Number 1 *January 2000*

North Carolina Medicaid Bulletin

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

Attention: All Providers

Holiday Observance

The Division of Medical Assistance (DMA) and EDS will be closed on Monday, January 17, 2000, in observance of Martin Luther King Jr.'s Birthday.

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

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

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Attention: All Providers

Update on Year 2000 Activities

Please refer to the Special Provider Bulletin for Year 2000 issued December 1999. The Special Bulletin consolidates information about Year 2000 activities and plans as well as instructions and suggestions for providers to move smoothly into the new century.

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 has replaced the old 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 was DOS based; the NCECS runs 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.

Based upon problems discovered internally, EDS has improved and corrected the NCECS product in several areas. This includes the following improvements:

- Providers will be able to print copies of the prepared claims
- Problems with the listing of recurring values has been corrected (i.e., allow multiple same last recipient names in drop down lists)
- The software no longer requires the patient status entry in Form Locator 22 of the UB-92 for Personal Care Claims. This change allows providers to follow the specific billing instructions for their services
- Enhancement of the changing dates of service function to allow mass change of dates of service for multiple recipients – this feature is often needed by the nursing home provider

The modifications are on a diskette that was mailed with instructions to each NCECS user. Providers who have installed the NCECS software from the CD-ROM need to be sure that they have also installed the modifications from the update diskette. Providers who have not received the diskette should contact the ECS Unit, EDS, at 1-800-688-6696 or 919-851-8888.

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
- CD ROM drive – recommended – NCECS software is normally distributed on CD ROM. 3.5 inch Diskettes can be provided upon request

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.
The Netscape version is available at http://home.netscape.com/computing/download/

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

Attention: Dialysis Providers

Dialysis Termination Dates

Dialysis Providers treating recipients who receive ongoing dialysis treatments are paid a monthly Composite Rate. The Composite Rate includes services normally rendered to dialysis recipients such as physician visits, lab tests and medical supplies. In order to accurately process dialysis claims the provider must submit a dialysis *start date*, which is entered into the recipient's dialysis file. Claims that include services covered in the Composite Rate will deny when the date of service is after the *dialysis start date*.

Recipients who have had acute illness involving the renal system, or receive successful kidney transplants which result in the return of normal renal function, may no longer require continued dialysis treatments.

It is imperative that providers notify EDS with the ***STOP date*** when dialysis treatments are terminated so the date of the last dialysis treatment can be entered in our records and future claims can be properly processed.

To notify EDS, providers should send a resolution inquiry form stating ***"Dialysis has terminated"*** including the ***Dialysis STOP date MM/DD/YYYY*** and the reason for discontinuation of the treatments to the address in the example given below:

EXAMPLE:

MEDICAID RESOLUTION INQUIRY
MAIL TO:
EDS PROVIDER SERVICES
P O BOX 300009
RALEIGH, NC 27622

Please Check: ☐ Claim Inquiry ☐ Time Limit Override

NOTE: PLEASE USE THIS FORM FOR **TIME LIMIT OVERRIDES AND INQUIRIES ONLY**. CLAIM, RAs, AND ALL RELATED INFORMATION MUST BE ATTACHED.
ADJUSTMENTS WILL NOT BE PROCESSED FROM THIS FORM.

Provider Number: **1234567**

Provider Name and Address: **Dr. B. Well, 99 Main Street, Yourtown NC 123345**

Patient's Name: **Joan Doe** Recipient ID: **987654321Z**

Date of Service: From: **11/01/99** to **11/01/99** Claim Number: **1019993439231123**

Billed Amount: **00.00** Paid Amount: **00.00** RA Date: **1/1/00**

Please Specify Reason for Inquiry Request:

Dialysis terminated 12/17/99 due to renal transplant 12/17/99

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

Attention: All Providers

2000 CPT Update

Effective with date of service January 1, 2000, Medicaid providers may bill the 2000 Current Procedural Terminology (CPT) codes. Claims filed with deleted 1999 CPT codes for dates of service January 1, 2000 through March 31, 2000 will be accepted for processing. However, the 2000 CPT codes must be used for dates of service on or after April 1, 2000.

