



# North Carolina Medicaid Bulletin

An Information Service of the Division of Medical Assistance  
 Published by EDS, fiscal agent for the North Carolina Medicaid Program

Visit DMA on the Web at: <http://www.dhhs.state.nc.us/dma>

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

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## Attention: All Providers

### Compliance Date for HIPAA Electronic Transactions

Effective October 1, 2005, the N.C. Medicaid program will cease acceptance of non-HIPAA compliant transaction formats. Providers currently filing on non-HIPAA compliant formats need to make the necessary changes to ensure compliance. The following article includes information regarding the Health Insurance Portability and Accountability Act (HIPAA), the importance of compliance and recommendations to become compliant.

HIPAA legislation requires the standardized transmission of electronic information. Covered entities were required to comply with these standards by October 16, 2003. Covered entities are defined in HIPAA as:

1. Health plans.
2. Health care clearinghouses or vendors.
3. Health care providers who transmit any health information in electronic format in connection with a transaction covered in the HIPAA Transaction Rule. These terms are defined in detail in 45 CFR 160.103.

The N.C. Medicaid program, as a covered entity, satisfied the HIPAA compliance date by implementing the American National Standard Institute (ANSI) Accredited Standards Committee (ASC) X12N standards, Version 4010A1 on October 13, 2003, for the following transactions:

- Health Care Claim (Professional, Institutional, Dental) – 837 Transaction
- Health Care Claim Payment/Advice – 835 Transaction
- Health Care Claim Status Request and Response – 276/277 Transaction
- Benefit Enrollment and Maintenance – 834 Transaction
- Payroll Deducted and Other Group Premium Payment for Insurance Products – 820 Transaction
- Eligibility Benefit Inquiry and Response – 270/271 Transaction
- Health Care Services Review-Request for Review and Response – 278 Transaction

The N.C. Medicaid program also implemented the National Council for Prescription Drug Programs (NCPDP), Versions 1.1 Batch and 5.1 Point-of-Sale, in accordance to HIPAA legislation, as the standard for all retail pharmacy transactions.

Although the compliance date mandated by HIPAA was October 16, 2003, CMS allowed payers, including the N.C. Medicaid program, to continue accepting non-compliant formats to minimize financial hardship for the associates with whom they exchange transactions. The N.C. Medicaid program has been accepting both compliant and non-compliant transactions since October 13, 2003. October 1, 2005 marks the date the N.C. Medicaid program will cease accepting transactions on non-compliant electronic formats.

#### **Compliance Options**

Providers currently submitting claims via non HIPAA-compliant formats have several options for meeting the compliance date indicated above. These options are briefly detailed below:

1. Vendor - Providers may purchase HIPAA compliant software, from a vendor, which allows the creation of HIPAA compliant transactions. Providers who exercise this option will be required to have a [Trading Partner Agreement](#) on file, and are required to complete transaction testing before submitting transactions in production to N.C. Medicaid.

2. Clearinghouse – Providers may contract for the services of a clearinghouse. A clearinghouse acts as a middle-man between the provider and payer. Providers submit claims to the clearinghouse; in turn, the clearinghouse forwards the transactions to payers for adjudication. Under this option, the [Trading Partner Agreement](#) exists between the clearinghouse and the fiscal agent for N.C. Medicaid program since the clearinghouse is the actual entity submitting transactions to N.C. Medicaid on behalf of the provider.

3. In-House – Providers with technical staff or services may create their own transactions based on the standard electronic formats. As with the vendor solution, providers are required to have a [Trading Partner Agreement](#) on file and test with N.C. Medicaid before transactions can be filed in production.

4. NCECSWeb - Providers may file claims directly to N.C. Medicaid using NCECSWeb. NCECSWeb replaces all previous versions of N.C. Medicaid created claims filing software such as NECS and NCECS. NCECSWeb is a claims filing tool only and is only compatible with N.C. Medicaid. NCECSWeb complies with the data content standards required by HIPAA.

Providers are encouraged to begin the transition to one of these HIPAA-compliant formats immediately to ensure ample time to test and address compliance errors, if necessary. Regardless of the option selected, all providers who wish to file claims electronically will be required to have an [Electronic Claims Submission Agreement](#) on file for their provider number.

Providers should ensure that vendors, clearinghouses, and other associates with whom they conduct business are HIPAA-compliant. Providers must also be aware that HIPAA is federal legislation and impacts more than N.C. Medicaid. It may be necessary for providers to make changes in claims filing practices with all associated health plans.

### **Additional Information**

Implementation guides for the ASC X12N and NCPDP (Pharmacy) transactions listed in this bulletin article have been established as the standard for HIPAA compliance. The implementation guides for ASC X12N transactions are available at <http://www.wpc-edi.com>. The NCPDP implementation guide is available at <http://www.ncpdp.org>. The guides offer a detailed layout for standard transaction formats. In addition, to ensure a seamless transition from non-compliant electronic formats to HIPAA standard formats, companion guides have been published. These guides provide the specifics requirements necessary to successfully exchange transactions electronically with the N.C. Medicaid program in ASC X12 and NCPDP standard formats. The information contained in the guides is for billing providers, their technical staff, clearinghouses or vendors. N.C. Medicaid companion guides are available at: <http://www.dhhs.state.nc.us/dma/hipaa/compguides.htm>. Please visit the website on a regular basis to see if changes have been made to the companion guides that may impact your electronic transaction exchange with EDS.

