### Attention: All Providers

#### Holiday Observance

The Division of Medical Assistance (DMA) and EDS will be closed on Monday, September 6, 1999, in observance of Labor Day.

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

#### Attention: All Carolina ACCESS Primary Care Providers

### Revision of the Carolina ACCESS Emergency Room Reimbursement Policy

The Carolina ACCESS Emergency Room Reimbursement Policy establishes criteria for Medicaid reimbursement of emergency room services. Effective May 1, 1999, the policy was rewritten to clarify the covered services, and the ICD-9 Code List for Identified Emergencies has been expanded. The policy also includes procedures for claims payment through the retrospective medical record review process. Refer to page 14.

Contact Carolina ACCESS at (919) 857-4022 for additional copies or questions regarding the policy.

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We want to thank the physicians, nurses, nurse practitioners, physician assistants, athletic trainers, behavioral specialists, emergency medical technicians and the administrative assistants who participated in the 1999 Special Olympics World Summer Games.

WHAT A GREAT JOB YOU DID. Excellent medical care was provided to athletes, members of delegations and Games Organizing Committee staff at 26 locations including all sports venues, the residence halls, the University of North Carolina and North Carolina State University Student Health Services, airport arrival center, opening and closing ceremonies and the Olympic villages. Special thanks to the UNC Memorial, Duke, Rex and WakeMed hospitals for providing ER and inpatient services.

We hope you enjoyed this great adventure as much as we did. Your great work contributed to making the 1999 Special Olympics World Summer Games the best ever.

Paul R. Perruzzi
Medical Commissioner

H. David Bruton, M.D.
Secretary, Department of Health and Human Services

Attention: All Providers

Automated Re-enrollment of Medicaid and NC Health Choice Recipients

Effective June 1, 1999, DMA implemented a process to automate re-enrollment of Medicaid for Infants and Children (MIC) and NC Health Choice for Children recipients. An annual determination of financial eligibility must be made to continue the child’s eligibility. The state generates a re-enrollment form (DMA-5063R) at the beginning of the month and mails it to those recipients whose enrollment period ends on the last day of the following month. For example, re-enrollment forms are mailed early August to recipients whose current eligibility ends September 30, 1999.

A cover letter enclosed with the form instructs the recipient to complete and sign the form, attach proof of income, and return the form to the local county department of social services by a specific date. An envelope is enclosed for the form to be mailed back to the county department of social services. The form is imprinted with the address of the social services department and can be folded so the address appears in the window of the envelope.

- Providers who become aware that a family has received their re-enrollment form in the mail should remind them to complete and return the form right away.

- Failure to return the form in a timely manner may cause a delay in or termination of benefits, resulting in the family having to reapply for health coverage.

If you have questions about the re-enrollment process please contact the: DMA Eligibility Unit at (919) 857-4019.
Attention: All Providers

Change of Address for State Offices

Beginning July 1, 1999 mail service for State Government Offices was centralized. As a result, the mailing addresses, including zip code, for State Offices have changed. (Mail addressed to the previous post office boxes will be forwarded for approximately six months.) Listed below are the new addresses for DMA. Please note that the name of the individual and/or section and a box number must be used to ensure receipt by the appropriate DMA section. Copy and post this article in your billing office or make the necessary changes in your office records to ensure that mail to the Division of Medical Assistance is correctly addressed to prevent delay in receipt.

(Director or Deputy Director)  (Carolina ACCESS, Managed Care)
Division of Medical Assistance  Division of Medical Assistance
2517 Mail Service Center  2516 Mail Service Center
Raleigh, NC 27699-2517  Raleigh, NC 27699-2516

(Third Party Recovery or Health Insurance Premium Payment Program (HIPP))  (Audit)
Division of Medical Assistance  Division of Medical Assistance
2508 Mail Service Center  2507 Mail Service Center
Raleigh, NC 27699-2508  Raleigh, NC 27699-2507

(Provider Enrollment)  (Program Integrity)
Division of Medical Assistance  Division of Medical Assistance
2506 Mail Service Center  2515 Mail Service Center
Raleigh, NC 27699-2506  Raleigh, NC 27699-2515

(Medical Policy/Utilization Control)  (Administration and Regulatory Affairs)
Division of Medical Assistance  Division of Medical Assistance
2511 Mail Service Center  2504 Mail Service Center
Raleigh, NC 27699-2511  Raleigh, NC 27699-2504

(Financial Operations)  (Hearing Office)
Division of Medical Assistance  Division of Medical Assistance
2509 Mail Service Center  2505 Mail Service Center
Raleigh, NC 27699-2509  Raleigh, NC 27699-2505

(Information Services)  (Mail Management)
Division of Medical Assistance  Division of Medical Assistance
2514 Mail Service Center  2513 Mail Service Center
Raleigh, NC 27699-2514  Raleigh, NC 27699-2513

(Claims Analysis and Medicare Buy-In)  (Community Care)
Division of Medical Assistance  Division of Medical Assistance
2519 Mail Service Center  2502 Mail Service Center
Raleigh, NC 27699-2519  Raleigh, NC 27699-2502

(Medicaid Mgt. Info. System (MMIS))  (Quality Control)
Division of Medical Assistance  Division of Medical Assistance
2510 Mail Service Center  2518 Mail Service Center
Raleigh, NC 27699-2510  Raleigh, NC 27699-2518

If you do not know to which DMA section or unit to send your request or correspondence, use the following general address:

(Name of DMA employee or Director)
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501
Attention: All Providers

Newly Enhanced Automated Voice Response (AVR) System

The Automated Voice Response (AVR) System has recently been updated. Providers should already have received a special bulletin describing how to use the new system. The current 1-800-723-4337 telephone number is still used for the new system. Some of the features of the AVR include (new features are in bold):

- An expansion of service hours to 24 hours each day – 7 days a week (*refer to Note below)
- An increased number of inbound phone lines
- The expansion of the eligibility and coordination of benefits (COB) response
- Recipient eligibility and coordination of benefits (COB)
- Claims status
- Checkwrite information
- Procedure codes requiring prior approval
- Procedure code pricing (with modifiers and coverage status)
- Drug coverage information
- Sterilization consent form information
- Hysterectomy statement information
- Optical refraction history
- Verification of dental x-ray, appliance, sealant and extraction history
- DME Prior Approval Verification
- Verification of Carolina ACCESS
- CAP status

The new AVR system works very similar to the previous system. Providers should follow the prompts in order to obtain the required information. One change has been made in the sequence of keys used to enter alphabetic information. The letters “Q” and “Z” use a different code sequence (see bolded changes below). The following codes are often used in MID number entries.

```
A- *21  F- *33  K- *52  P- *71  U- *82   Z-*12
B- *22  G- *41  L- *53  Q-*11  V- *83
C- *23  H- *42  M- *61  R- *72  W- *91
E- *32  J- *51  O- *63  T- *81  Y- *93
```

As in the past, EDS’ Service Relations Analysts are available between 8:00 a.m. and 4:30 p.m. Monday-Friday to discuss concerns not addressed by the Voice Inquiry System. Please call EDS Provider Services at 1-800-688-6696 if you have further questions regarding the new AVR System.

Note: Refer to the June 1999 Special Medicaid Bulletin for detailed instructions on the Voice Inquiry System. The voice inquiry system is available 24 hours with the exception of 1:00 a.m. to 5:00 a.m. on the 1st, 2nd, 4th, & 5th Sunday, and 1:00 a.m. to 7:00 a.m. on the 3rd Sunday.

EDS, 1-800-688-6696 or 919-851-8888
THIS DOCUMENT IS A YEAR 2000 READINESS DISCLOSURE

UNDER UNITED STATES FEDERAL LAW

Attention: All Providers

Update on Year 2000 Activities

EDS continues the effort to comply with year 2000 requirements. Starting in July, EDS began testing with providers who have completed the changes to submit year 2000 compliant claim formats. In September EDS will release the new NCECS software. Providers should continue to monitor bulletin articles on the status of year 2000 testing and implementation. It is important that claims using the new software or formats not be submitted before the final dates published by the ECS unit. This information will be provided in the instructions released with the software.

DMA will accept claims in their current non-Y2K compliant format until the end of the transition period for various indicated methods of submission. This capability provides a high degree of comfort and flexibility as providers make the transition to Y2K compliant formats. However, all providers are reminded that they will be required to make the conversion to Y2K claims compliance. Details applicable to the various submission forms are provided below.

NECS Submitters

The current NECS software will be replaced by a window-like software to be renamed the North Carolina Electronic Claims Submission (NCECS) software. As an added feature this software will output a file or diskette of claims that is not only Y2K compliant, but will also be in the ANSI 837 format. The NCECS software will be distributed to providers in September 1999. NCECS providers will not require testing by EDS prior to accepting claims since the software will be internally tested by EDS and providers will simply key data enter claims into the software.

