



# 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 1, 2001 in observance of New Years Day, and on Monday, January 15, 2001 in observance of Martin Luther King’s Birthday.

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

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

**Attention: All Physicians**

**New Oral Screening Preventive Package for Use in Primary Care Physician Offices (Effective February 1, 2001)**

Because fluoride varnishes have been proven effective in the prevention of early childhood caries, especially for children under thirty-six (36) months of age, the Division of Medical Assistance is adding coverage for a new oral screening preventive package. This package is recommended for all Medicaid eligible recipients from the time teeth erupt to thirty-six (36) months of age. Prior approval is not required for these procedures and services must not be billed until provider training has been obtained. (Up to six (6) applications allowed over a 3-year period.)

Procedure Code	Description
W8002	<p>Initial Oral Screening</p> <ul style="list-style-type: none"> <li>* includes early caries screening and detection of other notable findings in the oral cavity</li> <li>* includes prevention and dietary counseling</li> <li>* includes prescribing a fluoride supplement, if indicated</li> <li>* includes application of fluoride varnish</li> <li>* Medicaid can only allow reimbursement for this oral screening when teeth are present and fluoride varnish is applied to the teeth</li> <li>* limited to recipients under 3 years old</li> <li>* allowed once per provider for each recipient</li> <li>* periodic oral screening is recommended four (4) to six (6) months after the initial oral screening</li> <li>* exempt from third party liability</li> </ul>

**Reimbursement:** \$43.00 for the entire mouth

Procedure Code	Description
W8003	<p>Periodic Oral Screening</p> <ul style="list-style-type: none"> <li>* includes early caries screening and detection of other notable findings in the oral cavity</li> <li>* includes prevention and dietary counseling</li> <li>* includes application of fluoride varnish</li> <li>* Medicaid can only allow reimbursement for this oral screening when teeth are present and fluoride varnish is applied to the teeth</li> <li>* limited to recipients under 3 years old</li> <li>* periodic oral screening is recommended four (4) to six (6) months after the initial oral screening</li> <li>* periodic oral screening and fluoride varnish application are recommended two (2) times per year at four (4) to six (6) month intervals for the same or different provider</li> <li>* exempt from third party liability</li> </ul>

**Reimbursement:** \$35.00 for the entire mouth

**Initial Oral Screening must include:**

1. Early caries screening and detection of other notable findings (obvious pathology of hard and soft tissues) in the oral cavity using a tongue blade and directed light.
2. Counseling and educational materials on good oral hygiene practices and diet/nutrition for children.
3. Prescribing a fluoride supplement, if indicated, per the guidelines of the Dental Health Section, North Carolina Department of Health and Human Services (DHHS).
4. Initial application of fluoride varnish to all erupted primary teeth, beginning at tooth eruption until the child's third (3rd) birthday.
5. Documentation of services and findings in the patient's medical record.

**Periodic Oral Screening must include:**

1. Early caries screening and detection of other notable findings in the oral cavity using a tongue blade and directed light.
2. Counseling and educational materials on good oral hygiene practices and diet/nutrition for children.
3. Application of fluoride varnish to all erupted primary teeth (allowed at six month intervals) beginning at tooth eruption until the child's third (3rd) birthday.
4. Documentation of services and findings in the patient's medical record.

Providers are encouraged to have the recipient's drinking water tested for fluoride content if deemed necessary. Providers should refer the recipient to a dentist for continued treatment at the appropriate age.

**Providers of Service**

Licensed physicians or the designated physician extender (PA, Nurse Practitioner, RN, or LPN)

**Place of Service**

Physician's office, health department clinics, Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and other appropriate clinic settings.

**Claims Filing Process**

Prior approval is not required for these services. These services are to be billed on the HCFA-1500 claim form or electronically through ECS after provider training is obtained. Billing instructions will be given at all training sessions.

**Provider Training and Continuing Education**

It is required as a condition of participation, that the physician or physician extender attend a Medicaid recognized continuing education (CE) course of 1 to 2 hours to prepare for the delivery of these services. Only providers who have been trained should render these services and submit claims for payment. The N.C. Academy of Family Physicians and the N.C. Pediatric Society will implement the provider training. The UNC School of Dentistry and Public Health and the Dental Health Section are involved in designing the course and preparing brochures and other educational materials for distribution to the Medicaid recipient's family when services are rendered. Watch upcoming Medicaid Provider Bulletins and Academy and Society mailings for course dates and locations.