The following new CPT codes require further review by the Division of Medical Assistance and are currently not covered:

- CPT 33282 Implantation of patient-activated cardiac event recorder
- CPT 44201 Laparoscopy, surgical; jejunostomy (e.g. for decompression or feeding)
- CPT 99173 Screening test of visual acuity, quantitative, bilateral
- CPT 96570 Photodynamic Therapy by endoscopic application of light
- CPT 96571 Photodynamic Therapy by endoscopic application of light, each additional 15 minutes

The new 2000 CPT codes that are noncovered by North Carolina Medicaid are:

- CPT 58672 Laparoscopy, surgical; with fimbrioplasty
- CPT 58673 Laparoscopy, surgical; with salpingostomy
- CPT 58679 Unlisted Laparoscopy procedure, oviduct, ovary

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

Attention: All Labs

Reimbursement Rate Increase

New lab rates are effective with date of service January 1, 2000. A 1.4 % increase has been implemented not to exceed the national Medicare cap. A rate decrease has been implemented for lab codes in which the current rate exceeded the 2000 national Medicare cap. The actual billed amount on your claims must **always** contain your regular billed amount and not the price on the fee schedule unless the listed price represents what you normally bill another payor or patient. DMA considers the billed amount in their rate setting efforts. New fee schedules will be available at the end of January or early February. Please refer to instructions in the November 1999 bulletin on ordering fee schedules.

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

Attention: All Physicians

Reimbursement Rate: Physician Fees

Effective with dates of service January 1, 2000, Physicians' fees are based on the Medicare fee schedule resource based relative value system currently in effect. This change results in paying physician services equal to Medicare for the same procedure for the same date of service and uses updated (RBRVS) values.

Medicare has adopted a new relative value method to calculate physician fees for facility-based services furnished in hospital (inpatient, outpatient and emergency room), ambulatory surgical center and skilled nursing facility settings. This method is the facility based fee concept. It identifies two levels of practice expense RVUs, facility and non-facility, for each procedure code. The non-facility practice expense RVUs are used for services performed in a physician's office and for services to a patient in the patient's home, facility or institution **other than** hospital, skilled nursing facility (SNF) or ambulatory surgical center (ASC). The facility practice expense RVUs are used for services furnished to hospital, SNF and ASC patients.

The allowable for a specific code is determined by the **place of service**, as indicated on the claim, where the procedure is performed. There are numerous codes that are **only** performed by definition in a certain setting and will have only **one** level of practice expense. The fees for these types of codes are the same for non-facility and facility regardless of the place of service indicated on the claim. Modifier pricing is not affected by this change.

The voice inquiry system has been updated and will allow providers to enter the place of service in order to provide the appropriate allowable for the code in question.

New fee schedules will be available at the end of January or early February. Please refer to instructions in the November 1999 bulletin on ordering fee schedules.

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

Attention: Dentists

Reimbursement Rate Increase

Effective with date of service January 1, 2000, reimbursement rates increase by 1.4%. The actual billed amount on your claims must **always** contain your regular billed amount and not the price on the fee schedule unless the listed price represents what you normally bill another payor or patient. DMA considers the billed amount in their rate setting efforts. New fee schedules will be available at the end of January or early February. Please refer to instructions in the November 1999 bulletin on ordering fee schedules.

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

Attention: Hospice Providers

Hospice Rates

Effective with date of service January 1, 2000, hospice rates are as follows:

