

North Carolina Medicaid Special Bulletin



An Information Service of the
Division of Medical Assistance

Visit DMA on the web at <http://www.ncdhhs.gov/dma>

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

Number IV

October 2008

Attention: Independent Practitioners

Independent Practitioner Services

Bold, italicized material is excerpted from the American Medical Association Current Procedural Terminology (CPT) Codes. Descriptions and other data only are copyrighted 2007 American Medical Association. All rights reserved.

Table of Contents

Introduction	1
Audiology Services	1
Assessment.....	1
Treatment.....	1
Speech/Language Services	1
Assessment.....	1
Treatment.....	2
Occupational Therapy Services	2
Assessment.....	2
Treatment.....	2
Physical Therapy Services	3
Assessment.....	3
Treatment.....	3
Respiratory Therapy Services	4
Assessment.....	4
Treatment.....	4
Providers Eligible to Bill for the Service	4
Audiology.....	4
Speech/Language.....	4
Occupational Therapy.....	5
Physical Therapy.....	5
Respiratory Therapy.....	5
Prior Approval	5
Billing Guidelines	5
CMS 1500 Claim Form Instructions.....	6
Additional Billing Guidelines for Specialized Therapies	8
Common EOB Denials.....	9
Resolution Inquires.....	9
Time Limit Overrides.....	10
Time Limit Override on Third-Party Insurance.....	10
Claim Adjustments.....	11

INTRODUCTION

This special bulletin pertains to Independent Practitioner providers. Each service is addressed in a separate section.

AUDIOLOGY SERVICES

Assessment

Service may include testing and clinical observation, as appropriate for the recipient's chronological or developmental age, for one or more of the following areas, and shall yield a written evaluation report.

- Auditory sensitivity, including pure-tone air and bone conduction, speech detection, and speech reception thresholds
- Auditory discrimination in quiet and noise
- Impedance audiometry, including tympanometry and acoustic reflex testing
- Hearing aid evaluation, including amplification selection and verification of central auditory function
- Evoked otoacoustic emissions
- Brainstem auditory evoked response (ABR)

Treatment

Service may include one or more of the following, as appropriate:

- Auditory training
- Speech/reading
- Augmentative and alternative communication training, including sign language and cued speech training

SPEECH/LANGUAGE SERVICES

Assessment

Service must include testing and clinical observation, as appropriate for the recipient's chronological or developmental age, for **all** the following areas, and shall yield a written evaluation report.

- Expressive language
- Receptive language
- Auditory processing, discrimination, and memory
- Augmentative and alternative communication
- Vocal quality
- Resonance patterns
- Articulation/phonological development
- Pragmatic language
- Rhythm/fluency
- Oral mechanism/swallowing
- Hearing status based on pass/fail criteria

Note: Any of the above-named areas of functioning may also be addressed as a specialized assessment, following an overall evaluation of the child's speech-language skills.

Treatment

Service may include one or more of the following, as appropriate:

- Articulation/phonological training
- Language therapy
- Augmentative and alternative communication training
- Auditory processing/discrimination training
- Fluency training
- Voice therapy
- Oral motor training; swallowing therapy
- Speech/reading

OCCUPATIONAL THERAPY SERVICES

Assessment

Service may include testing and clinical observation, as appropriate for the recipient's chronological or developmental age, for one or more of the following areas, and shall yield a written evaluation report.

- Activities of daily living assessment
- Sensorimotor assessment
- Neuromuscular assessment
- Fine motor assessment
- Feeding/oral motor assessment
- Visual perceptual assessment
- Perceptual motor development assessment
- Musculoskeletal assessment
- Gross motor assessment
- Functional mobility assessment

Treatment

Service may include one or more of the following, as appropriate:

- Activities of daily living training
- Neuromuscular development
- Muscle strengthening/endurance training
- Feeding/oral motor training
- Adaptive equipment application
- Visual perceptual training
- Facilitation of gross motor skills
- Facilitation of fine motor skills
- Fabrication and application of splinting and orthotic devices
- Manual therapy techniques
- Sensorimotor training
- Functional mobility training
- Perceptual motor training

PHYSICAL THERAPY SERVICES

Assessment

Service may include testing and clinical observation, as appropriate for the recipient's chronological or developmental age, for one or more of the following areas, and shall yield a written evaluation report.