**Product information**

Duraphat® is a fluoride varnish accepted by the American Dental Association. According to experts at the UNC School of Dentistry, fluoride varnish is practical, safe, and easy to apply to the teeth of infants and very young children and is extremely useful in the prevention of early childhood caries. The varnish comes in a tube and is applied in a thin layer to all surfaces of CLEAN, DRY teeth using a disposable brush. Teeth should be cleaned for this age group with a soft wipe or a toothbrush prior to fluoride varnish application. Additional information will be available through the continuing education course materials and aids.

**Betty King-Sutton, D.M.D., Dental Program  
DMA, 919-857-4020**

## Attention: Nursing Facilities and Adult Care Homes

### Influenza and Pneumonia Vaccinations

The North Carolina General Assembly has enacted Senate Bill 1234 to ensure that consenting **residents and employees** of nursing facilities and adult care homes are immunized against influenza each year. The legislation relative to influenza becomes effective September 1, 2001, and vaccination is required unless it is medically contraindicated, would violate the resident's or employee's religious beliefs, or is refused after they are fully informed of the health risks of not being immunized. Although the legislation is not effective until September, facilities are encouraged to offer this very important health benefit now.

The legislation also requires that consenting **residents** receive the pneumonia vaccine as needed. This was effective September 2000. Recommendations from the Centers for Disease Control's (CDC) Advisory Committee on Immunization Practices for persons 65 and older state, "All persons in this category should receive the pneumococcal vaccine, including previously unvaccinated persons and persons who have not received vaccine within five years (and were less than 65 years of age at the time of vaccination). All persons who have unknown vaccination status should receive one dose of vaccine."

A November 22, 2000 Health Care Financing Administration (HCFA) press release recommends that both of these vaccinations be made a part of residents' annual drug regimen review to improve immunization rates. Between 20,000 and 40,000 deaths are attributed to flu and pneumonia in the United States each year. More than 90 percent of the deaths occur in people age 65 and over. Among elderly nursing home residents, influenza vaccine can be 50 to 60 percent effective in preventing hospitalization for pneumonia, and 80 percent effective in preventing death. Pneumococcal vaccination is 60 to 70 percent effective in preventing invasive (bacterial) pneumococcal infection.

In view of the shortage of flu vaccine, the CDC has issued a notice urging "both health care providers and the public to be patient, but persistent in their efforts to get flu vaccine." The CDC has "developed an Influenza Vaccine Availability website that provides information about the availability of influenza vaccine from manufacturers and wholesale distributors and will list state health departments that may have information about vaccine availability among local providers. The list will be updated weekly." The website can be accessed at [www.cdc.gov/nip/flu-vac-supply](http://www.cdc.gov/nip/flu-vac-supply). The National Pneumonia website at [www.nationalpneumonia.org](http://www.nationalpneumonia.org) contains documents developed for this particular flu season by HCFA and CDC.

Facilities requiring assistance from local health departments to provide immunizations are advised to contact those health departments early in 2001 to allow adequate planning time as well as time to order vaccine

**Ann H. Kimbrell, R.N.**  
**DMA, 919-857-4041**

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

## Attention: Nurse Practitioners and Physician Assistants

# Reducing Crossover Denials

When a recipient is eligible for both Medicare and Medicaid, Medicare automatically transmits claims electronically to the N.C. Medicaid program. These claims are known as crossover claims. Nurse practitioners and physician assistants employed by physicians have reported crossover claim denials.

Medicare requires nurse practitioners and physician assistants to bill all services not covered under Medicare’s “Incident To” policy under their own Medicare provider number.

Medicaid maintains a Medicare cross-reference file that is used to identify the correct Medicaid provider. Nurse practitioners and physician assistants must complete and return the form below to reduce crossover claim denials. Use the Medicaid provider number of your physician employer(s) in the block titled “Medicaid Provider number.”

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

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### MEDICARE CROSSOVER REFERENCE REQUEST

Provider Name: \_\_\_\_\_

Contact Person:(required) \_\_\_\_\_ Telephone Number: (required) \_\_\_\_\_

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Indicate your *Medicare Carrier*, the *Action to be taken*, and your *Medicare* and *Medicaid* provider numbers. **If this section is not completed, the form will not be processed.**

These are the only carriers for which EDS can currently cross-reference provider numbers.