Tape Submitters

EDS sent providers specifications for the new format in February 1999. All tape submitters will need to pass testing with EDS before Y2K compliant claims will be accepted. Providers are reminded to give as much notice as possible to their vendors or data processing support staff so that these changes can be made in a timely basis.

ECS Submitters

EDS sent providers specifications for the new format in March 1999. All ECS submitters will need to pass testing with EDS before Y2K compliant claims will be accepted. Providers are reminded to give as much notice as possible to their vendors or data processing support staff so that these changes can be made in a timely basis.

Paper Submitters

There will be no changes to the various paper claim forms. As space permits on the forms providers should input a four-digit year. Where only the provider indicates a two-digit year, EDS’ data entry staff will enter a four-digit year that is appropriate. For example, a 00 will be keyed as 2000; a 99 will be keyed as 1999.
ANSI 837 Submitters

Some providers not using the NCECS software will want to start submitting claims in the ANSI 837 format once EDS is capable of accepting them. The new NCECS software will provide claims in that format. EDS will use translator software to accept any ANSI 837 compliant claim. Each ANSI submitter not using NCECS software will be individually tested and then allowed to submit the ANSI format. EDS will begin accepting ANSI formats from non-NCECS submitters beginning in the 4th calendar quarter of 1999.

<table>
<thead>
<tr>
<th>Current formats</th>
<th>NCECS</th>
<th>Tape</th>
<th>ECS Vendors / Paper</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers Install</td>
<td>beginning Sept 1999</td>
<td>beginning March 1999</td>
<td>beginning April 1999</td>
</tr>
<tr>
<td>EDS Accepting Claims</td>
<td>until transition date established by DMA</td>
<td>beginning Sept 1999</td>
<td>beginning July 1999</td>
</tr>
</tbody>
</table>

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

Attention: All Providers

North Carolina Electronic Claims Submission Software (NCECS)

As mentioned in several recent bulletins, Medicaid is replacing the current NECS software with newer NCECS software. The new software creates files for transmission over modem as well as on a mail-in diskette. The NECS software is DOS based; the NCECS will run in Windows 95, Windows 98 or Windows NT 4.0, which are classified as 32 bit operating systems. NCECS will not operate in a Windows 3.1 environment since it is not a year 2000 compliant system.

Minimal PC requirements for the use of NCECS include:

- Pentium series recommended; 486 machines will function
- minimum of 32 megabytes of memory
- minimum 20 megabytes of hard drive storage
- a browser such as Microsoft Internet Explorer (version 3.0 or higher) or Netscape (version 3.0 or higher)
- a modem – minimal 2400 baud rate; at least 9600 baud rate recommended

Providers must supply the browser. These are on a release diskette as part of the windows 95, 98 and NT Software, or may be downloaded and installed from one of the following addresses:

The Microsoft version is found at [http://www.microsoft.com/catalog](http://www.microsoft.com/catalog).

ECS Unit
EDS, 1-800-688-6696 or 919-851-8888
Attention: All Providers Using Modifiers

Modifiers 25 and 57

Evaluation and management services billed on the same day as surgery are included in the service of surgery and not routinely allowed separate reimbursement.

Modifier 25 is used by providers when billing for an evaluation and management service rendered on the same day that a minor surgical service was performed on the same recipient. Minor procedures are defined as those with “0” or “10” post-operative days. Because the global period for minor procedures begins the day of the surgery, the physician should have determined, prior to billing, that the evaluation and management service is a service that is clearly distinct from the surgical service. When modifier 25 is appended to an evaluation and management service and billed on the same day as a minor surgical service, separate reimbursement is considered for both services.

During the recent modifier workshops questions concerning the use of various evaluation and management codes appended with modifier 25 were raised. The following is a guide for the use of modifier 25.

1. Initial evaluations and consultations are paid separately even if performed on the date of surgery. Therefore, modifier 25 does not have to be appended to these codes when a minor surgical procedure is performed in addition to a separately identifiable evaluation and management code:


2. The provider is allowed the option of billing the modifier with the above codes, which contain the word “new” or “new or established patient”, as defined by CPT. Because of the special needs of Medicaid providers, DMA includes nursing facility visits, newborn visits, and neonatal intensive care codes in this range. Appending modifier 25 on those codes is allowed, but is not necessary.

3. The evaluation and management codes which must have modifier 25 appended in addition to a minor surgical procedure in order to be considered for reimbursement are:

92012-92014, 99211-99215, 99217, 99218-99220, 99221-99223, 99231-99233, 99234-99236, 99238-99239, 99261-99263, 99291-99292, 99331-99333, 99347-99350, and 99433

Modifier 57 should be appended to an evaluation and management code only when the decision for surgery was made during the pre-operative period of a major surgery. A major surgical procedure has 60 or 90 follow-up days. The pre-operative period of a major surgical procedure is the day prior to surgery. The post-operative day does not begin until the day following a major surgery. Therefore, modifier 57 may also be appended to the evaluation and management code on the same day as a major surgical procedure.

The following is a guide for the use of modifier 57:

1. Modifier 57 applies to the same CPT evaluation and management codes as modifier 25.
2. Modifier 57 is not required on initial evaluation and consultation codes.
3. Modifier 57 can not be appended to an evaluation and management service provided during the pre-operative period of a minor procedure.
4. Modifier 57 should only be used for situations in which the decision for surgery was made during the pre-operative period of a surgical procedure with a 90 day follow-up, i.e., the day before or the day of surgery.

Modifiers 25 and 57 are part of a group of modifiers that allow the provider to bill for services that are not normally part of the global surgery package. This group also includes modifiers 24, 58, 78 and 79.

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

Modifier Questions and Answers

EDS recently conducted modifier workshops across the state. Each workshop had an interactive question and answer session during which providers could ask questions. In order to allow all providers required to bill under modifier guidelines to benefit from questions asked by their peers, EDS will use the next few general bulletins as a forum to present some commonly asked questions and answers.

1. **Question:** Can modifier 80 be used for the physician assistant when he assists the cardiologist during a cardiac catheterization?

   **Answer:** No. The procedure codes for cardiac catheterization are not approved for an assistant at surgery. (Refer to the April, 1999 Medicaid Bulletin for codes approved for assistant surgeon.) Modifier 80 can be used for approved assistant at surgery services if rendered by a physician assistant (PA) if the PA is employed by a physician. Assistant at surgery services must be billed as “incident to” services by the physician.

2. **Question:** Procedure code 58611 is used when a patient has a caesarean section and at the same time a bilateral tubal ligation is performed. Would modifier 51 be appended to procedure code 58611?

   **Answer:** No. Code 58611 is used “in addition to code for primary procedure.” Add on codes cannot be billed with modifier 51.

3. **Question:** How does a provider bill surgical procedures repeated on the same day, by the same or different provider?

   **Answer:** If the surgical procedure is performed by the same provider on the same day, modifier 51 is appended to the surgical procedure code. If the surgical procedure is performed by a different provider on the same day as the original procedure, no modifier should be billed.

4. **Question:** Can a physician turn over follow up care if they are in the same practice and use modifier 55?

   **Answer:** Yes, as long as the dates in block 16 of the HCFA-1500 format do not overlap. The provider who performed the procedure must append modifier 54 for surgical care only. The provider(s) performing post-op management must append modifier 55 to the procedure code and enter the dates he is responsible for the patient’s care in block 16 of the HCFA-1500 or in the post-op dates field on ECS formats.

5. **Question:** What modifier should the provider use if the provider performs both the technical and professional component of an x-ray?

   **Answer:** There are two answers to this question. Either the procedure is billed as a complete procedure with no modifier, or the provider can submit the procedure code with modifier 26 on one detail, and procedure code with modifier TC on the next detail.

6. **Question:** When using modifier 50, is the procedure code listed twice with the modifier on both procedure codes?

   **Answer:** No, list the procedure once and append modifier 50. Bill with one unit. Watch the code descriptions carefully. If the code description includes the term “bilateral”, the code cannot be appended with modifier 50.
7. **Question:** Would modifier 25 be appended to an E/M code or a procedure code?

**Answer:** Modifier 25 is appended to the E/M service rendered on the same day as a minor surgical procedure. Modifier 25 is not needed when the E/M is an initial or new patient code.

8. **Question:** After insertion of ear tubes, care is sometimes needed after the 10-day post-op period. Are modifiers needed for problems and treatment after the post-op period?

**Answer:** No.

9. **Question:** A patient in the post-op period returns to the OR for post-op related problem. Will the surgeon be paid for History and Physical (H&P) admission at the hospital?