- Neuromotor assessment
- Range of motion, joint integrity, functional mobility, and flexibility assessment
- Gait, balance, and coordination assessment
- Posture and body mechanics assessment
- Soft tissue assessment
- Pain assessment
- Cranial nerve assessment
- Clinical electromyographic assessment
- Nerve conduction, latency and velocity assessment
- Manual muscle test
- Reflex integrity
- Activities of daily living assessment
- Cardiac assessment
- Pulmonary assessment
- Sensory motor assessment
- Feeding/oral motor assessment

Treatment

Service may include one or more of the following, as appropriate:

- Manual therapy techniques
- Fabrication and application of orthotic device
- Therapeutic exercise
- Functional training
- Facilitation of motor milestones
- Sensory motor training
- Cardiac training
- Pulmonary enhancement
- Adaptive equipment application
- Feeding/oral motor training
- Activities of daily living training
- Gait training
- Posture and body mechanics training
- Muscle strengthening
- Gross motor development
- Modalities
- Therapeutic procedures
- Hydrotherapy
- Manual manipulation
- Wheelchair management

RESPIRATORY THERAPY SERVICES

Assessment

Service may include testing and clinical observation, as appropriate for evaluation of pulmonary status, for one or more of the following areas, and shall yield a written evaluation report.

- Collection of specimen for arterial blood gas analysis (ABG)
- Pulmonary function studies
- Breath sounds
- Acute and chronic lung disease progression
- Ventilator dependency

Treatment

Service may include one or more of the following, as appropriate:

- Bronchodilator and aerosol therapy
- Oxygen therapy
- Sterile and non-sterile suctioning techniques
- Tracheostomy care
- Chest vibrations, postural drainage, and breathing techniques
- Ventilator care
- Monitoring of respiratory status (ABG), pulse oximetry, pulmonary function studies, sputum cultures, apnea-bradycardiac monitors, etc.

PROVIDERS ELIGIBLE TO BILL FOR THE SERVICE

It is the responsibility of the provider agency to verify in writing that staff meet the qualifications listed in 42 CFR 440.110 and 440.185. A copy of this verification (current licensure or registration) must be maintained by the provider agency. All providers must be enrolled as Medicaid providers either as an individual or as part of a group (<http://www.ncghhs.gov/dma/provenroll.htm>). The therapist listed on the claim form must be the attending/rendering provider of the service.

Audiology

Eligible providers must have a valid license issued by the Board of Examiners for Speech and Language Pathologists and Audiology.

Speech/Language

Eligible providers must have

1. a valid license issued by the Board of Examiners for Speech and Language Pathologists and Audiologists; and
2. a Certificate of Clinical Competence (CCC) in Speech-Language Pathology from the American Speech and Hearing Association (ASHA); or documentation that the service provider **has completed**
 - a. the educational requirements and work experience necessary for the Speech-Language Pathology CCC; or
 - b. the academic master's degree program and is acquiring the supervised work experience necessary to qualify for the Speech-Language Pathology CCC.

Assessment services must be provided by a licensed speech-language pathologist. Treatment services may be performed by a speech-language pathologist or a speech-language pathology assistant who works under the supervision of an enrolled licensed practitioner.

Occupational Therapy

1. Assessment services must be provided by a licensed occupational therapist.
2. Treatment services must be provided by a licensed occupational therapist or a licensed occupational therapist assistant under the supervision of a licensed occupational therapist.
3. In addition to the requirements listed above, assessment and treatment of children with special health care needs and/or developmental disabilities must be provided or supervised by a licensed occupational therapist with an annual 20% pediatric caseload.

Physical Therapy

1. Assessment services must be provided by a licensed physical therapist.
2. Treatment services must be provided by a licensed physical therapist or a licensed physical therapist assistant under the supervision of a licensed physical therapist.

Respiratory Therapy

Assessment and treatment services must be provided by a respiratory therapist licensed under the provisions of the North Carolina Respiratory Care Practice Act.