- |                                     |   |   |
|-------------------------------------|---|---|
| <input type="checkbox"/> NC BC/BS   | <input type="checkbox"/> Palmetto                                     | <input type="checkbox"/> United Government Services of WI |
| <input type="checkbox"/> TN BC/BS   | <input type="checkbox"/> Riverbend Government Benefits Administration | <input type="checkbox"/> Admina Star*                     |
| <input type="checkbox"/> FL BC/BS * | <input type="checkbox"/> Mutual of Omaha *                            | <input type="checkbox"/> GA BC/BS                         |
| <input type="checkbox"/> TX BC/BS   | <input type="checkbox"/> United Healthcare *                          | <input type="checkbox"/> Other _____                      |
| <input type="checkbox"/> MS BC/BS   | <input type="checkbox"/> CIGNA  |   |

#### Action to be taken:

- Addition - This is used to add a new provider number (Medicare or Medicaid) to the crossover file.*  
 Medicare Provider number: \_\_\_\_\_ Medicaid Provider number: \_\_\_\_\_
- Change - This is used to change an existing provider number (Medicare or Medicaid) on the crossover file.*  
 Medicare Provider number: \_\_\_\_\_ Medicaid Provider number: \_\_\_\_\_

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Mail to: Provider Enrollment  
EDS  
PO Box 300009  
Raleigh, NC 27622

\* These are additional Medicare carriers whom EDS is in the process of working with to have claims cross over with North Carolina Medicaid.

## Attention: All Providers

## Pneumococcal Polysaccharide Vaccine (PPV23, CPT Code 90732) Billing Guidelines

The N.C. Medicaid program covers CPT code 90732 (PPV23). Due to the availability of this vaccine at no charge through the Vaccines for Children program (VFC), Medicaid will **not** reimburse for the **vaccine** for children through 18 years of age. Providers must, however, report PPV23 vaccine administration to Medicaid. CPT code 90732 must be listed on the claim with the appropriate modifiers.

Health departments must **not** bill an administration fee (W8012) if the vaccine is given on the same day as a Health Check screening. Providers should bill W8010 (regular periodic screening) or W8016 (interperiodic screening) with 90732 and the appropriate modifiers.

Private physicians may bill an immunization administration fee (W8012) on the same day a vaccine is administered. Private-sector providers may bill an administration fee if it is the only service provided that day or if it is provided in addition to a Health Check screening or an office visit. Providers must bill the W8012 with CPT code 90732 and the appropriate modifiers.

Medicaid will reimburse providers for Medicaid-eligible recipients receiving PPV23 vaccine (CPT code 90732) **after** 18 years of age when diagnosis code V03.8 or V05.8 is submitted on the claim. The usual and customary charge should be listed for those recipients **over** 18 years of age. In order for the **administration fee** to be reimbursed by Medicaid, providers must bill CPT code 90782, "Therapeutic, prophylactic or diagnostic injection (specify material injected); subcutaneous or intramuscular."

Refer to the following table when billing for PPV:

### BILLING GUIDELINES

Category by Age	Type of Service	Health Departments	Private Providers
Under 19 years of age	When <b>Health Check</b> screening <b>is</b> performed (vaccine is free):	Bill W8010 or W8016; report 90732 with the appropriate modifiers. Do <b>not</b> bill W8012.	Bill W8010 or W8016 and report CPT code 90732 with the appropriate modifiers. W8012 may be billed.
Under 19 years of age	When <b>Health Check</b> screening <b>is not</b> performed (vaccine is free):	Report 90732 with the appropriate modifiers. Bill W8012.	Report CPT code 90732 with the appropriate modifiers and bill W8012.
Between 19 and 21 years of age	When <b>Health Check</b> screening <b>is</b> performed:	Bill W8010 or W8016 and CPT code 90732 with the appropriate modifiers and the usual and customary fee. Do <b>not</b> bill W8012.	Bill W8010 or W8016 and CPT code 90732 with the appropriate modifiers and usual and customary fee. W8012 may be billed.

