

## Meeting Minutes

<b>Meeting Name:</b>	NCMGM Meeting
<b>Scribe:</b>	Kathryn Crotts
<b>Facilitator:</b>	Tina McKenna
<b>Date:</b>	June 10, 2004
<b>Time:</b>	10:30-12:00
<b>Location:</b>	EDS, Conference Rm. 3

### Invitees/Attendees \* in attendance,

Name	Name	Name	Name
Tina McKenna, EDS*	Chris Ferrell, EDS*	Kathryn Crotts, EDS*	Marianne Diana, EDS
Darren Noel, EDS	Amy Carlyle, EDS	Anna Contino, EDS	Christie Harris, EDS*
Sue Powell, HS OG*	Sandra Jarrett, SOA*	Deborah Cashion, CPA*	Robin Cantrell, CP
Linda Alexander, RMP	Kay Taul, UNC	MaryJo Lynch, LH	Ginger Drake, ECU*
Robert Williams, CMC	Debbie Rader, WP	Robert Hardyman, UPS*	Tim Bell, LCC*
Angela Floyd, DMA*	Lacey Barnes, DMA	Kirby Hughes, DMA	Tim Brookshire, DMA*
Carol Schele, NMS	Sharon Walker	Michelle Preece	Beth Phillips-Ferrell*
Barbara Perkins, DMA*			

### Agenda

Item No.	Subject	Presenter
1.	Follow-Items From Last Meeting a) Medicare Part B Changes dated Back to October 2002 b) Medicaid implement same time as Medicare c) G codes for Dialysis Providers	Tina McKenna
2.	Medicare Crossovers for CMS-1500	Tina McKenna
3.	New Contract for North Carolina Medicaid	Tina McKenna
4.	24-Visit Limitation	Tina McKenna
5.	Transfers to different Facilities	Tina McKenna
6.	Carolina Access Denials	Tina McKenna
7.	Obesity in Children	Tina McKenna
8.	ESRD Services-G codes	Tina McKenna
9.	Medicare and Medicaid alignment in changes	Tina McKenna
10.	Routine Pap Smears and V20.2	Tina McKenna
11.	Incorrect Payment on RA	Tina McKenna
12.	Vision Screening for 3 year olds	Tina McKenna
13.	Periodic vs. Interperiodic HealthCheck Screenings	Tina McKenna
14.	Prior Approval for Refractions	Tina McKenna

Item No.	Subject	Presenter
15.	Developmental Screenings	Tina McKenna

## Minutes

Agenda Item No.	Main Points, Conclusions/Discussions, Decisions, Next Steps
1.	<p>a) The volume of paperwork and manual posting required to recoup and repay renders a claims system recoup/repay unfeasible from both the provider standpoint as well as the system standpoint. DMA is working with an outside contractor (PCG) to review the claims that are on the Medicaid history file versus those that are present on the Medicare crossover file and evaluate unpaid transactions.</p> <p>The procedures that were put in place regarding the secondary filing requirement remain in place through the system change (est. September 2004) to handle outstanding claims. To ensure payment for services until the system changes are in place providers must continue to work through the secondary filing process.</p> <p>b) Question #8 of current agenda.</p> <p>c) North Carolina Medicaid will cover the “G” codes implemented by Medicare for billing physician management of patients receiving dialysis. EDS is in the process of making the necessary system changes to allow the codes to be billed. Providers will be notified through a general Medicaid bulletin or an announcement on the DMA website if the system is ready prior to the next bulletin publication.</p>
2.	<p>At this time, we do not have any reason to change the expected implementation date of September 2004. We expect the return to crossover for type 1500 claims only to be a percentage of the Medicare payment. This percentage will vary by provider/specialty types and will be determined through a thorough review of Medicare and Medicaid pricing and coverage. Detailed information regarding specific cutbacks and implementation date will be available in a future Medicaid Bulletin.</p> <p>Question: After the implementation date for crossovers, will claims still have to be billed as “Medicaid ready”, or will it be the way it was prior to the change in 10/02?</p> <p>Answer: Medicaid will be processing crossover claims based on what comes to Medicaid on the Medicare tape automatically so a “Medicaid Ready” claim would not need to be submitted.</p>
3.	<p>The new contract for the North Carolina Medicaid account was awarded to ACS. The new contract is for a five year time frame and will include implementing a new system. Currently, EDS will continue to service North Carolina Medicaid providers until June 2006. We will make this transition as seamless as possible for the providers of North Carolina Medicaid. There is a bulletin article in the June 2004 Bulletin on the award on page 2.</p> <p>Question: Will ACS continue to hold the NCMGM meeting?</p> <p>Answer: Per Angela Floyd, these meetings are very important to DMA and these meetings are something they are looking forward to continuing. She also passed around some information regarding ACS and an update on NCMMS.</p>