PRIOR APPROVAL

Prior approval (PA) requests of outpatient therapies for children receiving physical therapy, occupational therapy, respiratory therapy, audiology and speech language pathology services are required for all treatment services. Evaluations are not subject to PA. Providers must request PA under the same provider number that will be used for billing. All PAs are reviewed and approved by The Carolinas Center for Medical Excellence (CCME) at <http://www2.thecarolinascenter.org/ccme/>. PA numbers cannot be changed by CCME unless a new PA request is submitted.

Should CCME take adverse action to deny, reduce (change), terminate, or suspend a request, the recipient or his/her legal representative and provider will be notified. This notification will identify the action taken, citation to support the action, and appeal rights.

BILLING GUIDELINES

Claim Form Type	CMS-1500
Prior Approval for Evaluations	Not required
Prior Approval for Treatments	Required
Assessment	Billed on one claim form
Treatments	Billed on a separate claim form

All services must be provided one-to-one/face-to-face with the individual recipient. Group services are allowable only for speech therapy.

Effective May 23, 2008, all claims **must** contain a National Provider Identifier (NPI) and a taxonomy code. A taxonomy code is used to identify a provider’s type and specialty. A complete list of taxonomy codes can be found on the Washington Publishing Company’s website at <http://www.wpc-edi.com/taxonomy>.

The following billing guidelines for the CMS-1500 claim form are for those providers who have received a “Ready Letter” from the N.C. Medicaid Program indicating that claims submitted with their NPI have successfully mapped to their Medicaid provider number (MPN) in the claims payment system. Providers who have received a Ready Letter may begin submitting claims without their MPN listed on the claim.

CMS-1500 Claim Form Instruction

Block Number	Billing Instructions
Block #1	Type of coverage
Block #1A	Medicaid identification number
Block #2	Patient’s name
Block #3	Patient’s date of birth
Block #5	Patient’s address/telephone
Block #10	If applicable to patient’s condition
Block #15	First treatment date (if applicable)
Block #21	ICD-9-CM diagnosis appropriate for service provided
Block #24A	Date of service
Block #24B	Place of service 11 – Office 12 – Home 99 – School, Head Start, Child Care
Block #24C	Type of service Enter 01 or leave blank
Block #24D	Assessment = Treatment =
Block #24F	Charges
Block #24G	Enter number of unit(s)
Block #24I	ZZ qualifier
Block #24J	Attending provider taxonomy code
NPI	Attending provider NPI number
Block #28	Total charges
Block #29	Enter third party payment, (if applicable)
Block #30	Balance due
Block #31	Signature of provider
Block #32	Service facility location address including ZIP+4 (for example, 12345-2222)
Block #33	Billing provider information including ZIP+4 (for example,12345-2222)
Block #33a	Billing provider NPI or group NPI
Block #33b	ZZ qualifier preceded by billing provider taxonomy code

Below are billing guidelines for those providers who are submitting claims with their MPN, NPI, and taxonomy code.

Block Number	Billing Instructions
Block #1	Type of coverage
Block #1A	Medicaid identification number
Block #2	Patient's name
Block #3	Patient's date of birth
Block #5	Patient's address/telephone
Block #10	If applicable to patient's condition
Block #15	First treatment date (if applicable)
Block #19	ZZ qualifier preceded by the billing or group taxonomy code
Block #21	ICD-9-CM diagnosis appropriate for service provided
Block #24A	Date of service
Block #24B	Place of service 11 – Office 12 – Home 99 – School, Head Start, Child Care
Block #24C	Type of service Enter 01 or leave blank
Block #24D	Assessment = Treatment =
Block #24F	Charges
Block #24G	Enter number of unit(s)
Block #24I	1D qualifier
Block #24J	Rendering/attending MPN
NPI	Rendering/attending NPI number
Block #28	Total charges
Block #29	Enter third party payment, (if applicable)
Block #30	Balance due
Block #31	Signature of provider
Block #32	Service facility location address including ZIP+4 (for example, 12345-2222)
Block #32b continued	ZZ qualifier preceded by the Rendering/Attending providers taxonomy code
Block #33	Billing/group provider information including ZIP+4 (for example, 12345-2222)
Block #33a	Billing provider NPI or group NPI
Block #33b	1D qualifier preceded by billing/group MPN

ADDITIONAL BILLING GUIDELINES FOR SPECIALIZED THERAPIES

Outpatient therapy services delivered in accordance with the policy guidelines in **Section 5.0 of Clinical Coverage Policy #10B, *Independent Practitioners***, may be submitted for reimbursement. Separate CMS-1500 claim forms must be filed for assessment/evaluation and treatment services, and for each type of service provided. Because individual and group speech therapy are considered the same type of service, they may be listed on the same claim form. Group providers must have attending provider information listed on the claim.