<b>Between 19 and 21</b> years of age	When <b>Health Check</b> screening <b>is not</b> performed:	Bill CPT code 90732 with the appropriate modifiers and the usual and customary fee. Bill W8012.	Bill CPT code 90732 with the appropriate modifiers and usual and customary fee. Bill W8012.
<b>21</b> years of age <b>and over</b>	When an evaluation and management code <b>is</b> billed:	Bill CPT code 90732. Diagnosis code V03.8 or V05.8 must be on the claim. Do <b>not</b> bill an administration fee code.	Bill CPT code 90732. Diagnosis code V03.8 or V05.8 must be on the claim. Do <b>not</b> bill an administration fee code.
<b>21</b> years of age <b>and over</b>	When an evaluation and management code <b>is not</b> billed:	Bill CPT code 90732 and administration fee code 90782. Diagnosis code V03.8 or V05.8 must be on the claim.	Bill CPT code 90732 and administration fee code 90782. Diagnosis code V03.8 or V05.8 must be on the claim.

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

**Attention: All Providers**

**New Medicaid Identification Cards for Supplemental Security Income Recipients**

In an effort to increase efficiency and improve security, Medicaid identification (MID) cards for Supplemental Security Income (SSI) recipients will be printed differently effective February 2001. The SSI population was selected because the MID cards are produced separately from other Medicaid recipients and because they are a relatively stable population. The new design will allow more flexibility in getting information to recipients. Also, the cards will be printed using the postal bar code, which is expected to improve delivery of the cards statewide. The cards will be printed on 8½ X 11 inch watermarked paper. The paper is a lighter weight, making it more pliable, and will be perforated allowing the recipient the ability to detach the card. However, the card is still valid if not detached. SSI recipients will receive notice in both January and February of 2001 regarding the new cards.

**There is no change in the way recipients will use the cards.** SSI recipients may, on occasion, receive cards printed on the heavier stock paper. These cards are still valid.

**Renee Boston, Recipient and Provider Services, Medicaid Eligibility Unit  
DMA, 919-857-4019**

**Attention: All Providers****2001 CPT Updates**

Effective with date of service January 1, 2001, Medicaid providers may bill the 2001 Current Procedural Terminology (CPT) codes. Claims filed with obsolete 2000 codes for dates of service January 1, 2001 through March 31, 2001 will be accepted. Dates of service on and after April 1, 2001 must be filed with 2001 CPT codes.

The following new 2001 CPT codes are noncovered:

- 36540** *Collection of blood specimen from a partially or completely implantable venous access device*
- 43752** *Naso- or oro-gastric tube placement, necessitating physician's skill*
- 44133** *Donor enterectomy, open, with preparation and maintenance of allograft; partial, from living donor*
- 44136** *Intestinal allotransplantation; from living donor*
- 69714** *Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy*
- 69715** *Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator with mastoidectomy*
- 69717** *Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy*
- 69718** *Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator*
- 77522** *Proton treatment delivery; simple, with compensation*
- 77525** *Proton treatment delivery; complex*
- 89321** *Semen analysis, presence and/or motility of sperm*
- 93668** *Peripheral arterial disease (PAD) rehabilitation, per session*
- 97532** *Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes*
- 97533** *Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes*
- 97602** *Removal of devitalized tissue from wound; non-selective debridement, without anesthesia (e.g., wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session.*
- 97802** *Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes*
- 97803** *Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes*
- 97804** *Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes*
- 99172** *Visual function screening, automated or semi-automated bilateral quantitative determination of visual acuity, ocular alignment, color vision by pseudoisochromatic plates, and field of vision (may include all or some screening of the determination(s) for contrast sensitivity, vision under glare)*

The following procedure codes are under further review by the Division of Medical Assistance and are noncovered at this time.

- 90723** *Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DtaP-HepB-IPV), for intramuscular use*

**90740** *Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use*

**90743** *Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use*

**67221** *Destruction of localized lesion of choroid (e.g., choroidal neovascularization); photocoagulation (e.g., laser), one or more sessions*

Italicized material is excerpted from the American Medical Association *Current Procedural Terminology*. CPT codes, descriptions, and other data only are copyrighted 2000 American Medical Association. All rights reserved.

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

## Attention: All Physicians and Hospital Providers

### Clarification of the January 2000 Bulletin article "Reimbursement Rate: Physician Fees"

Effective with date of service January 1, 2000, the N.C. Medicaid program aligned with Medicare and adopted a new relative value method for calculating physician fees for facility-based services furnished in hospitals (inpatient, outpatient, and emergency rooms), ambulatory surgical centers (ASC), and skilled nursing facility (SNF) settings. This method is the facility-based fee concept.