Additional helpful information regarding HIPAA legislation can be found at:

- Centers for Medicare and Medicaid Services' HIPAA page: <http://www.cms.hhs.gov/hipaa>
- Workgroup for Electronic Data Interchange (WEDI) — HIPAA page: <http://www.wedi.org>
- June 2003, Special Bulletin II, HIPAA Update  
<http://www.dhhs.state.nc.us/dma/bulletin/0603specbull.htm>

For questions, please contact EDS Electronic Commerce Services at 1-800-688-6696, or 919-851-8888, option 1.

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

## Attention: All Providers

# Facts for Providers Regarding the Medicare Prescription Drug Plans That Will Become Available in 2006 Provider Action Needed

**The following article is reprinted from Medlearn Matters with permission from CMS.**

This special edition article provides updated information regarding the Medicare Prescription Drug Plans that will be available to Medicare beneficiaries in 2006. This new benefit was established by the Medicare Modernization Act (MMA), which was enacted in 2003. This new drug coverage requires **every** Medicare beneficiary to make a decision this fall. As a trusted source, your patients may turn to you for information about this new coverage. Because of this, we're looking to you and your staff to take advantage of this "teachable moment" and help your Medicare patients. Help can be as simple as referring them to CMS beneficiary educational resources such as 1-800-MEDICARE and <http://www.medicare.gov>. It is important to encourage your patients to learn more about the new coverage as it may save them money on prescription drug costs.

### The Basic Plan

Beginning January 1, 2006, new Medicare prescription drug plans will be available to all people with Medicare. Insurance companies and other private companies will be working with Medicare to offer these drug plans and negotiate discounts on drug prices. These plans are different from the Medicare-approved drug discount cards that phase out by May 15, 2006, or when a beneficiary's enrollment in a Medicare prescription drug plan takes effect, if earlier. The cards offered discounts, while the plans offer insurance coverage for prescription drugs. Medicare prescription drug plans provide insurance coverage for prescription drugs, and like other insurance plans, participating beneficiaries will pay:

- A monthly premium (generally around \$37 in 2006); and
- A share of the cost of their prescriptions (with costs varying depending on the drug plan chosen by the beneficiary).

In addition, drug plans can vary depending on the following:

What prescription drugs are covered?

- How much the beneficiary pays; and
- Which pharmacies the beneficiary can use.

All drug plans will provide a standard level of coverage which Medicare will set. However, for a higher monthly premium, some plans might offer more coverage and additional medications. When a Medicare beneficiary joins a drug plan, it is important that they choose one that meets their prescription drug needs. The following questions and answers provide key information that might be of interest to you, your staff, or your patient.

### When can your patients enroll in this new plan?

If a beneficiary currently has Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical Insurance), the beneficiary can join a Medicare prescription drug plan between November 15, 2005, and May 15, 2006. In general, a beneficiary can join or change plans once each year between November 15 and December 31. If they join a Medicare prescription drug plan:

- By December 31, 2005, their coverage will begin on January 1, 2006; and
- After December 31, 2005, their coverage will be effective the first day of the month after the month they join.

Even if a beneficiary does not use many prescription drugs now, they still should consider joining a plan. If they don't join a plan by May 15, 2006, and they don't have a drug plan that covers as much or more than a Medicare prescription drug plan, they will have to pay more each month to join later.

### **What if the Medicare beneficiary can not pay for a Medicare prescription drug plan?**

Some people with an income at or below a set amount and with limited assets (including their savings and stocks, but not counting their home) will qualify for extra help.

The exact income amounts will be set in early 2005. People who qualify will get help paying for their drug plan's monthly premium, and/or for some of the cost they would normally have to pay for their prescriptions.

The type of extra help received will be based on income and assets. In mid-2005, SSA will send people with certain incomes information about how to apply for extra help in paying for their prescription drug costs. If they think they may qualify for extra help, they can sign up with the Social Security Administration (SSA) or their local Medicaid office as early as the summer of 2005.

### **Will this new plan work with other Medicare coverage that your patients may have?**

Yes, Medicare prescription drug plans work with all types of Medicare health plans, and there will be:

- Medicare prescription drug plans that add coverage to the Original Medicare Plan (these plans will be offered by insurance companies and other private companies); and
- Medicare prescription drug plans that are a part of Medicare Advantage Plans (like HMOs), in some areas.

### **What if a Medicare beneficiary has a Medigap policy with drug coverage or prescription drug coverage from an employer or union?**

The Medicare beneficiary will get a detailed notice from their insurance company or the employer or union informing them whether or not their policy covers as much or more than a Medicare prescription drug plan.

This notice will explain their rights and choices.

If a Medicare beneficiary's employer or union plan covers as much as or more than a Medicare prescription drug plan, they can:

- Keep their current drug plan. If they join a Medicare prescription drug plan later, their monthly premium won't be higher; or
- Drop their current drug plan, and join a Medicare prescription drug plan. However, they may not be able to get their employer or union drug plan back.