**Answer:** If the patient is re-admitted during the post-op period for a return to the OR as a result of complications related to the original surgery, another H&P at the time of readmission is not allowed. Also, if the return to the OR is a result of a staged or planned procedure from the original procedure, an additional H&P is not allowed.

10. **Question:** When billing non-covered routine foot care by appending modifier YR, will the patient be responsible for payment?

**Answer:** The patient can only be billed for non-covered services if informed prior to rendering the Medicaid non-covered service that he or she will be responsible for payment. If the patient is not told prior to rendering the service that the service is non-covered, the provider cannot bill the patient. In addition, the provider cannot bill the patient if Medicaid is billed.

11. **Question:** When using modifier 58 on a subsequent procedure in the post-op period, does the same physician have to perform both procedures?

**Answer:** Yes. When appending modifier 58 to the subsequent procedure, it must be rendered by the same provider who performed the original procedure. But if a different provider renders the subsequent procedure, modifier 58 is not required.

12. **Question:** What modifier is used when a procedure, unrelated to the original procedure, is performed during the post-op period by a different physician?

**Answer:** No modifier should be used in this case. However, if performed by the same physician, append modifier 79.

13. **Question:** How does a CRNA or anesthesiologist bill when they perform an epidural and continue to monitor the patient?

**Answer:** The surgical procedure code is billed with modifier QS, and the total time spent performing the epidural and monitoring the patient during the procedure should be billed as the number of units. 1 unit = 1 minute.

14. **Question:** If an E/M service and a procedure are performed by providers of different specialties on the same date of service, what modifier is used?

**Answer:** No modifier should be billed in this case. The provider performing the E/M service should bill for the E/M code, and the provider performing the procedure should bill the procedure code.
15. **Question:** Is insertion of a Swan Ganz catheter included in the global anesthesia policy? How does a provider get reimbursed for insertion of a Swan Ganz when modifiers are implemented?

**Answer:** Insertion of a Swan Ganz catheter is not included in the global anesthesia policy. A provider is reimbursed separately by billing the procedure code with no modifier.

16. **Question:** If anesthesia was administered but the procedure was discontinued prior to starting due to hypotension, is a modifier needed in this case?

**Answer:** For physicians, modifier 53 is billed if the provider discontinues a procedure either after the induction of anesthesia or after initiation of the procedure if circumstances occur that put the patient at risk. If the service is performed in an ambulatory surgical facility, the facility bills modifier 73 if the procedure is discontinued prior to the administration of anesthesia, or modifier 74 if it is discontinued after the administration of anesthesia.

17. **Question:** Is onychomycosis of the nail covered only in the non-ambulatory patient or does it include ambulatory patients as well?

**Answer:** Refer to the June, 1999 bulletin for the policy on foot care. Coverage includes both ambulatory as well as non-ambulatory recipients as long as there is marked limitation or pain, and criteria is met to justify the service.

18. **Question:** Patient has x-rays in the physician's office prior to casting and has repeat x-rays after casting by the same physician on the same day. What modifier should be used?

**Answer:** Modifier 76 should be appended to the subsequent procedure. If the subsequent procedure is performed by a different physician on the same day as the original procedure, modifier 77 would be appended to the subsequent procedure.

19. **Question:** Why would a provider bill a service with modifier 90 to Medicaid since it will not be covered?

**Answer:** It would be best not to bill modifier 90 because Medicaid doesn't cover purchased services. However, Medicaid implemented modifier 90 as a means of allowing providers to use it if they want the denial for their records. Also, some providers bill Medicare for these services. If modifier 90 is billed to Medicaid, it will deny as a non-covered service.

EDS, 1-800-688-6696 or 919-851-8888
Attention: Durable Medical Equipment (DME) Providers

Addition of Oversized Equipment to the DME Fee Schedule

Effective with date of service August 1, 1999, the following codes for oversized equipment have been added to the DME Fee Schedule.

### Inexpensive or Routinely Purchased Items

<table>
<thead>
<tr>
<th>HCPCS CODE</th>
<th>DESCRIPTION</th>
<th>MEDICAID MAXIMUM</th>
<th>LIFETIME EXPECTANCY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>New</strong></td>
<td><strong>Used</strong></td>
</tr>
<tr>
<td>W4684</td>
<td>replacement pail for oversized bedside commode</td>
<td>6.32</td>
<td></td>
</tr>
<tr>
<td>W4685</td>
<td>bathtub transfer bench for weights 251# to 350#</td>
<td>115.00</td>
<td>86.25</td>
</tr>
<tr>
<td>W4686</td>
<td>bathtub transfer bench for weights 351# to 650#</td>
<td>560.00</td>
<td>420.00</td>
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<tr>
<td>W4687</td>
<td>bath seat for weights 251# to 650#</td>
<td>198.00</td>
<td>148.50</td>
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<tr>
<td>W4688</td>
<td>single point cane for weights 251# to 500#</td>
<td>25.50</td>
<td>19.13</td>
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<tr>
<td>W4689</td>
<td>quad cane for weights 251# to 500#</td>
<td>63.04</td>
<td>47.28</td>
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<tr>
<td>W4690</td>
<td>crutches for weights 251# to 500#</td>
<td>159.90</td>
<td>119.93</td>
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<tr>
<td>W4691</td>
<td>fixed-height forearm crutches for weights to 600#</td>
<td>400.00</td>
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<tr>
<td>W4692</td>
<td>oversized walker, adjustable, rigid, w/o wheels for weight 301# and greater</td>
<td>180.00</td>
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<td>oversized walker, adjustable, folding, w/o wheels for weights 301# and greater</td>
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<td>W4694</td>
<td>oversized walker, adjustable, folding, w/ wheels for weights 301# and greater</td>
<td>228.00</td>
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<tr>
<td>W4695</td>
<td>glides/skis for use with walker</td>
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<td>W4720*</td>
<td>oversized 2&quot; foam cushion</td>
<td>140.00</td>
<td>105.00</td>
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<td>W4733</td>
<td>replacement oversized innerspring mattress for hospital bed w/ width to 39&quot;</td>
<td>325.00</td>
<td>243.75</td>
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<td>W4736</td>
<td>replacement oversized innerspring mattress for hospital bed w/ width to 60&quot;</td>
<td>430.00</td>
<td>322.50</td>
</tr>
</tbody>
</table>