The facility-based fee concept identifies two levels of practice expense relative value units (RVUs), facility and nonfacility, for each procedure code. The facility practice expense RVUs are used for services furnished in a hospital, SNF, ASC, mental health facility, and solely owned hospital physician practices. Bill outpatient hospital as the place of service for services rendered in a solely owned hospital physician practice.

The allowable for a specific procedure code is determined by the **place of service**, as indicated on the claim. 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 procedure codes are the same for nonfacility and facility regardless of the place of service indicated on the claim.

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

## Attention: All Providers

# Corrected 1099 Requests – Action Required by March 1, 2001

Providers receiving Medicaid payments of more than \$600 annually 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, 2001. The 1099 MISC tax form will reflect the tax information on file with Medicaid as of the last Medicaid Checkwrite cycle date, December 15, 2000.

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. Correction ensures that 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 1, 2001** and must be accompanied by the following documentation:

- A copy of original 1099 MISC
- A completed Special W-9 (see next page) 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 Advice (RA), which reflects both the provider tax name and tax identification number on file. Additionally, a copy of the corrected 1099 MISC will be generated and mailed for your record retention. All corrected 1099 MISC 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: _____

**Attention: All Providers**

**E**nd-dated 2000 CPT Codes

Effective with date of service April 1, 2001, Medicaid providers may no longer bill the procedure codes that are deleted by CPT. Claims filed with deleted procedure codes for dates of service **prior** to April 1, 2001 will be accepted for processing.

52335	52336	52337	52338
52339	52340	70541	71036
76365	76934	76938	76960
82251	87060	87072	87082
87083	87085	87087	87117
87145	87151	87155	87163
87174	87175	87192	87208
87211	92597	92598	97770
99375	99378		

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

**Attention: All Providers**

**M**ail Service Center Addresses

Effective January 2, 2001, all mail to the Division of Medical Assistance (DMA) must be addressed to the appropriate Mail Service Center address. Mail sent to any address other than the Mail Service Center addresses will not be forwarded and will be returned to the sender. Refer to the table below for DMA’s Mail Service Center addresses.

UPS, FEDEX, Airborne, and other freight companies will continue to deliver to DMA’s physical address, 1985 Umstead Drive, Raleigh NC, 27626. Include the DMA employee’s name and section with the address to ensure that the delivery is routed correctly.

If you are using forms that have not been updated with DMA’s Mail Service Center addresses, refer to the table below for the correct Mail Service Center address.

<p><b><u>Administration and Regulatory Affairs</u></b>                  Division of Medical Assistance                  2504 Mail Service Center                  Raleigh, NC 27699-2504</p>	<p><b><u>Audit</u></b>                  Division of Medical Assistance                  2507 Mail Service Center                  Raleigh, NC 27699-2507</p>
<p><b><u>Carolina ACCESS; Managed Care</u></b>                  Division of Medical Assistance                  2516 Mail Service Center                  Raleigh, NC 27699-2516</p>	<p><b><u>Claims Analysis and Medicare Buy-In</u></b>                  Division of Medical Assistance                  2519 Mail Service Center                  Raleigh, NC 27699-2519</p>

<p><b><u>Community Care</u></b>                  Division of Medical Assistance                  2502 Mail Service Center                  Raleigh, NC 27699-2502</p>	<p><b><u>DHHS Accounts Receivable</u></b>                  Division of Medical Assistance                  2022 Mail Service Center                  Raleigh, NC 27699-2022</p>
<p><b><u>Director or Deputy Director</u></b>                  Division of Medical Assistance                  2517 Mail Service Center                  Raleigh, NC 27699-2517</p>	<p><b><u>Eligibility Unit</u></b>                  Division of Medical Assistance                  2512 Mail Service Center                  Raleigh, NC 27699-2512</p>
<p><b><u>Financial Operations</u></b>                  Division of Medical Assistance                  2509 Mail Service Center                  Raleigh, NC 27699-2509</p>	<p><b><u>Hearing Office</u></b>                  Division of Medical Assistance                  2505 Mail Service Center                  Raleigh, NC 27699-2505</p>
<p><b><u>Information Services</u></b>                  Division of Medical Assistance                  2514 Mail Service Center                  Raleigh, NC 27699-2514</p>	<p><b><u>Mail Management</u></b>                  Division of Medical Assistance                  2513 Mail Service Center                  Raleigh, NC 27699-2513</p>
<p><b><u>Medicaid Mgt. Info. System (MMIS)</u></b>                  Division of Medical Assistance                  2510 Mail Service Center                  Raleigh, NC 27699-2510</p>	<p><b><u>Medical Policy/Utilization Control</u></b>                  Division of Medical Assistance                  2511 Mail Service Center                  Raleigh, NC 27699-2511</p>
<p><b><u>Program Integrity</u></b>                  Division of Medical Assistance                  2515 Mail Service Center                  Raleigh, NC 27699-2515</p>	<p><b><u>Provider Services</u></b>                  Division of Medical Assistance                  2506 Mail Service Center                  Raleigh, NC 27699-2506</p>
<p><b><u>Quality Control</u></b>                  Division of Medical Assistance                  2518 Mail Service Center                  Raleigh, NC 27699-2518</p>	<p><b><u>Third Party Recovery or Health Insurance                  Premium Payment Program (HIPP)</u></b>                  Division of Medical Assistance                  2508 Mail Service Center                  Raleigh, NC 27699-2508</p>