If a Medicare beneficiary's employer or union plan covers less than a Medicare prescription drug plan, they can:

- Keep their current drug plan, and join a Medicare prescription drug plan to give them more complete prescription drug coverage; or
- Keep their current drug plan. However, if they join a Medicare prescription drug plan later, they will have to pay more for the monthly premium; or
- Drop their current drug plan and join a Medicare prescription drug plan. However, they may not be able to get their employer or union drug plan back.

### **Additional Information**

More information on provider education and outreach regarding drug coverage can be found at:

<http://www.cms.hhs.gov/medlearn/drugcoverage.asp>

The information contained in this article is based on a fact sheet for beneficiaries. To obtain a copy of this fact sheet for your patients, visit: <http://www.medicare.gov/Publications/Pubs/pdf/11065.pdf>

You can also find additional information regarding prescription drug plans at: <http://www.cms.hhs.gov/pdps/>

Further information on CMS implementation of the MMA can be found at the following CMS web site: <http://www.cms.hhs.gov/medicarereform/>

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

## Attention: All Providers

### Influenza Vaccine Coverage Billing Guidelines

#### **Reimbursement for the Injectable Vaccine for Recipients through Age 18:**

The Immunization Branch distributes childhood vaccines to local health departments, hospitals, and private providers to be used in accordance with the N.C. Universal Childhood Vaccine Distribution Program/Vaccine for Children (UCVDP/VFC) coverage criteria and state law/administrative code. The N.C. Medicaid program does not routinely reimburse for vaccines that are supplied through UCVDP/VFC for recipients through 18 years of age. However, due to the shortage of the influenza vaccine during the 2004-2005 flu season, Medicaid **will** reimburse providers who have purchased a supply of the injectable vaccine because the supply of free vaccine used for recipients through 18 years of age has been exhausted. Reimbursement for purchased vaccine will be made for dates of service October 1, 2004 through March 31, 2005.

Modifier SC, medically necessary service or supply, must be used to denote that the vaccine administered was purchased and not obtained from the UCVDP/VFC program. Modifier SC will only be effective for this time period and will only be applicable for recipients through age 18.

Providers must bill one of the following code combinations when purchased influenza vaccine was administered to a recipient less than 19 years of age, when the UCVDP/VFC vaccine was exhausted:

1. CPT code 90655 appended with the SC modifier
2. CPT code 90657 appended with the SC modifier
3. CPT code 90658 appended with the SC modifier

#### **Reimbursement for the Injectable Vaccine for Recipients 19 Years of Age and Older:**

Providers may bill Medicaid for influenza vaccine for high-risk adults 19 and 20 years of age using CPT code 90658. Refer to the 2004 Health Check Billing Guide, page 7 for billing guidelines.

All providers may bill Medicaid for purchased influenza vaccine for high-risk adults >20 years of age using CPT code 90658, and for the administration fee using CPT code 90471. An Evaluation and Management (E/M) code cannot be reimbursed to any provider on the same day that injection administration fee codes (90471, or 90471 and 90472) are reimbursed, unless the provider bills an E/M code for a separately identifiable service by appending modifier 25 to the E/M code.

#### **Reimbursement for FluMist Vaccine:**

##### **FluMist will be reimbursed only when administered at a local health department.**

All providers must use CPT code 90660, influenza virus vaccine, live, for intranasal use, when reporting FluMist administration. An administration fee will **not** be reimbursed in addition to the cost of the vaccine.

Due to the shortage of the influenza vaccine during this season, Medicaid **will** reimburse health department providers who have purchased a supply of FluMist when it is used for recipients age 5 through 18 years of

age. Reimbursement for this purchased vaccine will be made for dates of service October 1, 2004 through March 31, 2005.

Modifier SC must be used to denote that the vaccine administered was purchased. This modifier will only be effective for October 1, 2004 through March 31, 2005. Modifier SC will be applicable for recipients 5 through 49 years of age. For recipients 21 through 49 years of age, diagnosis code V04.81 should be provided on the claim.

Providers must bill one of these two ways for FluMist:

1. CPT code 90660 (with no modifier) to report the free vaccine.
2. CPT code 90660 (with modifier SC) to bill for the purchased vaccine. This can only be billed by health departments.

### **Billing Reminders for Vaccine Supplied Through VFC**

Medicaid does not reimburse for influenza vaccine that is supplied through UCVDP/VFC for recipients through 18 years of age. For the injectable influenza vaccines, report CPT code 90655 or 90657 for children > 6 months through 35 months of age and CPT code 90658 for children > 3 years of age through 18 years of age. Providers may bill for an administration fee with injectable vaccines using CPT code 90471 or 90471 and 90472, as appropriate. Local health departments, however, may only bill CPT code 90471 with the EP modifier for any visit other than a Health Check screening. Refer to the 2004 Health Check Special Bulletin, page 7, for billing guidelines.

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

Attention: All Providers

## **NC**Leads Update

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

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

## Attention: All Providers

# New Medicare Prescription Drug Program Provider Action Needed

**The following article is reprinted from Medlearn Matters with permission from CMS.**

### **STOP – Impact to You**

On January 1, 2006, a very important new benefit will be available to your Medicare patients. These new Medicare Prescription Drug Plans will be of significant value to your patients by providing assistance with prescription drug expenses. This program is authorized under the Medicare Modernization Act of 2003 (MMA). Your patients may ask you about this new benefit.