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4.	<p>24 visits are for recipients over the age of 21 and are counted per fiscal year, July 1-June 30. If a recipient goes over their 24 visit limit, then the provider will receive a 525 denial and are allowed to bill the patient. Unfortunately, the only way to count visits for a recipient is for that recipient to keep track of how many visits they have received in that time frame. Our system counts the visits as first received and paid towards the 24, they are not by date of service. The May 2004 General Medicaid Billing Guide on page 2-13 explains the 24 visit policy, what is included and how to exempt from the policy.</p> <p>Question: Does the 24 visit office limit also apply to prenatal visits and pap smears?  Answer: The 24 visit office limitation applies to evaluation and management services. Because of exemptions related to diagnosis, pregnancy related services are exempt from the 24 visit limitation.</p>
5.	<p>Examples were provided by Tim Bell. Two examples were provided and answers are below. For 1867 denial, two NICU charges are being billed on the same day by different providers. The current policy is that only one NICU services is to be paid per date of service. In order to have this policy reviewed, it would need to be in writing to DMA Medical Policy with the example give to me. This will be added to the agenda for next time to have DMA review.</p> <p>For 708 denial, this would deny because a same or different provider is billing for an admission history and physical for the same recipient during the same hospitalization within a 15 day period. These are reviewed on an individual basis and situations that would constitute this being paid would be: 1) an indication of a life threatening chronic illness(i.e. renal failure, sickle-cell anemia) or condition that requires frequent hospitalizations, 2) a transfer to a better equipped facility when a recipient is a sick newborn, a trauma victim, or from an area that does not have adequate hospital care. Something to note is a transfer or care in the same facility from a pediatric specialty followed by an admission for rehab or psych does not constitute a new admission. In order to have this policy reviewed, it would need to be in writing to DMA Medical Policy with this example.</p>
6.	<p>The CA provider number the recipient is enrolled with (linked with in the system) on a specific DOS must be provided on the CMS-1500 claim form in block 33 as either the group or attending number or in block 19 as a referral. Providers must submit a Carolina ACCESS Provider Information Change form to DMA Provider Services if their Medicaid provider number is changing, per Section 4.17 of the Carolina ACCESS participation agreement. The CA Provider Information Change form is available on DMA's website at <a href="http://www.dhhs.state.nc.us/dma/forms">http://www.dhhs.state.nc.us/dma/forms</a>. (Often times provider number changes cause the denials when practices begin billing using their new Medicaid provider number, but the CA number has not been updated.) If the Carolina Access PCP is a group, then the group number should be used. If the doctor's name is on the card, then the doctor's individual number should be used. If you have examples, please send me the claim numbers to review the issues.</p> <p>Discussion: Several of the managers mentioned that CA denials are steadily increasing in their offices. Sned some examples for review.</p>
7.	<p>Discussion: Several providers mentioned that they were getting claims denied when they tried to bill for obesity. DMA would like examples of situations where this was an issue to review the information.</p>