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

**(Name of DMA employee)**  
 Division of Medical Assistance  
 2501 Mail Service Center  
 Raleigh, NC 27699-2501

**Clarence Rogers, Financial Operations  
 DMA, 919-857-4015**

## Attention: Durable Medical Equipment (DME) Providers

### Coverage of Negative Pressure Wound Therapy Pumps and Supplies

Effective with date of service January 1, 2001, negative pressure wound therapy (NPWT) pumps are being added to the Frequently Serviced category of the DME Fee Schedule. Supplies for use with the pumps will be added to the DME Related Supply category of the DME Fee Schedule. NOTE: Coverage of these supplies when monthly rental payments are being made is an exception to Sections 6.1 and 6.1.2 of the DME Manual (March 1, 1999 Reprint). The codes, maximum reimbursement rates, and quantity limitations are as follows:

Code	Description	Rental	New	Limitations
K0538	negative pressure wound therapy electrical pump, stationary or portable	\$1,686.31	N/A	N/A
K0539	dressing set for negative pressure wound therapy electrical pump, stationary or portable, each	N/A	\$26.92	15/month
K0540	canister set for negative pressure wound therapy electrical pump, stationary or portable, each	N/A	\$24.11	10/month

Providers are expected to bill their usual and customary rates.

Prior approval is required for the pump. Medical necessity for the pump and supplies must be documented on the Certificate of Medical Necessity and Prior Approval form. Coverage criteria are as follows:

#### INITIAL COVERAGE

An NPWT pump and supplies are covered when the following criteria are met:

#### Ulcers and Wounds in the Home Setting:

The patient has a chronic Stage III or IV pressure ulcer, neuropathic (for example, diabetic) ulcer, venous or arterial insufficiency ulcer, or chronic (being present for at least 30 days) ulcer of mixed etiology. A complete wound therapy program described by criterion 1 and criteria 2, 3, or 4, as applicable depending on the type of wound, should have been tried or considered and ruled out prior to application of NPWT:

1. For all ulcers or wounds, the following components of a wound therapy program must include a minimum of all the following general measures, which should either be addressed, applied, or considered and ruled out to application of NPWT:
  - a) Documentation in the patient's medical record of evaluation, care, and wound measurements by a licensed medical professional, and
  - b) Application of dressings to maintain a moist wound environment, and
  - c) Debridement of necrotic tissue if present, and
  - d) Evaluation of and provision for adequate nutritional status.
2. For Stage III or IV ulcers:
  - a) The patient has been appropriately turned and positioned, and
  - b) The patient has used a group 2 or 3 support surface for pressure ulcers on the posterior trunk or pelvis (Note: a group 2 or 3 support surface is not required if the ulcer is not on the trunk or pelvis), and
  - c) The patient's moisture and incontinence have been appropriately managed.

3. For neuropathic (for example, diabetic) ulcers:
  - a) The patient has been on a comprehensive diabetic management program, and
  - b) Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities.
4. For venous insufficiency ulcers:
  - a) Compression bandages and/or garments have been consistently applied, and
  - b) Leg elevation and ambulation have been encouraged.

NPWT pumps (K0538) must be capable of accommodating more than one wound dressing set for multiple wounds on a patient. Therefore, more than one K0538 billed per patient for the same time period will be denied as not medically necessary.

Initial authorization will be given for a maximum of 3 months.