### Capped Rental/Purchased Equipment

<table>
<thead>
<tr>
<th>HCPCS CODE</th>
<th>DESCRIPTION</th>
<th>MEDICAID MAXIMUM</th>
<th>LIFETIME EXPECTANCY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Rental</strong></td>
<td><strong>New</strong></td>
</tr>
<tr>
<td>W4679</td>
<td>bedside commode for weights 251# to 650#</td>
<td>19.80</td>
<td>198.00</td>
</tr>
<tr>
<td>W4680</td>
<td>bedside commode for weights 651# to 1000#</td>
<td>62.00</td>
<td>620.00</td>
</tr>
<tr>
<td>W4681</td>
<td>bedside commode for weights 1001# and greater</td>
<td>75.00</td>
<td>750.00</td>
</tr>
<tr>
<td>HCPCS CODE</td>
<td>DESCRIPTION</td>
<td>MEDICAID MAXIMUM</td>
<td>LIFETIME EXPECTANCY</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------</td>
<td>------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>W4682</td>
<td>drop-arm bedside commode for weights 251# to 600#</td>
<td>Rental 65.00 New 650.00 Used 487.50</td>
<td>3 years</td>
</tr>
<tr>
<td>W4683</td>
<td>drop-arm bedside commode for weights 651# to 1000#</td>
<td>Rental 79.50 New 795.00 Used 596.25</td>
<td>3 years</td>
</tr>
<tr>
<td>W4696</td>
<td>manual wheelchair for weights 451# to 600#</td>
<td>Rental 140.00 New 1400.00 Used 1050.00</td>
<td>3 years</td>
</tr>
<tr>
<td>W4697</td>
<td>manual wheelchair for weights 601# and greater</td>
<td>Rental 242.00 New 2420.00 Used 1815.00</td>
<td>3 years</td>
</tr>
<tr>
<td>W4698</td>
<td>seat width 21&quot; and 22&quot; for manual wheelchair</td>
<td>Rental 13.95 New 139.55 Used 104.66</td>
<td>3 years</td>
</tr>
<tr>
<td>W4699</td>
<td>seat width 23&quot; and 24&quot; for manual wheelchair</td>
<td>Rental 28.30 New 283.00 Used 212.25</td>
<td>3 years</td>
</tr>
<tr>
<td>W4700</td>
<td>seat width 25&quot; and greater for manual wheelchair</td>
<td>Rental 88.70 New 887.00 Used 665.25</td>
<td>3 years</td>
</tr>
<tr>
<td>W4701</td>
<td>seat depth 19&quot; and 20&quot; for manual wheelchair</td>
<td>Rental 41.16 New 411.66 Used 308.75</td>
<td>3 years</td>
</tr>
<tr>
<td>W4702</td>
<td>seat depth 21&quot; and 22&quot; for manual wheelchair</td>
<td>Rental 60.00 New 600.00 Used 450.00</td>
<td>3 years</td>
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<tr>
<td>W4703</td>
<td>seat depth 23&quot; and greater for manual wheelchair</td>
<td>Rental 58.83 New 588.33 Used 441.25</td>
<td>3 years</td>
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<tr>
<td>W4704</td>
<td>power wheelchair for weights 251# to 400#</td>
<td>Rental 385.40 New 3854.00 Used 2890.50</td>
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<tr>
<td>W4705</td>
<td>power wheelchair for weights 401# to 600#</td>
<td>Rental 613.30 New 6133.00 Used 4599.75</td>
<td>4 years</td>
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<tr>
<td>W4706</td>
<td>power wheelchair for weights 601# and greater</td>
<td>Rental 700.00 New 7000.00 Used 5250.00</td>
<td>4 years</td>
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<tr>
<td>W4707</td>
<td>seat width 21&quot; and 22&quot; for power wheelchair</td>
<td>Rental 38.75 New 387.50 Used 290.63</td>
<td>4 years</td>
</tr>
<tr>
<td>W4708</td>
<td>seat width 23&quot; and 24&quot; for power wheelchair</td>
<td>Rental 77.00 New 770.00 Used 577.50</td>
<td>4 years</td>
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<tr>
<td>W4709</td>
<td>seat width 25&quot; and greater for power wheelchair</td>
<td>Rental 107.50 New 1075.00 Used 806.25</td>
<td>4 years</td>
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<tr>
<td>W4710</td>
<td>seat depth 19&quot; and 20&quot; for power wheelchair</td>
<td>Rental 50.00 New 500.00 Used 375.00</td>
<td>4 years</td>
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<tr>
<td>W4711</td>
<td>seat depth 21&quot; and 22&quot; for power wheelchair</td>
<td>Rental 88.00 New 880.00 Used 660.00</td>
<td>4 years</td>
</tr>
<tr>
<td>W4712</td>
<td>seat depth 23&quot; and greater for power wheelchair</td>
<td>Rental 92.90 New 929.00 Used 696.25</td>
<td>4 years</td>
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<tr>
<td>W4713</td>
<td>oversized footplates for weights 301# and greater, pair</td>
<td>Rental 16.00 New 160.00 Used 120.00</td>
<td>3 years</td>
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<tr>
<td>W4714</td>
<td>swingaway special construction footrests for weights 401# and greater, pair</td>
<td>Rental 67.70 New 677.00 Used 507.75</td>
<td>3 years</td>
</tr>
<tr>
<td>W4715</td>
<td>swingaway reinforced legrest, elevating, for weights 301# to 400#, pair</td>
<td>Rental 40.00 New 400.00 Used 300.00</td>
<td>3 years</td>
</tr>
<tr>
<td>W4716</td>
<td>swingaway special construction legrest, elevating, for weights 401# and greater, pair</td>
<td>Rental 60.00 New 600.00 Used 450.00</td>
<td>3 years</td>
</tr>
<tr>
<td>W4717</td>
<td>oversized calf pads, pair</td>
<td>Rental 20.00 New 200.00 Used 150.00</td>
<td>2 years</td>
</tr>
<tr>
<td>W4718</td>
<td>oversized solid seat</td>
<td>Rental 55.00 New 550.00 Used 412.00</td>
<td>3 years</td>
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<tr>
<td>W4719</td>
<td>oversized solid back</td>
<td>Rental 55.00 New 550.00 Used 412.00</td>
<td>3 years</td>
</tr>
<tr>
<td>W4721</td>
<td>group 27 gel cell battery</td>
<td>Rental 40.00 New 400.00 Used 300.00</td>
<td>1 year</td>
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<tr>
<td>W4722</td>
<td>oversized full support footboard</td>
<td>Rental 20.00 New 200.00 Used 150.00</td>
<td>3 years</td>
</tr>
<tr>
<td>W4723</td>
<td>oversized full support calfboard</td>
<td>Rental 20.00 New 200.00 Used 150.00</td>
<td>3 years</td>
</tr>
</tbody>
</table>
### Capped Rental/Purchased Equipment

<table>
<thead>
<tr>
<th>HCPCS CODE</th>
<th>DESCRIPTION</th>
<th>MEDICAID MAXIMUM</th>
<th>LIFETIME EXPECTANCY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rental</td>
<td>New</td>
<td>Used</td>
</tr>
<tr>
<td>W4724*</td>
<td>manual hospital bed for weights 351# to 450# w/ mattress and any type side rails</td>
<td>153.90</td>
<td>1539.00</td>
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<tr>
<td>W4725*</td>
<td>semi-electric hospital bed for weights 351# to 450# w/ mattress and any type side rails</td>
<td>195.93</td>
<td>1959.33</td>
</tr>
<tr>
<td>W4726*</td>
<td>total electric hospital bed for weights 351# to 450# w/ mattress and any type side rails</td>
<td>223.00</td>
<td>2230.00</td>
</tr>
<tr>
<td>W4727*</td>
<td>semi-electric hospital bed for weights 451# to 1000# w/ width to 39&quot; w/ mattress and any type side rails</td>
<td>737.50</td>
<td>7375.00</td>
</tr>
<tr>
<td>W4728*</td>
<td>semi-electric hospital bed for weights 451# to 1000# w/ width to 48&quot; w/ mattress and any type side rails</td>
<td>777.50</td>
<td>7775.00</td>
</tr>
<tr>
<td>W4729*</td>
<td>semi-electric hospital bed for weights 451# to 1000# w/ width to 54&quot; w/ mattress and any type side rails</td>
<td>815.00</td>
<td>8150.00</td>
</tr>
<tr>
<td>W4730*</td>
<td>total electric hospital bed for weights 451# to 1000# w/ width to 39&quot; w/ mattress and any type side rails</td>
<td>910.00</td>
<td>9100.00</td>
</tr>
<tr>
<td>W4731*</td>
<td>total electric hospital bed for weights 451# to 1000# w/ width to 48&quot; w/ mattress and any type side rails</td>
<td>935.00</td>
<td>9350.00</td>
</tr>
<tr>
<td>W4732*</td>
<td>total electric hospital bed for weights 451# to 1000# w/ width to 54&quot; w/ mattress and any type side rails</td>
<td>960.00</td>
<td>9600.00</td>
</tr>
<tr>
<td>W4737*</td>
<td>trapeze bar, free standing, complete with grab bar for weight 451# to 750#</td>
<td>225.00</td>
<td>2250.00</td>
</tr>
</tbody>
</table>

Note: Codes indicated with asterisks require prior approval.

Medical necessity must be documented for all items on the Certificate of Medical Necessity and Prior Approval (CMN/PA) form regardless of the requirement for approval. The documentation must substantiate medical necessity for the comparable standard size equipment and the need for the oversized equipment. The patient’s height, weight, and body measurements must be given. The body measurements must be taken in the appropriate position for the requested equipment, i.e. sitting for bedside commodes, bath seats, and wheelchairs, supine for hospital beds, and standing for canes, crutches, and walkers. The dimensions of the requested equipment and the manufacturer’s specified weight capacity for the equipment must be submitted.

**Melody B. Yeargan, P.T., DMA Medical Policy**

**DMA, 919-857-4020**
CAROLINA ACCESS EMERGENCY ROOM
REIMBURSEMENT POLICY

The Carolina ACCESS Emergency Room Reimbursement Policy establishes criteria for Medicaid reimbursement of emergency room services.

- The policy covers medical screening exams without regard to prior authorization 24 hours per day, 7 days a week.
- The policy also covers the stabilization of identified emergencies (see attached ICD–9 diagnostic code list) without regard to prior authorization 24 hours per day, 7 days a week.
- The list of identified emergencies (see attached ICD–9 diagnostic code list) is not exclusive of other conditions determined to be an emergency through retrospective medical record review.

Treatment in the Emergency Room for non-emergent care is not generally covered.

1. A non-emergent service rendered Monday through Friday, 8 a.m. to 5 p.m. will result in a denied claim. Medicaid may be billed a medical screening exam fee of $25.16. The screening fee (W9922) must be filed on the HCFA-1500.

