
<thead>
<tr>
<th>Well Child Visit (months)</th>
<th>Procedure Performed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Six</td>
<td>Yes (if teeth are erupted)</td>
</tr>
<tr>
<td>Nine</td>
<td>Yes (if teeth are erupted)</td>
</tr>
<tr>
<td>Twelve</td>
<td>Yes</td>
</tr>
<tr>
<td>Eighteen</td>
<td>Yes</td>
</tr>
<tr>
<td>Twenty-four</td>
<td>Yes</td>
</tr>
<tr>
<td>Before thirty-six</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Begin providing the services as soon as the first teeth erupt. If services are provided at the six- or nine-month well child checkup, you must wait at least three months before providing the services again. Ideally, the procedure should be performed every 4 to 6 months, but flexibility is allowed to get patients on schedule.

Complete information regarding the Oral Screening Preventive Package was printed in the February 2001 general Medicaid bulletin. For training information call Kelly Haupt, Project Coordinator at 919-833-2466.

Kelly Haupt, Project Coordinator
919-833-2466
Checkwrite Schedule

October 9, 2001  November 6, 2001  December 11, 2001
October 16, 2001  November 14, 2001  December 18, 2001
November 29, 2001

Electronic Cut-Off Schedule

October 5, 2001  November 2, 2001  December 7, 2001
October 12, 2001  November 9, 2001  December 14, 2001
October 19, 2001  November 16, 2001  December 21, 2001
November 21, 2001

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.