		Routine Home Care	**Continuous Home Care**	**Inpatient Respite Care**	**General Inpatient Care**	**Hospice Intermediate R & B**	**Hospice Skilled R & B**
Metropolitan Statistical Area	SC	RC 651 Daily	RC 652 Hourly (1)	RC 655 Daily (2) (3) (4)	RC 656 Daily (3) (4)	RC 658 Daily (5)	RC 659 Daily (5)
Asheville	39	95.76	23.29	99.77	426.98	88.92	118.54
Charlotte	41	101.17	24.60	104.17	449.38	88.92	118.54
Fayetteville	42	91.77	22.32	96.51	410.44	88.92	118.54
Greensboro/WS/HP	43	100.16	24.36	103.35	445.21	88.92	118.54
Hickory	44	95.51	23.23	99.56	425.91	88.92	118.54
Jacksonville	45	85.73	20.85	91.59	385.41	88.92	118.54
Raleigh/Durham	46	102.08	24.83	104.91	453.15	88.92	118.54
Wilmington	47	98.68	24.00	102.14	439.06	88.92	118.54
Rural	53	89.76	21.83	94.87	402.10	88.92	118.54
Goldsboro	105	92.79	22.57	97.34	414.66	88.92	118.54
Greenville	106	99.34	24.16	102.68	441.80	88.92	118.54
Norfolk, Currituck Co	107	90.94	22.12	95.84	407.00	88.92	118.54
Rocky Mt.	108	96.29	23.42	100.19	429.15	88.92	118.54

Note: Because providers are expected to bill their usual and customary charges, no adjustments will be accepted.

Key to Hospice Rate Table:

SC = Specialty Code

RC = Revenue Code

1. A minimum of eight hours of Continuous Home Care must be provided.
2. There is a maximum of five consecutive days including the date of admission but not the date of discharge for Inpatient Respite Care. Bill for the sixth and any subsequent days at the routine home care rate.

3. Payments to a Hospice for inpatient care are limited in relation to all Medicaid payments to the agency for hospice care. During the 12 month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days, inpatient respite, and general inpatient, may not exceed 20 percent of the aggregate total number of days of hospice care provided during the same time period for all the hospice's Medicaid patients. Hospice care provided for patients with acquired immune deficiency syndrome (AIDS) is excluded in calculating the inpatient care limit. The Hospice refunds any overpayments to Medicaid.
4. Date of Discharge: For the day of discharge from an inpatient unit, the appropriate home care rate should be billed instead of the inpatient care rate unless the recipient dies as an inpatient. When the recipient is discharged as deceased, the inpatient rate (general or respite) is billed for the discharge date.

5. When a **Medicare/Medicaid** recipient is in a nursing facility, Medicare is billed for the routine or continuous home care, as appropriate, and Medicaid is billed for the appropriate long term care rate. When a **Medicaid only** hospice recipient is in a nursing facility, the Hospice may bill for the appropriate long term care (SNF/ICF) rate in addition to the home care rate provided in revenue code 651 or 652. See section 8.15.1, page 8-11, of the Medicaid Community Care Manual for details.

DMA, 919-857-4165

Attention: CAP Providers

Reimbursement Rate Increase: CAP Providers

Effective with date of service January 1, 2000, the maximum allowable rate for the following CAP services increased. Providers must bill their usual and customary charges.

Procedure Code	Description	Reimbursement Rate
W8111	CAP-MR/DD Personal Care	$3.18/15" Unit
W8116	CAP/DA Respite Care-In Home	$3.18/15" Unit
W8119	CAP-MR/DD Respite Care Community Based	$3.18/15" Unit
W8141	CAP/DA In-Home Aide Level II	$3.18/15" Unit
W8142	CAP/DA In-Home Aide Level III-Personal Care	$3.18/15" Unit
W8143	CAP/C Personal Care	$3.18/15" Unit
W8144	CAP-MR/DD In-Home Aide Level I	$3.18/15" Unit
W8167	CAP/AIDS Respite Care-In-Home/Aide Level	$3.18/15" Unit
W8172	CAP/AIDS In-Home Aide II	$3.18/15" Unit
W8173	CAP/AIDS In-Home Aide III-Personal Care	$3.18/15" Unit

No adjustments will be made for claims already processed. Contact the EDS Provider Services Unit for detailed billing instructions.

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

Attention: Personal Care Providers (excluding Adult Care Homes)

Reimbursement Rate Increase: Personal Care Providers

Effective with date of service January 1, 2000, the Medicaid maximum reimbursement rate for personal care service is $3.18 per 15-minute unit ($12.72/hour). No adjustments will be made to previously filed claims.