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8.	As detailed in # 1, the review of Medicaid covered and paid procedures from October 2002 through the implementation will be the same for all provider types. DMA will base their review on coverage and policy as of that time.
9.	Due to the fact that Medicare often does not give any notice that changes are going into effect, often times there is not sufficient time to review the Medicaid state plan and guidelines before the effective date of Medicare changes. Changes are implemented as soon as DMA has completed their policy review and appropriate system edits are enacted.
10.	V20.2 will deny when it is billed with anything other than the HealthCheck codes. According to EDS, there is an edit in place so that only certain codes can be billed with V20.2. We would need to see an example of their denied claim before an exact answer can be given. However, for the initial pap smear, codes V76.2 or V15.89 should go through and process. If an additional Pap is done within a year and those diagnosis codes are used again, the claim will deny. EDS can research further if given a claim example. The actual pap smear would not be billed by the Health Check provider in most instances because the pap code needs to be billed by the referring lab that actually looks at the specimen.
11.	Please provide examples of what issue this is in reference to. Examples were provided by Beth Phillips-Ferrell. After reviewing the information, there was an issue on the 12/9/03 checkwrite and only the 12/9/03 checkwrite that caused labs to be denied for various reasons, including EOB 5201, erroneously. Claims are being identified currently and will be reprocessed. A time frame has not been confirmed on the reprocess.
12.	If the patient is unable to comprehend, yet the test was attempted, then the vision screening can be billed with HealthCheck so that the HealthCheck is paid, the information would need to be documented in the patient's chart. If the patient is deaf or blind, then the Preventative code would be billed without the hearing and/or vision, the claim would deny 1771 and an adjustment would need to be filed with documentation of the current state of the child. If the child is uncooperative, the test can be attempted. Then the child can be brought back into to complete the test, if they are still uncooperative, this information can be documented in the chart and the hearing/vision can be billed with the HealthCheck and the HealthCheck would pay.
13.	Patients over the age of 6 can have a Periodic Screening every 3 years after the age of 6 according to the Periodicity Schedule. North Carolina Medicaid does follow the <i>Recommendations for Preventive Pediatric Health Care from the AAP</i> . If for some reason, they would need to come in between these times, then an interperiodic screening can be billed but the requirements of an interperiodic screening would need to be met. They are: developmental delays, sports physical, kindergarten physical, etc. Please review the April 2004 Special Bulletin page 10, for HealthCheck to see specifics on these situations.

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14.	<p>Currently, Prior Approval for Refractions is optional and not required and can be done through the AVR system. Getting prior approval is safeguard you as a provider, to make sure the recipient has not already had a refraction in the time span that they are allowed. Patients under 25 are limited to 1 per year and patients over 25 are limited to 1 per every 2 years. Please refer to page 4-4 and 4-5 of the Optical December 2001 Guide on DMA's website. There are no immediate plans to change the AVRS prior approval process, but the feedback regarding the access time is greatly appreciated and will be beneficial in future review and possible revision.</p>
15.	<p>As of July 1, 2004, the developmental screening will be billed out separately from the HealthCheck screening. The code will be 96110 with an EP modifier and a \$0.00 reimbursement. It will be required for ages 6 months, 12 months, 18 or 24 months, 3, 4, and 5 years of age. A new standardize tool will need to be used for documentation. This is also located in the April 2004 Special Bulletin for HealthCheck.</p> <p>For infants and young children, the American Academy of Pediatrics (AAP) recommends, "All infants and young children should be screened for developmental delays. Screening procedures should be incorporated into the ongoing health care of the child as part of the provision of a medical home. Developmental surveillance is an important method of detecting delays. Moreover, the use of standardized developmental screening tools at periodic intervals will increase accuracy. For successful early identification of developmental disabilities, the pediatrician must be skilled in screening techniques, seek parental concerns about development and create links to available resources in the community."</p> <p>Please refer to the North Carolina Medicaid Special Bulletin, April 2004, Number 1 for the new information regarding developmental screenings and billing process. Also available in the bulletin, is the AAP's recommendations and conclusions from the Policy Statement on Developmental Surveillance and Screening of Infants and Young Children (RE0062), Volume 108, Number 1, July 2001 pp 192-196, on page 40. The entire policy statement can be found on the AAP website at <a href="http://aappolicy.aappublications.org">http://aappolicy.aappublications.org</a>.</p> <p>Health Check follows the recommendations of the AAP now requiring that a formal, standardized developmental screening tool be used when screening children. A list of screening tools may be accessed on the Developmental and Behavioral Peds website at <a href="http://www.dbpeds.org/">http://www.dbpeds.org/</a>. Two tools, the Ages and Stages Questionnaire (ASQ) and Parents Evaluation of Developmental Status (PEDS) are validated first level screening tools, which have been "put to the test" in practices across North Carolina. These are two examples of what is practical, what works in the primary care practice, and what providers will find on the website.</p>