Laboratory and other tests needed to evaluate the existence of an emergent condition may be covered through retrospective medical record review based upon "prudent layperson"* standards and medical necessity criteria.

Documentation may be submitted to the Carolina ACCESS program for retrospective medical record review. This documentation must include a copy of the completed Retrospective Medical Record Review form as a cover sheet, the denied claim, remittance advice (RA), and medical records to demonstrate medical necessity. The Quality Management (QM) staff will review the documentation with all recommended denials receiving a physician review. The review decision will be based upon "prudent layperson" criteria and accepted standards for medical practice.

If approved for payment, the claims will be forwarded to EDS. The hospital will be notified of any payment denials. Retrospective medical record review requests may be mailed to:

Attention: Division of Medical Assistance
Managed Care Section
Attn: Retrospective Medical Record Review
2516 Mail Service Center
Raleigh, NC 27699-2516
2. The Primary Care Provider (PCP) may authorize payment for non-emergent treatment after hours (5:00 pm to 8:00 am, Monday through Friday and 24 hours on weekends) and should be contacted for an authorization number following the medical screening exam. Authorized claims for non-emergent care require the authorization number in form locator 11 on the UB-92 and in form locator 19 on the HCFA-1500. Retrospective authorization (i.e., authorization after the service has been provided to the recipient) may be provided at the discretion of the PCP.

Information for Hospital Coders:

1. Carolina ACCESS emergency room claims are edited against form locator 76 "Principal and Other Diagnosis" in addition to form locators 68-75. If an identified emergency diagnosis code as defined in this Carolina ACCESS ER Reimbursement Policy appears in any of these form locators, the claim will process and will not require authorization.

2. Hospital coders can place the **presenting diagnosis code** in form locator 76. The American Hospital Association has recommended this form locator be used when a presenting diagnosis is the triggering diagnosis for payment.

* Refer to the information on COBRA/EMTALA/BBA Regulations on page 21.

Questions regarding this policy should be directed to the Carolina ACCESS Quality Management Section by call 919-857-4022.
ICD-9 Diagnostic Code List for Identified Emergencies

**Infectious and Parasitic Diseases**

- 036-036.9 Meningococcal infection
- 038-038.9 Septicemia
- 091.1, 091.2, 091.9, 093.9, 094.9, 091.0 Syphilis (Primary)
- 099.9 Venereal disease
- 099.50-099.56 Chlamydia
- 098.0, 098.11, 098.14, 098.15, 098.2, 098.19, 098.31, 098.35 Gonorrhea
- 131.00-131.03, 131.09, 131.8, 131.9 Trichomoniasis
- 082.0 Rocky Mountain Spotted Fever¹

**Endocrine, Nutritional, Metabolic, Immunity**

- 242-242.91 Thyrotoxicosis with or without goiter
- 250.1-250.13 Diabetes with ketoacidosis
- 250.2-250.23 Diabetes with hyperosmolar coma
- 250.3-250.33 Diabetes with other coma
- 251.0 Hypoglycemic coma
- 255.4 Corticoadrenal insufficiency (Addisonian crisis)
- 261 Nutritional marasmus - up to age 18
- 276-276.9 Disorders of fluid, electrolyte, and acid-base balance

**Blood and Blood-forming Organs**

- 282.62 Hb-S disease with mention of crisis
- 286.0-286.9 Coagulation defects

**Mental Disorders**

- 291.0-292.9 Alcoholic & drug psychoses
- 293.0 Acute delirium
- 295.00-295.94 Schizophrenic disorders (all codes except when the 5th digit=5="in remission")
- 296.00-296.99 Affective psychoses (all codes except when the 5th digit =6="in full remission")
- 489.24.1.1 Nonorganic psychoses
- 300.9 Suicide risk or tendencies
- 303.00-303.02 Acute alcoholic intoxication
- 312.34 Intermittent explosive disorder

¹Italics indicates a new emergency diagnosis code.
ICD-9 Diagnostic Code List for Identified Emergencies (continued)

**Nervous System and Sense Organs**

- 320-326 Meningitis, encephalitis, intracranial abscess
- 345.1-345.11 Generalized convulsive epilepsy
- 489.24 Grand mal seizures
- 346.80, 346.81 Other forms of migraine headache
- 349.0 Headache following lumbar puncture
- 360.5-360.69 Intraocular foreign body
- 361.0-361.9 Retinal detachments and defects
- 362.3-362.37 Retinal vascular occlusion
- 364.0-364.05 Acute iridocyclitis
- 365.22 Acute angle-closure glaucoma
- 370.0-370.07 Corneal ulcer
- 374.81 Hemorrhage of eyelid
- 489.24 Retained foreign body of eye lid
- 376.01 Orbital Cellulitis
- 379.0-379.09 Scleritis and episcleritis
- 388.61 Cerebrospinal fluid otorrhea

**Circulatory System**

- 401.0 Essential hypertension, malignant
- 410-410.92 Acute myocardial infarction
- 411-411.89 Other acute and subacute forms of ischemic heart disease
- 413-413.9 Angina pectoris
- 415-415.19 Acute pulmonary heart disease
- 420-420.99 Acute pericarditis
- 421-421.9 Acute and subacute endocarditis
- 422-422.99 Acute myocarditis
- 424.0-424.99 Diseases of endocardium
- 426-426.9 Conductive disorders
- 427-427.9 Cardiac dysrhythmias
- 428-428.9 Heart failure
- 430 Subarachnoid hemorrhage
- 431 Intracerebral hemorrhage
- 432-432.9 Intracranial hemorrhage
- 433.11, 433.21, 433.91 Occlusion and stenosis of precerebral arteries with cerebral infarction
- 434.01, 434.11, 434.91 Occlusion of cerebral arteries with cerebral infarction
- 435.0-435.9 Transient cerebral ischemia
- 436 Acute cerebrovascular disease
- 437.2 Hypertensive encephalopathy
- 441-441.9 Aortic aneurysm
- 444-444.9 Arterial embolism and thrombosis

**Diseases of Veins and Lymphatics and other Diseases of Circulatory System**

- 451-453.9 Phlebitis, thrombophlebitis, and thrombosis
- 455.2 Internal hemorrhoids with other complications
ICD-9 Diagnostic Code List for Identified Emergencies (continued)

Respiratory System

464.11 Acute tracheitis with obstruction
464.21 Acute laryngotracheitis with obstruction
464.31 Acute epiglottitis with obstruction
464.4 Croup, up to age 8
466-466.19 Acute bronchitis and bronchiolitis, up to age 8
475 Peritonsillar abscess
478.21-478.25, Cellulitis, abscess or edema of pharynx or nasopharynx
478.29
478.6 Edema of larynx
478.71 Cellulitis and perichondritis of larynx
478.75 Laryngeal spasm
480-480.9 Viral pneumonia
481 Pneumococcal pneumonia
482-482.9 Other bacterial pneumonia
483-483.8 Pneumonia due to other specified organism
484-484.8 Pneumonia in infectious diseases classified elsewhere
485 Bronchopneumonia, organism unspecified
486 Pneumonia, organism unspecified
487.0 Influenza with pneumonia
487.1 Influenza with other respiratory manifestations
491.21 Obstructive chronic bronchitis with acute exacerbation
493.0-493.91 Asthma
507-507.8 Aspiration pneumonia
510.0-510.9 Empyema
511.1-511.9 Pleurisy with effusion
512-512.8 Pneumothorax
513-513.1 Abscess of lung & mediastinum
514 Pulmonary congestion and hypostasis
518.0 Pulmonary collapse
518.4 Acute edema of lung
518.5 Pulmonary insufficiency following trauma
518.81-518.82 Respiratory failure
519.0 Tracheostomy complication
519.2 Mediastinitis

Digestive System

530.4 Perforation of esophagus
530.7 Mallory Weiss Syndrome
530.82 Other pulmonary insufficiency, NOS
531-531.61 Gastric ulcer, acute or chronic with hemorrhage and/or perforation
532-532.61 Duodenal ulcer, acute or chronic with hemorrhage and/or perforation
533-533.61 Peptic ulcer, acute or chronic with hemorrhage and/or perforation
534-534.61 Gastrojejunal ulcer, acute or chronic with hemorrhage and/or perforation
536.2 Persistent vomiting
540-542 Appendicitis
550.1-550.13 Inguinal hernia with obstruction
552.9 Hernia with obstruction
560.0-560.2 Intestinal obstruction
560.9 Unspecified intestinal obstruction
562.01-562.03 Diverticulitis of small intestine and diverticulosis of small intestine with hemorrhage
562.11-562.13 Diverticulitis of colon and diverticulosis of colon with hemorrhage
567-567.9 Peritonitis
### Digestive System (continued)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>574.0-574.11</td>
<td>Calculus of gallbladder with cholecystitis</td>
</tr>
<tr>
<td>574.3-574.41</td>
<td>Calculus of bile duct with cholecystitis</td>
</tr>
<tr>
<td>574.6-574.81</td>
<td>Calculus of gallbladder and bile duct with cholecystitis</td>
</tr>
<tr>
<td>575.0</td>
<td>Acute cholecystitis</td>
</tr>
<tr>
<td>575.4</td>
<td>Perforation of gallbladder</td>
</tr>
<tr>
<td>576.1</td>
<td>Cholangitis</td>
</tr>
<tr>
<td>577.0</td>
<td>Acute pancreatitis</td>
</tr>
<tr>
<td>578-578.9</td>
<td>Gastrointestinal hemorrhage</td>
</tr>
</tbody>
</table>