Note: Providers must request PA under the same provider number that will be used for billing. PA numbers cannot be changed by CCME unless a new PA request is submitted.

Claims submitted for services provided to a child who has had a Children's Developmental Service Agency (CDSA) or CDSA-approved evaluation and is therefore eligible for a six-month exemption from PA should follow the guidelines listed below: Once a first treatment date is entered on a claim, per discipline, and the six months have been exhausted, there cannot be another first treatment date or six unmanaged visits. If there is no first treatment date on the claim, PA will be required. If a recipient starts on a six-unmanaged-visit track within a particular discipline, the recipient is not able to change to a 6-month track within that same discipline.

Providers who bill on the CMS-1500 claim form must enter the date of the physician's order for services in block 15 and must include one of the discipline-specific ICD-9-CM diagnosis codes listed below as a secondary diagnosis on the claim.

V57.0 – Respiratory Therapy

V57.1 – Physical Therapy

V57.21 – Occupational Therapy

V57.3 – Speech Therapy

This does not change the requirement to bill the primary diagnosis that justifies the need for the specialized therapy. Remember: The primary treatment ICD-9-CM diagnosis code must be entered first on the claim form. The discipline-specific V code should follow the primary treatment code.

Note: Obtaining PA does not obviate the need for compliance with the Medicaid program's stipulation that all claims must be received by EDS within 365 days of the first date of service in order to be accepted for processing and payment.

Refer to Clinical Coverage Policy #10B, *Independent Practitioners*, for additional billing information (<http://www.ncdhhs.gov/dma/mp/mpindex.htm>).

Common EOB Denials

Denial Code	Resolution
EOB 0018 – Claim denied. No history to justify time limit override	Resubmit claims with proper documentation to EDS Provider Services Unit
EOB 0023 – Service requires prior approval	Verify that prior approval has been obtained
EOB 0027 – Diagnosis code is missing or invalid. Verify and enter the correct diagnosis code and submit as a new claim	Correct/add diagnosis and resubmit claim. Claim needs to be submitted with the appropriate treatment diagnosis and the appropriate secondary diagnosis.
EOB 0079 – This service is not payable to your provider type or specialty in accordance with Medicaid guidelines	Verify that valid attending NPI number was used.
EOB 0082 – Service is not consistent with/or not covered for this diagnosis/or description does not match diagnosis	Correct diagnosis and resubmit claim. Claim needs to be submitted with the appropriate treatment diagnosis and the attending provider appropriate secondary diagnosis.
EOB 0094 – Indicate private insurance payment or attach denial and submit as a new claim. Attach Medicare vouchers if applicable	The Remittance and Status Report (RA) will indicate the other insurance company (by code), the policy holder name, and the certificate or policy number. A complete list of the third party insurance codes can be found at http://www.ncdhhs.gov/dma/tpr.html
EOB 5308 – Prior authorized units exceeded	Contact CCME to see if additional units may be granted
EOB 5400 – Exact duplicate of previously paid claim [same attending provider information, procedure code, type of service, date of service, modifier, detail line, but a different ICN]	Check prior RA for payment history.
EOB 8918 – Insufficient documentation to warrant time limit override	Resubmit claim with proof of timely filing—a previous RA, time limit override letter, or other insurance payment or denial letter within the previous six months

Resolution Inquires

The Medicaid Resolution Inquiry form is used to submit claims for a **Time Limit Override** or a **Third Party Override**. When submitting inquiry requests, always attach the claim and a copy of any Remittance and Status Reports (RA’s) related to the inquiry request, as well as any other information related to the claim. Each inquiry request requires a separate form and copies of documentation (vouchers and attachments). A copy of the form may be printed from DMA’s website at <http://www.ncdhhs.gov/dma/formsprov.html>.