### **CAUTION – What You Need to Know**

The Centers for Medicare & Medicaid Services (CMS) is preparing an extensive campaign for both providers and beneficiaries, and will be disseminating information to these audiences. Over the next year, as materials are developed, you will be notified through a series of Medlearn Matters articles and other resources. Some providers will choose to be active in giving information to their Medicare patients, and we will help you do that. CMS encourages and appreciates the work providers are willing to do to help people with Medicare learn about this important new benefit.

### **GO – What You Need to Do**

Stay informed. Go to the newly established web site:

<http://www.cms.hhs.gov/medicarerereform/pdbma/> and check it often as new information is always being added. This easy-to-use website has a "General Information" link to the press releases, issue papers, fact sheets, and full copies and summaries of both regulations. Users can follow the menu and select the area that best matches their area of interest. Refer your Medicare patients to information resources – **1-800- MEDICARE** and [www.medicare.gov](http://www.medicare.gov).

### **Background**

On December 8, 2003, the Medicare Modernization Act (MMA) was enacted, adding a very important new benefit to the Medicare program. This new benefit takes effect on January 1, 2006, and provides a much needed new drug benefit to help serve the 41 million Americans who rely on Medicare for their health care needs. On January 21, 2005, Health and Human Services Secretary Tommy G. Thompson announced the final regulations establishing the new Medicare prescription drug benefit program. This is a very important step in making this great addition to the Medicare program a reality for your Medicare patients. This is a very special time for your patients with Medicare, full of many exciting program improvements and enhancements. Great opportunities exist right now, through the MMA, to make the Medicare program more personalized and more up to date, and to keep it up to date. The Medicare Drug Benefit is a major step in that direction. A very important step toward fulfilling that opportunity is in the final regulation for the Medicare Drug Benefit Program. Along with the new Medicare Preventive benefits, this major program improvement bring Medicare's coverage up to date with 21st Century prevention-minded medicine.

### **WE NEED YOUR HELP**

Because people with Medicare trust their physicians, other clinicians, pharmacists, and other health care providers, you are in a unique position to direct them to the resources available to help them learn about the new benefit. If any of your patients rely on caregivers, CMS appreciates your efforts to get this information into their hands as well.

CMS will be pursuing a number of activities to make sure the physician, provider, and supplier communities know about this new benefit, understand how it works, and will be highlighting the information that may be of

most value to your Medicare patients. As educational materials are developed, you will be notified of their availability. These materials will help you and your staff understand the new benefit. CMS will keep you up-to-date with education and outreach efforts on the new drug benefit. Here's how you can stay connected:

- Pay attention to correspondence from your Medicare carrier or fiscal intermediary or your national professional associations. They are part of the information stream from CMS to the community of professionals who serve people with Medicare; sign up for their listservs and read their newsletters;
- Register to receive listserv email messages to alert you when new Medlearn Matters articles have been released on the new drug benefit (and other Medicare information). Medlearn Matters articles provide succinct and timely messages on Medicare claims processing and other changes. These articles can be found on the web at <http://www.cms.hhs.gov/medlearn/matters>
- Participate in CMS Open Door Forums to hear from and ask questions of CMS leadership on topics of interest to your particular provider-type. Information regarding these Open Door Forums may be found on the web at: <http://www.cms.hhs.gov/opendoor>

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

## Attention: All Providers

### Provision of Orthotic and Prosthetic Devices

Effective with date of service July 1, 2005, Medicaid will change coverage of orthotic and prosthetic devices to include recipients age birth through 115 years; previously, coverage was limited to recipients under age 21. Session Law 2004-124 allowed for this change in Medicaid's coverage of orthotic and prosthetic devices. The law also requires that providers of orthotics and prosthetics be board-certified.

Below is a list of the new provider qualifications for orthotic and prosthetic providers, which is effective July 1, 2005:

1. American Board for Certification in Orthotics and Prosthetics (ABC)-Certified Orthotist or Board for Orthotist/Prosthetist Certification (BOC)-Certified Orthotist
2. American Board for Certification in Orthotics and Prosthetics (ABC)-Certified Prosthetist or Board for Orthotist/Prosthetist Certification (BOC)-Certified Prosthetist
3. American Board for Certification in Orthotics and Prosthetics (ABC)-Certified Prosthetist/Orthotist or Board for Orthotist/Prosthetist Certification (BOC)-Certified Prosthetist/Orthotist
4. Board for Certification in Pedorthics-Certified Pedorthist
5. National Examining Board of Ocularists-Certified Ocularist
6. American Board for Certification in Orthotics and Prosthetics (ABC)-Registered Fitter-Orthotics
7. Board for Orthotist/Prosthetist Certification (BOC)-Certified Orthotic Fitter
8. American Board for Certification in Orthotics and Prosthetics (ABC)-Registered Fitter-Mastectomy
9. Board for Orthotist/Prosthetist Certification (BOC)-Certified Mastectomy Fitter
10. American Board for Certification in Orthotics and Prosthetics (ABC)-Registered Fitter-Orthotics Mastectomy.