### Genitourinary System

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>584-584.9</td>
<td>Acute renal failure</td>
</tr>
<tr>
<td>590.0-590.9</td>
<td>Infections of kidney</td>
</tr>
<tr>
<td>592-592.9</td>
<td>Calculus of kidney and ureter</td>
</tr>
<tr>
<td>599.6</td>
<td>Urinary obstruction</td>
</tr>
<tr>
<td>601.0</td>
<td>Acute prostatitis</td>
</tr>
<tr>
<td>604.0</td>
<td>Orchitis, epididymitis, and epididymo-orchitis, with abscess</td>
</tr>
<tr>
<td>605</td>
<td>Paraphimosis</td>
</tr>
<tr>
<td>607.3</td>
<td>Priapism</td>
</tr>
<tr>
<td>608.2</td>
<td>Torsion of testis</td>
</tr>
<tr>
<td>614-614.0</td>
<td>Acute salpingitis and oophoritis</td>
</tr>
<tr>
<td>614.3</td>
<td>Acute parametritis and pelvic cellulitis</td>
</tr>
<tr>
<td>614.5</td>
<td>Acute or unspecified pelvic peritonitis</td>
</tr>
<tr>
<td>489.24.2</td>
<td>Abscess of Bartholin's Gland</td>
</tr>
</tbody>
</table>

### Pregnancy, Childbirth, Puerperium

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>632</td>
<td>Missed abortion</td>
</tr>
<tr>
<td>633-634.92</td>
<td>Ectopic pregnancy/spontaneous abortion</td>
</tr>
<tr>
<td>640-640.93</td>
<td>Hemorrhage in early pregnancy</td>
</tr>
<tr>
<td>641-641.93</td>
<td>Antepartum hemorrhage, abruptio placentae, and placenta previa</td>
</tr>
<tr>
<td>642-642.94</td>
<td>Hypertension complicating pregnancy, childbirth and the puerperium</td>
</tr>
<tr>
<td>643-643.93</td>
<td>Excessive vomiting in pregnancy</td>
</tr>
<tr>
<td>489.24.1</td>
<td>Early or threatened labor</td>
</tr>
<tr>
<td>646.6</td>
<td>UTI in pregnancy</td>
</tr>
<tr>
<td>656.4-656.43</td>
<td>Intrauterine death</td>
</tr>
<tr>
<td>666.00-666.34</td>
<td>Postpartum hemorrhage</td>
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### Skin and Subcutaneous Tissue

<table>
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<tr>
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<th>Description</th>
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</thead>
<tbody>
<tr>
<td>692.4</td>
<td>Dermatitis due to chemical products</td>
</tr>
<tr>
<td>695.1</td>
<td>Erythema multiforme</td>
</tr>
<tr>
<td>708.0</td>
<td>Allergic urticaria</td>
</tr>
</tbody>
</table>
ICD-9 Diagnostic Code List for Identified Emergencies (continued)

**Symptoms, Signs and Ill-Defined Conditions**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>780.0 - 780.09</td>
<td>Coma and stupor</td>
</tr>
<tr>
<td>780.1</td>
<td>Hallucinations</td>
</tr>
<tr>
<td>780.2</td>
<td>Syncope and collapse</td>
</tr>
<tr>
<td>780.3</td>
<td>Convulsions</td>
</tr>
<tr>
<td>780.6</td>
<td>Fever, age 1 year of less, temp. 100.4 or &gt; (R)</td>
</tr>
<tr>
<td>781.4</td>
<td>Transient paralysis of limb</td>
</tr>
<tr>
<td>781.6</td>
<td>Meningismus</td>
</tr>
<tr>
<td>781.7</td>
<td>Tetany</td>
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<tr>
<td>782.5</td>
<td>Cyanosis</td>
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<td>782.7</td>
<td>Spontaneous ecchymoses (petechiae)</td>
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<td>784.7</td>
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<td>489.24</td>
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<td>785.1</td>
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<td>785.5-785.59</td>
<td>Shock without mention of trauma</td>
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<td>Dyspnea and Respiratory Abnormality</td>
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<td>786.5-786.59</td>
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<td>788.2-788.20</td>
<td>Retention of urine</td>
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<td>788.5</td>
<td>Oliguria and anuria</td>
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<td>Abdominal rigidity</td>
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<tr>
<td>789.6</td>
<td>Abdominal rebound tenderness</td>
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<td>798-798.9</td>
<td>Sudden death, cause unknown</td>
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<tr>
<td>799.0</td>
<td>Asphyxia</td>
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<td>799.1</td>
<td>Respiratory arrest</td>
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**Injury and Poisoning**

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<th>Code</th>
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<tr>
<td>800-999.9</td>
<td>Entire range is covered. If claims deny within this range of diagnoses please contact the CA office at 1-800-228-8142.</td>
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<tr>
<td>V61.21</td>
<td>Child abuse</td>
</tr>
<tr>
<td>V70.1</td>
<td>General psychiatric examination, requested by the authority</td>
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<tr>
<td>V70.4</td>
<td>Examination for medicolegal reasons</td>
</tr>
<tr>
<td>V71.4</td>
<td>Observation following other accident</td>
</tr>
<tr>
<td>V71.5</td>
<td>Observation following alleged rape or seduction</td>
</tr>
<tr>
<td>V71.6</td>
<td>Observation following other inflicted injury</td>
</tr>
<tr>
<td>94.13</td>
<td>ICD-9 procedure code- Evaluation for commitment</td>
</tr>
</tbody>
</table>
“COBRA/EMTALA/BBA REGULATIONS”

Abbreviated Review of Federal Regulations
as it applies to Emergency Department Visits

42 CFR 489 (COBRA/EMTALA)

489.24 Special Responsibilities of Medicare/Medicaid hospitals in emergency cases.

(a) General. In the case of a hospital that has an emergency department, if any individual (whether or not eligible for Medicare benefits and regardless of ability to pay) comes by him or herself to the emergency department and a request is made on the individual’s behalf for examination or treatment of a medical condition by qualified medical personnel (as determined by the hospital in its rules and regulations), the hospital must provide for an appropriate medical screening examination within the capability of the hospital’s emergency department, to determine whether or not an emergency medical condition exists. The examinations must be conducted by individuals determined qualified by hospital by-laws or rules and regulations and who meet the requirements of 482.55 concerning emergency services personnel and direction. (482.55 states, ...that emergency services be supervised by a qualified member of the medical staff and that there be adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility).

Emergency medical condition means-

(i) A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such *that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect (BBA, Section 1932 (b)(2))the absence of immediate medical attention to result in

   (A) Placing the health of the individual (or with respect to a pregnant woman or her unborn child) in serious jeopardy;
   (B) Serious impairment to bodily functions or
   (C) Serious dysfunction of any bodily organ or part; or

(ii) With respect to a pregnant woman who is having contractions----

   (A) That there is inadequate time to safely transfer to another hospital before delivery; or
   (B) That transfer may pose a threat to the health or safety of the woman or the unborn child.

Stabilize means - That no material deterioration of the condition is likely within reasonable medical probability, to result from or occur during the transfer of the individual from a facility.

To stabilize means - With respect to an emergency medical condition, to provide such medical treatment of the condition necessary, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.
Transfer means - The movement (including the discharge) of an individual outside a hospital’s facilities at the direction of any person employed by (or affiliated or associated directly or indirectly with) the hospital.

Screening examination

CFR vol. 59, No. 119, June 22, 1994. Response to comments section, pg. 32099 and 32108. It is impossible to define in advance all of the circumstances in which an individual may come to a hospital emergency department. What will constitute an appropriate medical screening examination will vary according to the condition of the individual and the capabilities of the hospital’s emergency department. Within those capabilities, the examination must be sufficient to permit the hospital to decide whether or not the individual has an emergency medical condition. The regulations presently allow a hospital to delegate its responsibility to perform initial medical screening examinations to qualified medical personnel if it does so in its by-laws.