Time Limit Overrides

All claims must be received by EDS within 365 days of the first date of service in order to be accepted for processing and payment. If a claim was filed within the 365-day time period, providers have 18 months from the RA date to refile a claim. If the claim was initially received and processed within the 365-day time limit, that claim can be resubmitted on paper or electronically as a new day claim. The new day claim must have an exact match of recipient Medicaid identification (MID) number, provider number, “from” date of service, and total billed.

Because DMA and EDS must follow all federal regulations to override the billing time limit, requests for time limit overrides must document that the original claim was submitted within the initial 365-day time period. Examples of acceptable documentation for time limit overrides include

- Dated correspondence from DMA or EDS about the specific claim received that is within 365 days of the date of service.
- An explanation of Medicare benefits or other third-party insurance benefits dated within 180 days from the date of Medicare or other third-party payment or denial.
- A copy of the RA showing that the claim is pending or denied (the denial must be for reasons other than the time limit).

The billing date on the claim or a copy of an office ledger is not acceptable documentation. The date that the claim was submitted does not verify that the claim was received by EDS within the 365-day time limit.

If the claim is a crossover from Medicare or any other third-party commercial insurance, regardless of the date of service on the claim, you have **180** days from the EOB date listed on the explanation of benefits from that insurance provider (whether the claim was paid or denied) to file the claim to Medicaid. You must include the Medicaid Resolution Inquiry Form, a copy of the claim, and a copy of the third-party or Medicare EOB in order to request a time limit override.

If a claim is submitted for processing beyond the 365-day time limit, attach the claim and required documentation to the Medicaid Resolution Inquiry form and mail to the address indicated on the inquiry form.

Time Limit Override on Third-Party Insurance

All requests for time limit overrides due to a third-party insurance carrier that does not respond within its time limit must be submitted to the Third Party Recovery section and must include documentation verifying that the claim was timely filed to the third-party insurance carrier.

If the third-party insurance carrier does not respond within the Medicaid time limit, time limit overrides may be granted if the claim is filed within 180 days of the third-party denial or payment. Submit the claim, attached to the Medicaid Resolution Inquiry form, and the third-party voucher.

If the insurance company or other third-party payer terminates coverage, providers must complete a Health Insurance Information Referral (DMA-2057) and attach a copy of the written denial. Send the form and the claim to DMA’s Third Party Recovery section at the address shown on the form.

Use the same form to report lapsed insurance coverage or insurance coverage not indicated on the MID card. A copy of the form is available on DMA’s website at <http://www.ncdhhs.gov/dma/formstpr.html>.

Complete the Health Insurance Information Referral form (DMA-2057) form in the following instances:

- To delete insurance information (that is, the recipient no longer has third-party insurance, but the MID card indicates other insurance)
- To add insurance information (that is, a recipient has third-party insurance that is not indicated on the MID card)
- To change existing information (that is, a recipient never had the third-party coverage that is indicated on the MID card)

Claim Adjustments

The Medicaid Claim Adjustment form is used to adjust a previously paid claim or a denied claim. Do not use the Medicaid Claim Adjustment form to inquire about the status of a claim or to submit a claim for dates of service that have exceeded the filing time limit.

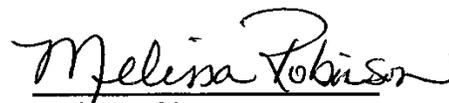
When submitting adjustment requests, always attach a copy of any RA related to the adjustment as well as any medical records that could justify the reason for paying a previously denied claim. It is suggested that providers include a corrected claim when submitting an adjustment, but it is not required if the claim was filed electronically.

Within 30 days of filing a Medicaid Claim Adjustment request, you will see the status of the claim listed on the RA as “pending.” If the status code does not appear as pending, verify that the recipient’s MID number and the internal claim number (ICN) are complete and correct. If the MID number or ICN is incorrect, re-file the adjustment request with the correct information.

A copy of the Medicaid Claim Adjustment form is on DMA’s website at <http://www.ncdhhs.gov/dma/formsprov.html>.



William W. Lawrence, Jr. M.D.
Acting Director
Division of Medical Assistance
Department of Health and Human Services



Melissa Robinson
Executive Director
EDS, an HP Company