The providers' customary charges to the general public must be shown in form locator 47 on each UB-92 claim form filed. Public providers with nominal charges that are less than 50 percent of cost should report the cost of the service in form locator 47. The payment of each claim will be based on the lower of the billed charges or the maximum allowable rate.

Debbie Barnes, Financial Operations
DMA, 919-857-4165

Attention: Home Health Providers, PDN Providers and Community Alternatives Program Case Managers

Amendments to Home Health Medical Supply List

Based on recommendations of a committee representing the Association for Home Health and Hospice Care of North Carolina and the Division of Medical Assistance, the home health medical supply list is amended effective with date of service January 1, 2000.

HCPCS Code W4645 - I.V. infusion start kit (venipuncture kit) is replaced with HCPCS Codes W4740 and W4741 to allow providers to bill for the kits separately. Effective with date of service January 1, 2000, claims for W4645 will not be paid.

HCPCS Code	Description	Billing Unit	Maximum Rate
W4740	I.V. infusion start kit (sterile drape; tourniquet; 2x2; tape; alcohol/ iodine wipe; transparent dressing)	Each	2.63
W4741	Venipuncture kit (includes butterfly needle, all sizes; tourniquet; 2x2's (2); tape; alcohol swabs (2); iodine prep)	Each	2.63

The following items are added to the supply list and may be billed effective with date of service January 1, 2000:

HCPCS Code	Description	Billing Unit	Maximum Rate
W4742	Cotton-tip applicators (sterile)	Each	.10
W4738	Catheter (Coude'-type)	Each	4.20
W4739	Drain sponge	Each	.85

DMA, 919-857-4021

Attention: Durable Medical Equipment (DME) Providers

Coverage of Blood Glucose Monitors with Special Features

Effective with date of service January 1, 2000, blood glucose monitors with special features (e.g. voice synthesizers, automatic timers, etc.), are being added to the Capped Rental category of the DME Fee Schedule. The code, maximum reimbursement rates, and lifetime expectancy are as follows:

CODE	DESCRIPTION	RENTAL	NEW	USED	LIFETIME EXPECTANCY
E0609	blood glucose monitor with special features (e.g. voice synthesizers, automatic timers, etc.)	$ 60.50	$605.02	$453.78	5 years

Providers are expected to bill their usual and customary rates.

Prior approval is required. Medical necessity must be documented on the Certificate of Medical Necessity and Prior Approval form. **All** of the following coverage criteria must be met:

1. The patient has a diagnosis of insulin-dependent diabetes, non-insulin dependent diabetes, or gestational diabetes (ICD-9CM codes 250.0-250.93 or 648.8) which is being treated by a physician;
2. The glucose monitor and related accessories and supplies have been ordered by the physician who is treating the patient's diabetes;
3. The patient (or the patient's caregiver) has successfully completed training or is scheduled to begin training in the use of the monitor, test strips, and lancets;
4. The patient (or the patient's caregiver) is capable of using the test results to assure the patient's appropriate glycemic control;
5. The device is designed for home use;
6. The patient's physician certifies that the patient has a severe visual impairment and documents the patient's best corrected visual acuity. A severe visual impairment is defined as a best corrected visual acuity of 20/200 or worse.

DMA, 919-857-4020

Attention: All Carolina ACCESS Providers

Changes Made within Your Practice

Carolina ACCESS (CA) primary care providers (PCPs) must communicate all pertinent changes made within the practice to the local Managed Care Representative. Changes may involve hospital admitting privileges, the CA contact person for the office, new office hours, new providers added to the practice, etc. The Managed Care Representative will notify the DMA Managed Care Section and the change will be made to the CA Application and Agreement on file. If you need to know your Managed Care Representative's name or phone number, please call the DMA Managed Care Section at 919-857-4022.