489.24 (c) (ii) (3) Delay in examination or treatment

A participating hospital may not delay providing an appropriate medical screening examination or further medical examination and treatment in order to inquire about the individual’s method of payment or insurance status.

If the medical screening exam is appropriate and does not reveal an emergency medical condition, the hospital has no further obligations under CFR 489.24 (TAG Number A406, Interpretive Guidelines-Responsibilities of Medicare Participating Hospital in Emergency Cases-HCFA, 05-98).
Carolina ACCESS Emergency Room Retrospective Medical Record Review Form

Patient Name

Patient Medicaid ID #       Date of Birth

Date of Service               Time of Service

Day of Week

Place of Service

Diagnosis Code #1

Diagnosis Code #2

Diagnosis Code #3

Diagnosis Code #4

Diagnosis Code #5

Presenting symptoms met Prudent Layperson standard (as defined in BBA) for emergency.

☐ Illness severity required emergency treatment

☐ Ancillary diagnostic testing required to determine emergency treatment requirements

☐ PCP not available when contact was attempted on____________by ________________________ (Hospital Personnel)

☐ PCP would not authorize ER visit when telephoned on____________by ________________________ (PCP Personnel)

☐ PCP call not required - Hospital/PCP written protocol for specific medical condition exists

☐ Other, please explain

Return To:
Managed Care
Division of Medical Assistance
Attn: Retrospective Medical Record Review
2516 Mail Service Center
Raleigh, NC  27699-2516

Please group UB-92 and HCFA-1500 claim forms with the medical record if physician and hospital services are to be reviewed.
Incomplete records will be returned

Revised 6/99
Attention: Physicians, Ophthalmologists, and Optometrists

**Cataract Surgeries and Modifier Billing**

With the implementation of modifiers, claims from physicians and certain other practitioners received on and after June 25, 1999 are processed using modifier guidelines. Eye care providers, including ophthalmologists and optometrists, were included in the implementation of modifiers. Optical suppliers were not affected.

Modifiers 54 and 55 allow a provider other than the surgeon to receive reimbursement for the follow-up care related to a major or minor surgery. Modifier 54 denotes “surgical care only” and is appended to a surgical procedure code if the surgeon agrees to relinquish the postoperative management to another provider. Modifier 55 denotes “postoperative management” only and is appended to a surgical procedure code if a provider other than the surgeon renders postoperative care.

Following is a comparison of billing before and after modifier processing and an explanation on the use of modifiers 54 and 55 as they pertain to ophthalmologists and optometrists and cataract surgery.

<table>
<thead>
<tr>
<th>Prior to implementation of modifiers</th>
<th>Effective with claims received June 25, 1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmologists who performed only the surgical part of cataract surgery billed these codes:</td>
<td>Ophthalmologists performing only the surgical part of cataract surgery use the applicable CPT procedure codes 66983, 66984, or 66985 for cataract surgery and append modifier 54 to the code.</td>
</tr>
<tr>
<td>W9931 Intracapsular cataract extraction with insertion of lens prosthesis (no follow-up care)</td>
<td>“W” codes were replaced with CPT codes.</td>
</tr>
<tr>
<td>W9941 Extracapsular cataract extraction with insertion of lens prosthesis (no follow-up care)</td>
<td></td>
</tr>
<tr>
<td>W9951 Insertion of intraocular lens subsequent to cataract removal</td>
<td></td>
</tr>
<tr>
<td>Ophthalmologists or optometrists who rendered only postoperative care following cataract surgery billed these codes:</td>
<td>Ophthalmologists or optometrists rendering part or all of the follow-up care bill the applicable CPT codes 66983, 66984, or 66985 for cataract surgery and append modifier 55 to the code.</td>
</tr>
<tr>
<td>Y5575 Follow-up care for codes W9931, W9941, or W9951 (for one eye)</td>
<td>“Y” codes were replaced with CPT codes with modifier 55 appended.</td>
</tr>
<tr>
<td>Y5576 Follow-up care for codes W9931, W9941, or W9951 (for two eyes)</td>
<td></td>
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</table>
EXAMPLE I: SURGERY AND PREOPERATIVE CARE ONLY

Situation: The ophthalmologist performs procedure 66984. All postoperative care is transferred to another provider.

Billing: The ophthalmologist who performs the surgery enters 66984-54 on the claim.

EXAMPLE II: PROVIDER (OTHER THAN SURGEON) RENDERS ALL POSTOPERATIVE CARE FOLLOWING SURGERY

Situation: The optometrist provides all follow-up care to the patient who has had cataract surgery (66984).

Billing: The optometrist submits a claim entering the surgical CPT procedure code 66984-55, with same date of service (date of surgery) and place of service as the surgeon.

The dates the provider is responsible for postoperative care must be entered in the FROM and TO dates in block 16 on the HCFA-1500 claim or in the designated field for tape or ECS formats.

EXAMPLE III: OPHTHALMOLOGIST PROVIDES INITIAL POSTOPERATIVE CARE AND TRANSFERS REMAINDER

Situation: Ophthalmologist provides initial postoperative care and transfers remainder of the follow-up care to another provider.

Billing: The ophthalmologist performs procedure 66985 for cataract surgery and enters procedure code 66985-54 on first detail.

On the second detail, the provider enters procedure code 66985-55 with same date of surgery and place of service as on first detail.

The dates the provider is responsible for postoperative care must be entered in the FROM and TO dates in block 16 on the HCFA-1500 claim or in the designated field for tape or ECS format.

Note: The provider who has accepted responsibility for the remainder of postoperative days (ophthalmologist or optometrist), will also bill the surgical procedure code with modifier 55. In the above example, the provider would bill 66985-55.

EXAMPLE IV: OPHTHALMOLOGIST PERFORMS SURGERY AND ALL POSTOPERATIVE CARE

Situation: The ophthalmologist performs procedure 66983 for cataract surgery.

Billing: Procedure code 66983 is entered on the claim without modifier 54 or 55.
Reimbursement for Modifiers 54 and 55:

Reimbursement for codes billed with modifiers 54 and 55 is based on the Federal Register Percentage Table. This table shows the percentage of the total global reimbursement amount that is allocated to the preoperative care, the surgical care, and the postoperative care. Reimbursement for global surgical care rendered by more than one physician, regardless of the number of physicians, cannot exceed the amount allowable if all services were rendered by one physician.

When a recipient is covered by both Medicare and Medicaid, the provider will follow Medicare billing guidelines. Medicaid will continue to pay coinsurance and deductible on crossover claims.

Bilateral Procedures:

When cataract surgery is performed on both eyes at the same time, modifier 50 (denotes a bilateral procedure) is added to the surgical procedure code along with either modifier 54 or 55. Appending modifier 50 indicates the procedure was performed bilaterally during the same operative session and will reimburse the lesser of the submitted charge or 150% of the fee schedule amount. For further information on modifier 50, refer to the Modifier Special Bulletin, April 1999, page 42.

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

Attention: Obstetric Providers

Codes Included in the Total OB Package Codes

The following list includes all codes that are included in the OB package. These codes should not be billed separately by the OB provider.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</tr>
</tbody>
</table>

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

Attention: All Providers
Anesthesia Policy

Following publication of the Modifier Special Bulletin in April 1999 the Division of Medical Assistance has received numerous inquiries concerning "changes" to current anesthesia policy.

Four significant changes to anesthesia policy were addressed with the completion of the modifier project. The following are those changes:

1. The addition of coverage for Monitored Anesthesia Care.
2. A review of anesthesia base units to align with Medicare. These changes can be obtained by faxing a request to Financial Operations at the Division of Medical Assistance at (919) 715-0896.
3. Implementation of modifiers allows system auditing of a previously published policy in the Medicaid Bulletin, August 1994, page 3, titled, “CPT Anesthesia Guidelines”. Taken directly from the CPT anesthesia section, this continues to be the Division’s policy on anesthesia services.
4. “Providers of anesthesia services are reminded that Medicaid reimbursement for anesthesia procedures follows CPT Anesthesia Guidelines. As defined, these services include the usual preoperative and postoperative visits, the anesthesia care during the procedure, the administration of fluids and/or blood and the usual monitoring services (i.e., ECG, temperature, blood pressure, oximetry, capnography and mass spectrometry). Unusual forms of monitoring (i.e., intra-arterial, central venous and SwanGanz) are not included.”
5. Use of modifier 59 to “unbundle” procedures usually included in anesthesia, but considered for payment when a distinct procedural service is performed.

No other changes to existing anesthesia policy and billing requirements were made.