Currently enrolled durable medical equipment providers will need to enroll their board certified staff members in order to receive prior approval or bill for orthotic and prosthetic devices on or after July 1, 2005.

Upcoming bulletins will inform providers when DMA will begin enrolling these certified practitioners and will also announce orthotic and prosthetic provider seminar dates and locations.

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

Attention: All Providers

## Clinical Coverage Policies

The following new or amended clinical coverage policies are now available on the Division of Medical Assistance's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm>:

### **8C – Outpatient Behavioral Health Services Provided by Direct Enrolled Providers**

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

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

Attention: All Providers

## 2004 Claim Adjustments for Physician, Laboratory, and Independent Mental Health Procedure Codes

N.C. Medicaid will be adjusting claims for physician procedure codes, laboratory procedure codes, and independent mental health procedure codes that had a rate change in 2004. This adjustment is necessary due to Medicare providing a second set of Medicare rates for 2004. The adjustment will affect claims with a date of service January 1, 2004 through February 18, 2004.

These adjustments will begin on the May 5, 2005 checkwrite and will continue for several checkwrites. You will be able to identify these adjustment by their batch numbers. The first few batch numbers to be used for these adjustments will begin with these numbers 902004354, 902004360, 902004361, 902005022, 902005023, and 902005030.

Should you have any questions, please contact EDS Provider Services at 1-800-688-6696.

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

Attention: Employees of Physicians Offices, Hospital Outpatient Departments, Local Health Departments Who Provide Mental Health Services, and Local Management Entities.

**D**irect Enrollment for Outpatient Behavioral Health Services

Effective July 1, 2005 all PhD's, LPA, LCSW, LPC, Nurse Practitioners, CNS, LMFTs, CCS, and CCAS must be enrolled with Medicaid whether in an individual practice, a group practice or employed by a physician, physician group, hospital outpatient department, health department or the area program/LME with one exception.

**If one of the above disciplines is employed by a physician and is practicing only under the "incident to" guidelines, direct enrollment is optional. Please refer to the May 2005 Special Bulletin IV, Outpatient Behavioral Health Services for additional information.**

**S**eminar Schedule for the Expansion of Provider Types for Outpatient Behavioral Health Services

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

Providers are encouraged to arrive 30 minutes before the seminar begins to complete registration. Unregistered providers are welcome to attend if space is available. No food or drinks will be provided.

Providers may register for the seminars by completing and submitting the registration form on the next page or by registering online at <http://www.dhhs.state.nc.us/dma/provem.htm>.

The [May 2005 Special Bulletin IV, Outpatient Behavioral Health Services Provided by Direct Enrolled Providers](#), will be used as the primary training document for the seminar. The special bulletin will be available on DMA's website beginning May 1<sup>st</sup> 2005 at <http://www.dhhs.state.nc.us/dma/bulletin.htm>. Please print the special bulletin and bring it to the seminar.

Tuesday, June 7, 2005 (9:00 a.m. – 1:00 p.m.) Blue Ridge Community College Bo Thomas Auditorium Flat Rock, NC	Wednesday, June 8, 2005 Holiday Inn Conference Center 530 Jake Alexander Blvd Salisbury, NC
Thursday June 9, 2005 (9:00 a.m. – 1:00 p.m.) Greenville Hilton 207 Greenville Blvd. SW Greenville, NC	Friday, June 10, 2005 (9:00 a.m. – 1:00 p.m.) Jane S. McKimmon Center 1101 Gorman Street Raleigh, NC

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

## **Blue Ridge Community College, Bo Thomas auditorium – Flat Rock, North Carolina**

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

## **Greenville Hilton – Greenville, North Carolina**

Take US 64 east to US 264 east. Follow 264 east to Greenville. Once you enter Greenville, turn right on Allen Road. After traveling approximately 2 miles, Allen road becomes Greenville Boulevard / Alternate 264. Follow Greenville Boulevard for approximately 2 ½ miles. The Greenville Hilton is located on the right.

## **Jane S. McKimmon Center – Raleigh, North Carolina**

### Traveling East on I-40

Take exit 295 and turn left onto Gorman Street. Travel approximately one mile. The McKimmon Center is located on the right at the corner of Gorman Street and Western Boulevard.

### Traveling West on I-40

Take exit 295 and turn right onto Gorman Street. Travel approximately one mile. The McKimmon Center is located on the right at the corner of Gorman Street and Western Boulevard.

## **Holiday Inn Conference Center – Salisbury, North Carolina**

### Traveling South on I-85

Take exit 75. Turn right onto Jake Alexander Boulevard. Travel approximately ½ mile. The Holiday Inn is located on the right.

### Traveling North on I-85

Take exit 75. Turn left onto Jake Alexander Boulevard. Travel approximately ½ mile. The Holiday Inn is located on the right.