DMA Managed Care Section 919- 857-4022

Attention: All Providers

Corrected 1099 Requests - Action Required by March 15, 2000

Providers receiving Medicaid payments of more than $600 annually will receive a 1099 MISC tax form from Electronic Data Systems Corporation (EDS). This 1099 MISC tax form is generated as required by IRS guidelines. It will be mailed to each provider no later than January 31, 2000. The 1099 MISC tax form will reflect the tax information on file with Medicaid as of the last Medicaid Checkwrite cycle date, December 23, 1999. If the tax name or tax identification number on the annual 1099 MISC you receive is **incorrect,** a correction to the 1099 MISC can be requested. Requesting a correction is in your best interest. Correction ensures accurate tax information is on file with Medicaid and sent to the IRS annually. When the IRS receives incorrect information on your 1099 MISC it may require backup withholding in the amount of **31 percent of future Medicaid payments.** The IRS could require EDS to initiate and continue this withholding to obtain correct tax data.

A correction to the original 1099 MISC must be **submitted by March 15, 2000** and must be accompanied by the following documentation:

- A copy of original 1099 MISC
- A completed Special W-9 (included in this bulletin) clearly indicating the correct tax identification number and tax name or a completed IRS W-9 form (ensure all fields are completed as required)
- A signed and dated Special W-9 or IRS W-9 certifying that the tax information provided is correct

Fax both documents to (919) 859-9703 Attention: Corrected 1099 Request

or

mail both documents to:

EDS
4905 Waters Edge Drive
Raleigh, NC 27606
Attention: Corrected 1099 Request – Financial

Upon receipt of the fax or mailed correction request, tax information on file with Medicaid will be updated according to the Special W-9 or IRS W-9. Tax information updates can be verified by checking the last page of each Medicaid Remittance and Status Report (RA) which reflects both provider tax name and tax identification number on file. Additionally, a copy of the corrected 1099 will be generated and mailed for your record retention. All corrected 1099 requests will be summarized and reported to the IRS as required.

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

Special W-9

Complete all four parts below and return to EDS. Incomplete forms will be returned to you for proper completion.

Provider Name: Provider Number:

Part I. Provider Taxpayer Identification Number:

Your tax identification number should be reflected below exactly as the IRS has on file for you and/or your business. Please verify the number on file (per the last page of your most recent RA) and update as necessary in the correction fields listed below:

Correction Field (please write clearly in black ink):

Employer Identification Number/Taxpayer Identification Number

Social Security Number **If you do not have an employer ID then indicate social security number if you are an individual or sole proprietor only.

Part II. Provider Tax Name:

Your tax name should be reflected below exactly as the IRS has on file for you and/or your business. Individuals and sole proprietors must use their proper personal names as their tax name. Please verify the name on file (per the last page of your most recent RA) and update as necessary in the correction fields listed below:

Correction Field:

Part III. Type of Organization - Indicate below:

___ Corporation/Professional Association _____ Individual/Sole Proprietor _____ Partnership

___ Other: _____ _____ Government: _____

Part IV. Certification

Certification - Under the penalties of perjury, I certify that the information provided on this form is true, correct, and complete.

_____

Signature Title Date

EDS Office Use Only

Date Received: Name Control: Date Entered:

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Attention: Inpatient Psychiatric Hospital Providers

Update On Continued Stay Review

First Mental Health (FMH) performs utilization review of inpatient services in all psychiatric hospitals and in specified general hospitals for individuals under the age of 21, and through 64 years of age in psychiatric units of specified general hospitals. This includes pre-admission and concurrent review. As a result of this review, either additional days are certified because the information is complete and the client meets criteria for continued stay, or the case has to be referred for a physician consultation due to insufficient information to justify the stay. At this time, FMH arranges a "peer to peer" telephone conference between the consulting physician and the attending physician to discuss the case and obtain more information. Failure of the client's physician to keep the appointment for the "peer to peer" consultation will result in denial of continued stay for the client. This denial is an administrative or technical denial. There is no appeal process for the client.

The Division of Medical Assistance recommends all participants follow through in the "peer to peer" consultation. If a conference is scheduled and it is subsequently decided that the conference is not needed, please call and cancel.

In January 2000, FMH will send a letter to hospital administrators in facilities that have administrative denials. This letter will serve as a reminder to comply with procedures involving the "peer to peer" consultation. In subsequent months a letter will be sent to facilities whose physicians continue to cause administrative or technical denials.

If there are questions, contact Carolyn Wiser, RN or Callie Silver, RN, at 919-857-4025.