Agenda Item No.	Main Points, Conclusions/Discussions, Decisions, Next Steps
Misc.	<p>1. When will Medicaid accept HCPC codes such as A4561 and A4562? If they are not accepting them, can a waiver be signed and the patient be billed?</p> <p>These two codes are not listed in our system. As long as the patient is told upfront that the service is non-covered, then the patient can be billed. A waiver can be signed but is not required.</p> <p>2. HCPCS code J3490 (unlisted drug code) for Hydroxyprogesterone caproate drug that is used at MFM for preventing premature deliveries is not accepted by Medicaid. When will they accept this code? If they are not accepting this code, can a waiver be signed and the patient be billed?</p> <p>The J3490 is a covered code, however, it may not be covered for that particular drug. They would need to submit their claim with the invoice attached if it is covered. Bob Hardyman to get examples.</p> <p>3. How are undocumented aliens identified in order to bill the correct delivery codes?</p> <p>An undocumented alien would be identified by the program code listed on the Medicaid card or that they are covered for only emergency services and the card only is covered for one date of service.</p> <p>4. With HIPAA will Medicaid require all blocks on a CMS-1500 to be completed ?</p> <p>Currently, Medicaid is not requiring all the blocks.</p> <p>5. When does Medicaid update the Blue E system?</p> <p>Eligibility information comes from DSS, gets downloaded into MMIS and then is sent to Blue Cross Blue Shield to be displayed. Timeframes for how quickly Blue Cross Blue Shield displays the information is unknown.</p> <p>6. Is the Blue E system going away?</p> <p>Currently, CMS has stated they both non-compliant and compliant formats are being accepted. Until this changes, Blue E will continue to provide information.</p>

### Action Items

Item No.	Open Date	Description	Assigned To	Date Closed
AI1.				
AI2.				
AI3.				
AI4.				
AI5.	6/10/04	EOB 1867, Can two different charges for NICU from different providers be paid on the same date of service if it is warranted with medical documentation?	DMA	Agenda Item at Next Meeting
AI6.	6/10/04	Examples are requested.	Group	Agenda Item at Next Meeting

Item No.	Open Date	Description	Assigned To	Date Closed
AI7.	6/10/04	Examples are requested by DMA.	Group	Agenda Item at Next Meeting
AI8.				
AI9.				
AI10.	6/10/04	Examples are requested.	Group	Agenda Item at Next Meeting
AI11.				
AI12.				
AI13.				
AI14.				
AI15.				
Misc.	6/10/04	Example requested on J3490.	Bob Hardyma n	Agenda Item at Next Meeting

<b>Next Meeting Date:</b>	September 16, 2004 10:30-12:00
<b>Next Meeting Location:</b>	EDS, Crossroads, Conference Rm. #3
<b>Facilitator:</b>	Kathryn Crotts
<b>Scribe:</b>	Chris Ferrell