(cut and return the registration form only)

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**Outpatient Behavioral Health Provider Expansion Seminar Registration Form**  
**(No Fee)**

Provider Name \_\_\_\_\_ Provider Number \_\_\_\_\_

Address \_\_\_\_\_

City, Zip Code \_\_\_\_\_ County \_\_\_\_\_

Contact Person \_\_\_\_\_ E-mail \_\_\_\_\_

Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

**1** or **2** (circle one) person(s) will attend the seminar at \_\_\_\_\_ on \_\_\_\_\_

Return to: Provider Services  
EDS P.O. Box 300009  
Raleigh, N.C. 27622

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

Attention: Independent Practitioners, Local Education Agencies, and Physicians

Revision to Rates for Occupational Therapy, Physical Therapy, Respiratory Therapy, and Audiology Services

Effective with dates of service May 1, 2005, the rates for the following CPT codes have changed:

<b>Procedure Code</b>	<b>Description</b>	<b>Non-Facility Fee Maximum Reimbursement Rate</b>	<b>Facility Fee Maximum Reimbursement Rate</b>
92553	Pure tone audiometry (threshold); air and bone	\$23.36	\$23.36
92555	Speech audiometry threshold	\$13.58	\$13.58
92556	Speech audiometry threshold; with speech recognition	\$20.36	\$20.36
92557	Comprehensive audiometry threshold evaluation and speech recognition (92553 & 92556 combined)	\$42.39	\$42.39
92568	Acoustic reflex testing	\$13.58	\$13.58
92571	Filtered speech test	\$13.91	\$13.91
92572	Staggered spondaic word test	\$3.23	\$3.23
92579	Visual reinforcement audiometry (VRA)	\$25.69	\$25.69
92582	Conditioning play audiometry	\$25.69	\$25.69
92585	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive	\$90.52	\$90.52
94010	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation	\$48.30	\$29.12

<b>Procedure Code</b>	<b>Description</b>	<b>Non-Facility Fee Maximum Reimbursement Rate</b>	<b>Facility Fee Maximum Reimbursement Rate</b>
94150	Vital capacity, total (separate procedure)	\$33.21	\$18.63
94664	Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device	\$23.86	\$11.25
94667	Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation	\$36.25	\$18.47
94668	Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or subsequent	\$32.18	\$15.45
94760	Noninvasive ear or pulse oximetry for oxygen saturation; single determination	\$4.58	\$1.79
97001	Physical therapy evaluation	\$69.33	\$59.34
97002	Physical therapy re- evaluation	\$36.72	\$29.72
97003	Occupational therapy evaluation	\$73.89	\$57.91
97004	Occupational therapy re- evaluation	\$44.38	\$28.39

**Note:** Providers must bill their usual and customary charges.

**Laurie Seaver, Financial Management  
DMA, 919-855-4200**

## Attention: All Optical Providers

### **P**rior Approval and Billing Reminders for Routine Eye Exams (With Refraction) and Refraction Only

#### **Prior Approval**

Routine eye exams (92004 and 92014) and refraction only (92015) do not require prior approval. However, it is in the best interest of the provider to confirm coverage by obtaining a confirmation number through the Automated Voice Response (AVR) system. The 14-digit confirmation number is for the provider's records. It is not necessary to enter the confirmation number in block 23 of the CMS-1500 claim form.

For a confirmation number, providers should call the AVR system at 1-800-723-4337, press 1 (N.C. Medicaid Inquiries), then press 5 (Verify Prior Approval), and finally, press 3 (Verify Refraction Benefits).

It is in the provider's best interest to obtain this confirmation number **on** the day of the service, **prior to** the service being rendered. If a confirmation number is obtained through the AVR system **prior to** the service being rendered, and the claim is denied for previous eye exam/refraction, contact EDS Prior Approval at 1-800-688-6696 for assistance.

#### **Billing**

Bill routine eye exams (92004 and 92014) and refraction only (92015) with a refraction diagnosis code using the refraction date as the date of service. Billing with a medical diagnosis will cause claims to deny.

For additional information on using the AVR, refer to the July 2001 Special Bulletin II, Automated Voice Response System Instructions on DMA's website at <http://www.dhhs.state.nc.us/dma/bulletin.htm>.

Please call EDS Optical Prior Approval if there are any questions: 1-800-688-6696, Option 2 for Prior Approval and Option 2 for Optical.

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

## Attention: Physicians and Independent Laboratories

### CLIA Certification Related Claim Denials

Some claims submitted for waived laboratory tests have denied even though the provider has a CLIA certification that allows them to perform provider-related microscopy procedure tests. These claims were incorrectly denied with EOB 0936, certification not valid for DOS/Level. System changes have been made to correct this problem. Denied claims may now be resubmitted for processing.

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

## Attention: Physicians, Nurse Practitioners and Nurse Midwives

### Obstetrical Ultrasounds of Multiple Fetuses

New and revised obstetrical ultrasound CPT codes were published by the American Medical Association on January 1, 2003. Some of these codes provide a mechanism for billing ultrasounds based on the number of fetuses in a multigestational pregnancy. Since the implementation of these codes, providers have been receiving inappropriate denials for some claims for ultrasound of multiple fetuses. The system has been corrected to allow appropriate reimbursement.

Effective May 1, 2005, the time limit filing requirement has been waived to allow providers to resubmit previously denied claims with dates of service on or after January 1, 2003 through December 31, 2003. However, providers must submit these claims before August 31, 2005. The waiver of the time limit filing requirement applies only to the following codes:

76801	76802	76805
76810	76811	76812
76815	76816	76817

**Note:** Denied claims for 2004 dates of service must be resubmitted within the usual time filing period.

When billing for the ultrasound of multiple fetuses, the following guidelines should be observed.