Attention: All Prescribers

Conversion From UPIN To DEA Number

In order to identify prescribers better in our claims processing system, we are going to move from using the UPIN on pharmacy claims to using the DEA number. The target date for the implementation of this change is April 1, 2000.

This change in information submitted on the pharmacy claims will facilitate the work of the Third Party Recovery Section, the Drug Utilization Review Program, and the Pharmacy Review Section.

If you receive inquiries from EDS or DMA to verify your provider numbers and DEA numbers, please respond immediately. It is critical that these numbers match in our system and that our provider files are correct.

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

Attention: All Providers

Third Party Billing

The Third Party Recovery Section within the Division of Medical Assistance frequently receives telephone calls from Medicaid recipients concerning providers who bill them for services, which have already been filed with Medicaid and other health insurance plans.

When a provider bills the Medicaid program and indicates an insurance payment on the claim form and/or attaches an insurance EOB, the third party payment is applied toward the Medicaid allowable for the claim. If the third party payment is equal to or greater than the Medicaid allowed amount, Medicaid will pay $0.00 on that claim. If the third party payment is less than the Medicaid allowed amount, Medicaid will pay the difference between the third party payment and the Medicaid allowed amount. The provider must not bill the Medicaid recipient (or any financially responsible relative or representative of that recipient) for any difference above the Medicaid payment or other third party payment.

If the provider is notified of the availability of other insurance coverage after Medicaid has made payment, the provider must file the charges with the third party payer. Upon receipt of the insurance payment, the provider must refund Medicaid the lesser of the two payments.

When the recipient's private health insurance company pays the recipient directly, the provider may bill the recipient for the amount of the insurance payment. If the amount is unknown, the provider may bill the total charges until the payment amount is known. When the provider has determined the amount of the insurance payment, the provider may then file the claim with Medicaid, indicating the insurance payment amount in the appropriate block on the claim form. Medicaid will process the claim for payment, less the insurance payment. The provider may continue to bill the recipient up to the amount of the insurance payment until full insurance payment is received.

Third Party Recovery Section, DMA, 919-733-6294

Attention: Hospital Providers

Ancillary Services Paid without Prior Authorization

The Carolina ACCESS Emergency Room Reimbursement Policy includes payment of the following ancillary services without prior authorization from the primary care provider:

- Basic Metabolic Panel: CPT Codes 80048, 80051, 80053, 80076
- Complete Blood Count: CPT Codes 85013, 85014, 85018, 85021, 85022, 85023, 85024, 85025, 85027, 85031
- Urinalysis: CPT Codes 81000, 81001, 81002, 81003
- Electrocardiograms-All EKG services performed in the Emergency Room and billed on a UB-92

DMA Managed Care Section, Quality Management Unit 919-857-4022.

Attention: Certified Registered Nurse Anesthetists (CRNA) & Anesthesiologist Providers

Individual Visits

EDS is offering individual provider visits for Certified Registered Nurse Anesthetists (CRNA) and Anesthesiologist providers. Please complete and return the form below. An EDS Provider Representative will contact you to schedule a visit and discuss the type of issues to be addressed.

(cut and return registration form only)

.....

CRNA & Anesthesiologist Provider Visit Request Form
(No Fee)

Provider Name_____ Provider Number _____

Address _____ Contact Person _____

City, Zip Code_____ County _____

Telephone Number_____ Date _____

List any specific issues you would like addressed in the space provided below.

_____

_____

_____

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

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

Attention: Health Check Providers

Health Check Seminar

Health Check seminars will be held in March 2000. The February 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

_____

_____

_____

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

Attention: Home Health Providers

Home Health Seminar Schedule

Seminars for Home Health providers will be held in February 2000. Each provider is encouraged to send new and/or appropriate administrative, clinical, and clerical personnel. The primary topic is the October 1999 Special Bulletin regarding new Home Health billing instructions effective with February 1, 2000 date of service. The agenda also includes Program Integrity issues, commonly identified Home Health program errors, and a review of procedures for filing home health claims, common billing errors, and follow-up procedures.