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

Attention: All Providers

Stand-by Procedure Code 99360

Effective with date of service July 1, 1999, CPT Code 99360 cannot be used for anesthesia stand-by services or pre-anesthesia evaluations. This code is only available for physician stand-by services at high-risk deliveries.

Please refer to the June 1999 Medicaid Bulletin.

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

Prior Approval of Services

Medicaid recipients may be enrolled in a Health Maintenance Organization (HMO) through the Medicaid Program in the following counties: Davidson, Durham, Forsyth, Gaston, Guilford, Harnett, Mecklenburg, Orange, Person, Rockingham, Stokes, and Wake. The HMO is responsible for providing the following services to its members:

- Adult Health Screenings
- Ambulance
- Chiropractic Services
- Clinic Services- Except for Mental Health and Substance Abuse
- Diagnostic Services
- Dialysis
- Durable Medical Equipment
- Emergency Room
- Eye Care
- Family Planning Services and Supplies
- Health Check (EPSDT)
- Hearing Aids
- Home Health
- Home Infusion Therapy
- Hospice
- Inpatient Hospital- Except for Mental Health and Substance Abuse
- Laboratory Services
- Midwife
- Occupational Therapy
- Optical Supplies
- Outpatient Hospital
- Physical Therapy
- Physician Services- Including Physician Assistants and Family Nurse Practitioners- Except for Mental Health and Substance Abuse
- Private Duty Nursing
- Prosthetics/Orthotics
- Radiology Services
- Speech Therapy
- Sterilization
- Total Parenteral Nutrition

Providers must contact the HMO for prior approval of these services. Providers are responsible for verifying Medicaid eligibility as well as managed care enrollment each month. The Medicaid identification (MID) card provides eligibility and HMO enrollment information. HMO enrollment is printed in the middle of the card and lists the HMO’s name, address, and telephone numbers. The Member Services telephone number is first and is used to request authorization of services for HMO members. HMO enrollment can also be verified through EDS Voice Inquiry by calling 1-800-723-4337. If Voice Inquiry confirms that a Medicaid recipient is enrolled with an HMO, then the provider may call DMA’s Managed Care Section at 919-857-4022 for specific HMO information. Electronic Data Interchange (EDI) is another source for eligibility and HMO enrollment information. Approved EDI vendors are listed in the February 1998 Medicaid Bulletin. All other Medicaid-covered services are paid by Medicaid, and prior approval is obtained from EDS Prior Approval.

DMA, Managed Care Section, 919-857-4022
Attention: All Providers Performing Laboratory Services

Clinical Laboratory Improvements Amendment (CLIA) Certification Expiration Date

HCFA has changed the certification period from 24 months to 6 months for CLIA certificates that have unpaid fees. Claims will be denied when the date of service exceeds the expiration date on file for the CLIA certificate number. Medicaid of North Carolina encourages providers to review your CLIA certification documentation to assure all applicable fees have been paid.

If there are further CLIA certification questions, contact the CLIA state agency in which the CLIA certification was obtained.

In North Carolina:

CLIA Certification Division of Facility Services 2713 Mail Service Center Raleigh, North Carolina 27699-2713 919-733-3032

In states other than North Carolina:

Contact the representative from the attached listing from the appropriate state:

<table>
<thead>
<tr>
<th>State</th>
<th>Telephone</th>
<th>State</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska</td>
<td>907/561-8081</td>
<td>Nevada</td>
<td>702/687-4475</td>
</tr>
<tr>
<td>Alabama</td>
<td>334/261-6525</td>
<td>New Hampshire</td>
<td>603/271-4832</td>
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<td>Arizona</td>
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<td>Arkansas</td>
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<td>Washington</td>
<td>206/361-2806</td>
</tr>
<tr>
<td>Minnesota</td>
<td>612/643-2105</td>
<td>West Virginia</td>
<td>304/558-0050</td>
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<td>Mississippi</td>
<td>601/354-7300</td>
<td>Wisconsin</td>
<td>608/266-5753</td>
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<td>Missouri</td>
<td>314/751-6318</td>
<td>Wyoming</td>
<td>307/777-6057</td>
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<td>406/444-1451</td>
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<tr>
<td>Nebraska</td>
<td>402/471-0928</td>
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</tr>
</tbody>
</table>

EDS, 1-800-688-6696 or 919-851-8888
Attention: Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Providers

Reimbursement for Core Services

Medicaid coverage includes the RHC/FQHC core services defined in Section 1861 (aa) (1) (A)-(C) of the Social Security Act. RHC and FQHC services are divided into 2 categories: core and ambulatory services. Core services are services covered by both Medicare and Medicaid and provided in a clinic setting. Laboratory and other diagnostic services incidental to the clinic visit are included in core services.

Medicare reimburses for core services according to the core visit rates established by HCFA. Medicare Rates are reviewed annually subsequent to the annual cost settlement for each provider. When a rate change is received from the fiscal intermediary RHC and FQHC providers are responsible for contacting the DMA Financial Operations at (919) 857-4015. This will ensure that the current core rate is on file with DMA. Core services are considered Part A Medicare services and will be reimbursed according to North Carolina Medicaid policy. Non-core ambulatory services include physician, dental, DME, home health services and services provided to hospital patients (including emergency room services). Non-core services are Part B Medicare services.

Medicaid billing for core services

Core services are billed with HCPCS code Y2058 for RHC core services and Y2089 for FQHC core services on the HCFA-1500 claim form. The RHC/FQHC alpha suffix “A” provider number must be on the claim form. (Example: 3403800A)

Medicaid billing for non-core services

Non-core services (outpatient and emergency room hospital services) are billed using the appropriate HCPCS and CPT procedure codes on the HCFA-1500 claim form. The RHC/FQHC alpha suffix “C” denotes the non-core service was rendered, and must be on the claim form. The appropriate suffix provider number must be billed for the service rendered, for example: the dental services suffix is “D” DME is “E”, Home Health is “F”. If applicable to the clinic, these provider numbers are assigned by DMA.

Crossover claims

Medicare tape crossover claims containing core visit revenue codes (RC520, RC521, or RC522) will be paid the core rate times the number of visits less the Medicare reimbursement amount for RHC and FQHC claims. Medicare crossover claims for core services that have a negative Medicare paid amount will be cost-settled at fiscal year-end by Medicare.

EDS, 1-800-688-6696 or 909-851-8888
GET THE LEAD OUT

DID YOU KNOW: That blood lead levels as low as 10 ug/dL are associated with significant harmful effects on a child’s behavior and ability to learn.

DID YOU KNOW: That almost 2000 young children (3.6%) screened in NC in 1998, had blood lead levels > 10 ug/dL.

DID YOU KNOW: That simple nutrition and environmental interventions (such as frequent and careful dusting and mopping) can reduce blood lead levels.

DID YOU KNOW: That a national study indicates that young children on Medicaid or WIC are nearly five times more likely to have an elevated blood lead level than other children.

DID YOU KNOW: That only 25% of children ages one and two in NC were screened for lead in 1998.

DO YOU RECALL: That children on Medicaid, NC Health Choice or WIC are required to be screened at ages one and two, or before 72 months if they have not been screened previously.

WHAT ARE YOU WAITING FOR: Screen young children for lead

KIDS RUN BETTER UNLEADED

Ed Norman, Division of Environmental Health  (919) 715-5381
Attention: Independent Practitioner Providers (IPPs)

Independent Practitioner Seminars

Independent Practitioner seminars will be held in October 1999. The September Medicaid Bulletin will have the registration form and a list of site locations for the seminars. Please list any issues you would like addressed at the seminars. Return form to:

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

Attention: Adult Care Homes (ACH) Providers

Adult Care Home (ACH) Seminars

Adult Care Home (ACH) seminars will be held in October 1999. The September Medicaid Bulletin will have the registration form and a list of site locations for the seminars. Please list any issues you would like addressed at the seminars. Return form to:

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

Attention: All Providers

NCECS Software Training Seminars

NCECS software training seminars will be held in October 1999. The September Medicaid Bulletin will have the registration form and a list of site locations for the seminars. Please list any issues you would like addressed at the seminars. Return form to:

ECS Department
EDS
P.O. Box 300009
Raleigh, NC 27622

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

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- August 10, 1999   September 8, 1999   October 12, 1999
- August 17, 1999   September 14, 1999  October 19, 1999
- August 26, 1999   September 21, 1999  October 28, 1999
- September 30, 1999

Electronic Cut-Off Schedule *

- August 6, 1999   September 3, 1999  October 8, 1999
- August 13, 1999   September 10, 1999  October 15, 1999
- August 20, 1999   September 17, 1999  October 22, 1999
- September 24, 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
Division of Medical Assistance
Department of Health and Human Services

James R. Clayton
Executive Director
EDS

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