- The primary transabdominal code must be billed as one detail with one unit of service. (These codes are 76801, 76805, and 76811.)
- The add-on code must be billed on one detail line with the units of service equaling the number of additional fetuses (76802, 76810, and 76812).
- Each add-on code must be billed with the correct primary code.
- The add-on codes for “each additional fetus” must be billed with the appropriate multiple gestation diagnosis code from the 651 range of ICD-9-CM codes. (Do not use the fifth-digit subclassification digit 0.) The units billed for the add-on ultrasound procedure code is based on the number of “each additional” living fetus(es).

- One combination of primary and add-on ultrasound codes is allowed per day. Claims denied for additional ultrasounds may be resubmitted as an adjustment with documentation to support the medical necessity of a repeat ultrasound on the same date of service.
- 76815 is defined to include “one or more fetuses” and can only be reimbursed for one unit of service.
- When billing 76816 for multiple fetuses, bill 76816 on one detail without a modifier and with one unit for the first fetus. Additional fetuses must be billed on the next detail line using 76816 with modifier 59; the units should equal the number of additional fetuses. This code must also be billed with the appropriate diagnosis code from the 651 series of diagnosis codes as outlined above.
- In addition to the transabdominal ultrasounds, one unit of 76817 is covered on the same date of service if medically necessary. No modifier is needed. Medical necessity must be documented in the recipient’s medical record.
- Fetal biophysical profiles (76818 and 76819) are covered for additional fetuses. The profile for the first fetus must be billed on one detail, no modifier, and one unit of service. Profiles for additional fetuses must be billed on the next detail, using modifier 59, with the number of units equaling the number of additional fetuses. The appropriate diagnosis code from the 651 series should be billed as outlined above.
- Claims for fetal biophysical profiles submitted with more than one unit and without the appropriate diagnosis code will be denied. Providers should correct the claim and resubmit as a new claim.
- Claims for multigestational transabdominal ultrasounds submitted without the appropriate diagnosis will be denied. Providers should correct the claim and resubmit as a new claim.
- Medical records are required for multiple gestation diagnosis codes from the 651 range that note “fetal loss” or “other” and/or “unspecified multiple gestation.”
- In cases of fetal demise, the ultrasound procedure that confirms the loss of one, or more, fetuses may be billed with units to include the total number of additional fetuses, dead and living. Subsequent billings should be billed with the units based on the number of “each additional” living fetus.
- A fetal biophysical profile must not be billed for a fetus that has died.
- Auditing for single fetus pregnancy ultrasounds will not be changed.
- CPT code 76830 must not be billed for a transvaginal ultrasound performed for any pregnancy related condition.
- Because pregnancies with multiple fetuses are high-risk pregnancies, there is no limit to the number of ultrasounds performed during the pregnancy when billed according to these instructions. However, excessive billing of ultrasounds during a pregnancy is subject to post-payment review for medical necessity, which must be documented in the medical record.

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

## Attention: Physicians, Nurse Practitioners, Local Health Departments, Federally Qualified Health Centers, and Rural Health Centers

### Into the Mouths of Babes: Oral Screening and Fluoride Varnish Program

Since October 1, 2004, providers are no longer required to send the two-part encounter form to the Dental Varnish Project office. This discontinuation does affect Medicaid reimbursement. Providers may continue to file claims using the three appropriate Current Dental Terminology Codes (D0150 or D0120; D1203; and D1330) for the physician fluoride varnish procedure.

Providers may copy and continue to use the encounter forms for documentation and as a guide to evaluating caries risk for patients. Providers who choose not to use the form must still document in the patient's medical record the three parts of the procedure (oral screening, parent education, and fluoride varnish application) as well as any problems noted and any referrals made for dental treatment. If you have questions or concerns please contact the Into the Mouths of Babes project coordinator, Kelly Haupt, at 919-833-2466 or [khaupt@ncafp.com](mailto:khaupt@ncafp.com).

**Kelly Haupt, Into the Mouths of Babes Project Coordinator  
N.C. Academy of Family Physicians, 919-833-2466**

## Attention: Portable X-Ray Providers

### Electronic Billing for Portable X-Ray and New Level II HCPCS Modifiers for R0075

#### Electronic Billing for Portable X-Ray and New Level II HCPCS Modifiers for R0075

Currently, portable x-ray providers are required to submit claims to N.C. Medicaid on paper, indicating on the claim that the patient is “non-ambulatory”. Effective with date of service June 1, 2005, providers are no longer required to bill on paper and may begin billing electronically. To allow providers to submit claims electronically and with the institution of Level II HCPCS modifiers for portable x-ray transportation code R0075, the following changes will be made effective with date of service June 1, 2005.

#### Code Descriptions from HCPCS 2005

R0070 - Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, one patient seen.

R0075 - Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen.

#### Billing Guidelines

Providers are no longer required to write “non-ambulatory” on their claim. R0070 and R0075 must be billed in conjunction with the CPT radiology codes listed below but only when the x-ray equipment used was actually transported to the location where the x-ray was taken. R0070 and R0075 do not apply if the x-ray equipment was stored in the location where the x-ray was performed (e.g., a nursing home).