Due to limited seating, pre-registration is required. Providers not registered are welcome to attend when reserved space is adequate to accommodate. Please select the most convenient site and return the completed registration form to EDS as soon as possible. Seminars begin at 10:00 a.m. and end at 1:00 p.m. Providers are encouraged to arrive by 9:45 a.m. to complete registration.

Note: Providers are requested to bring their most updated Community Care Manual. Additional manuals will be available for purchase at $20.00.

Directions are available on page 19 of this bulletin.

Tuesday, February 8, 2000
Four Points Sheraton
5032 Market Street
Wilmington, NC

Thursday, February 10, 2000
Martin Community College
Kehakee Park Road
Williamston, NC
Auditorium

Wednesday, February 16, 2000
Catawba Valley Technical College
Highway 64-70
Hickory, NC
Auditorium

Tuesday, February 15, 2000
Holiday Inn
530 Jake Alexander Blvd., S.
Salisbury, NC

Monday, February 21, 2000
WakeMed
MEI Conference Center
3000 New Bern Avenue
Raleigh, NC
Park at East Square Medical Park

(cut and return registration form only)

Home Health Provider Seminar Registration Form

(No Fee)

Provider Name_____ Provider Number _____

Address _____ Contact Person _____

City, Zip Code _____ County _____

Telephone Number _____ Date _____

_____ persons will attend the seminar at _____(location) on _____(date)

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

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Directions to the Home Health Seminars

The Registration form for the Home Health workshops is on page 17of this bulletin.

WILMINGTON, NORTH CAROLINA

FOUR POINTS SHERATON
Tuesday, February 8, 2000

I-40 East into Wilmington to Highway 17 - just off of I-40. Turn left onto Market Street and the Four Points Sheraton is located on the left.

WILLIAMSTON, NORTH CAROLINA

MARTIN COMMUNITY COLLEGE
Thursday, February 10, 2000

Highway 64 into Williamston. The college is approximately 1-2 miles west of Williamston. The Auditorium is located in Building 2.

HICKORY, NORTH CAROLINA

CATAWBA VALLEY TECHNICAL COLLEGE
Wednesday, February 16, 2000

Take I-40 to exit 125 and go approximately ½ mile to Highway 70. Head East on Highway 70 and the college is approximately 1.5 miles on the right. Ample parking is available. Entrance to Auditorium is between the Student Services and the Maintenance Center. Follow sidewalk (towards Satellite Dish) and turn right to Auditorium Entrance.

SALISBURY, NORTH CAROLINA

HOLIDAY INN CONFERENCE CENTER
Monday, February 21, 2000

Take I-85 to exit 75 and go approximately ½ mile. The Holiday Inn is located on the right.

RALEIGH, NORTH CAROLINA

WAKEMED MEI CONFERENCE CENTER
Monday, February 21, 2000

Directions to the Parking Lot:
Take the I-440 Raleigh Beltline to New Bern Avenue, Exit 13A (New Bern Avenue, Downtown). Go toward WakeMed. Turn left at Sunnybrook road and park at the East Square Medical Plaza which is a short walk to the conference facility. **Parking is not allowed in the parking lot in front of the Conference Center. Vehicles will be towed if not parked in the East Square Medical Plaza parking lot located at 23 Sunnybrook Road.**

Directions to the Conference Center from Parking Lot:
Cross the street and ascend steps from sidewalk up to Wake County Health Department. Cross Health Department parking lot and ascend steps (with a blue handrail) to MEI Conference Center. Entrance doors are on the left.

Checkwrite Schedule

January 12, 2000	February 8, 2000	March 7, 2000
January 19, 2000	February 15, 2000	March 14, 2000
January 27, 2000	February 24, 2000	March 21, 2000
		March 30, 2000

Electronic Cut-Off Schedule

January 7, 2000	February 4, 2000	March 3, 2000
January 14, 2000	February 11, 2000	March 10, 2000
January 21, 2000	February 18, 2000	March 17, 2000
		March 24, 2000

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.

Paul R. Perruzzi, Director
Division of Medical Assistance
Department of Health and Human Services

John W. Tsikerdanos
Executive Director
EDS

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