70250	70260	71010	71015	71020	71021	71022	71030	71100	71101	71110	71111	71120
71130	72010	72020	72040	72050	72052	72069	72070	72072	72074	72080	72090	72100
72110	72114	72120	72170	72190	72220	72202	72220	73000	73010	73020	73030	73060
73070	73080	73090	73092	73100	73110	73120	73130	73140	73500	73510	73520	73540
73550	73560	73562	73564	73565	73590	73592	73600	73610	73620	73630	73650	73660
74000	74010	74020	74022									

**Note:** Portable x-ray providers must continue billing modifier TC with the CPT radiology codes.

#### R0070

- Do not bill modifier 26. A modifier is not necessary when billing this code.
- Use of this code on the claim indicates that only one recipient was seen per trip.
- If multiple radiological services are performed on one recipient during the same trip, bill R0070 only once.
- Bill place of service: 04 (home), 07 (ICF), and 08 (SNF).
- Rate: \$101.20.

#### R0075

- Do not bill modifier 26.
- Use of this code on the claim indicates that multiple recipients were seen per trip.
- Bill place of service: 04 (home), 07 (ICF), and 08 (SNF).
- Rate: Reimbursement for multiple recipients is priced according to the number of recipients served with a maximum reimbursement of \$101.20.
- One of the following modifiers must be used with this code based on the number of recipients seen. Claims without one of the following modifiers will deny.

<b>Modifier</b>	<b>Description</b>
UN	Two Patients Served
UP	Three Patients Served
UQ	Four Patients Served
UR	Five Patients Served
US	Six or more Patients Served - Regardless of the number over six, only the maximum reimbursement is allowed.

**Limitation Guidelines**

The use of R0070 and/or R0075 is limited to two transportation codes per day per recipient in any combination, by the same or different provider.

**Example 1**

<b>DOS</b>	<b>Initial Trip-Same Location</b>	<b>Transportation Code</b>	<b>Modifier</b>	<b>Radiology Code</b>
06012005	Recipient A	R0075	UN	70250
06012005	Recipient B	R0075	UN	70260, 71010

<b>DOS</b>	<b>Repeat Trip</b>	<b>Transportation Code</b>	<b>Modifier</b>	<b>Radiology Code</b>
06012005	Recipient A	R0070		70250

Any further transportation claims (R0070 or R0075) for recipient A on this day of service will deny due to the billing of R0070 and R0075 for the same day for the same recipient.

**Example 2**

<b>DOS</b>	<b>Initial Trip</b>	<b>Transportation Code</b>	<b>Modifier</b>	<b>Radiology Code</b>
06022005	Recipient C	R0070		70250, 71010

<b>DOS</b>	<b>Repeat Trip</b>	<b>Transportation Code</b>	<b>Modifier</b>	<b>Radiology Code</b>
06022005	Recipient C	R0070		70250

Any further transportation claims (R0070 or R0075) for this recipient on this day of service will deny due to the billing of R0070 twice in the same day for the same recipient.

**Documentation Guidelines**

Physicians ordering a portable x-ray must document the following on a written order:

1. The recipient’s diagnosis;
2. The recipient’s suspected condition; and
3. The reason why a portable service is required.

The following information must be maintained by the portable x-ray provider in the recipient's medical record for up to five years:

1. The physician's written order, which includes the recipient's diagnosis, the recipient's suspected condition, and the reason why a portable service is required;
2. The date of service;
3. The recipient's non-ambulatory status;
4. The recipient's name and Medicaid identification number;
5. The description of the procedures ordered and performed;
6. The name(s) of the operator(s) of the portable x-ray equipment who performed the procedure(s); and
7. The name of the physician who received the x-ray and the date it was sent.

**Portable EKG**

Portable EKGs performed by portable x-ray providers are not covered by Medicaid. Therefore, effective with date of service, June 1, 2005, the following transportation procedure codes will no longer be accepted.

**R0007** – Portable EKG, one patient seen per trip.

**R0076** – Transportation of portable EKG to facility or location, per patient.

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

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## Proposed Clinical Coverage Policies

In accordance with Session Law 2003-284, proposed new or amended Medicaid clinical coverage policies are available for review and comment on DMA's website at <http://www.dhhs.state.nc.us/dma/prov.htm>. To submit a comment related to a policy, refer to the instructions on the website. Providers without Internet access can submit written comments to the address listed below.

Gina Rutherford  
Division of Medical Assistance  
Clinical Policy Section  
2501 Mail Service Center  
Raleigh, NC 27699-2501

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

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## Holiday Schedule

The Division of Medical Assistance and EDS will be closed on Monday, May 30, 2005 in observance of Memorial Day.

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### Electronic Cut-Off Schedule

04/29/05	06/03/05	07/08/05
05/06/05	06/10/05	07/15/05
05/13/05	06/17/05	07/22/05
05/20/05	07/01/05	07/29/05

### Checkwrite Schedule

05/03/05	06/07/05	07/12/05
05/10/05	06/14/05	07/19/05
05/17/05	06/23/05	07/28/05
05/26/05	07/07/05	08/02/05

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

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Mark T. Benton, Interim Director  
Division of Medical Assistance  
Department of Health and Human Services



Cheryll Collier  
Executive Director  
EDS

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