### **EXCLUSIONS FROM COVERAGE**

An NPWT pump and supplies will be denied at any time as not medically necessary if one or more of the following are present:

- the presence in the wound of necrotic tissue with eschar, if debridement is not attempted;
- untreated osteomyelitis within the vicinity of the wound;
- cancer present in the wound;
- the presence of a fistula to an organ or body cavity within the vicinity of the wound.

### **CONTINUED COVERAGE**

For wounds and ulcers described above, once placed on an NPWT pump and supplies, in order to continue, a licensed medical professional must do the following:

1. On a regular basis,
  - a) directly assess the wound(s) treated with the NPWT pump, and
  - b) supervise or directly perform the NPWT dressing changes, and
2. On at least a monthly basis, document changes in the ulcer's dimension and characteristics.

Re-authorizations for continued coverage will be given for a maximum of 1 month.

If the continued coverage criteria are not fulfilled, continued coverage of the NPWT pump and supplies will be denied as not medically necessary.

For the purposes of this policy, a licensed medical professional may be a physician, physician's assistant, registered nurse, licensed practical nurse, or physical therapist. The practitioner should be licensed to assess wounds and/or administer wound care within the state where the beneficiary is receiving NPWT.

Lack of improvement of a wound, as used within this policy, is defined as a lack of progress in quantitative measurements of wound characteristics including wound length and width (surface area), or depth measured serially and documented, over a specified time interval. Wound healing is defined as improvement occurring in either surface area or depth of the wound.

The staging of pressure ulcers used in this policy is as follows:

- Stage I: nonblanchable erythema of intact light-toned skin or darker or violet hue in darkly pigmented skin.
- Stage II: partial thickness skin loss involving epidermis and/or dermis.
- Stage III: full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia.
- Stage IV: full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone, or supporting structures.

**Melody B. Yeargan, P.T., Medical Policy Section  
DMA, 919-857-4020**

Attention: All Providers

## Synagis Administration Billing Clarification

Synagis is billable through the pharmacy program under the guidelines most recently published in the October 2000 Medicaid Bulletin. When billing for Synagis administration, do not list a code for the drug itself. Use only the administration fee code 90782.

CPT code 90782 must be used to bill for administration of Synagis. The administration code is billable when the following conditions are met:

1. The injection is the sole reason for the visit to the physician's office.
2. The injectable drug is not given in conjunction with chemotherapy agents.
3. The fee is not billed in conjunction with an office visit.

Do not bill the Health Check immunization administration fee code W8012.

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

## Attention: Health Departments

### Frequently Asked Questions

**1. Where can I find a complete listing of recognized Medicaid modifiers?**

A complete listing of Medicaid modifiers is on pages 69 and 70 of the May 2000 Special Bulletin.

**2. What place of service should be billed on CPT procedure codes?**

Bill the place of service that best describes the location the service was rendered. The place of service for health departments is 71.

**3. Can state-created procedure codes that begin with a W or Y be billed after July 1, 2000?**

For dates of service prior to July 1, 2000 it is acceptable to bill a state-created procedure code. After July 1 date of service, the appropriate CPT procedure code should be billed, except for the state-created codes that have not changed.

**4. How does a local health department resolve denied claims?**

Health department staff should review the Remittance and Status Advice report and read the denial Explanation of Benefit (EOB). The EOB provides guidance on how to correct a billing error. The claim can be resubmitted as a new claim when the EOB instructs providers "to correct and resubmit." Health departments can also contact EDS Provider Services at 1-919-851-8888 or 1-800-688-6696 for assistance.

**5. When a child is seen for a periodic or interperiodic Health Check screening (W8010 or W8016) does the health department need to list CPT codes on the claim form for every immunization given?**

Yes. Health departments are required to list on the claim form the procedure code for each immunization given when billing W8010 or W8016.

**6. How does a health department bill for a venipuncture?**

The N.C. Medicaid program reimburses for venipuncture specimen collection, code G0001, only to the provider who extracted the specimen. The provider billing for this collection fee must send the lab work outside the office to be performed. One collection fee is allowed for each recipient per date of service, regardless of the number of specimens drawn.

**7. What modifier should be appended with G0001, venipuncture specimen collection?**

No modifier should be appended with G0001.

**8. The table on page 22 of the May 2000 Special Bulletin lists procedure codes that may not be billed in addition to 59425 and 59426. Does that mean that other laboratory services may be billed separately?**

All services rendered to Medicaid recipients must be medically necessary. When the provider determines additional laboratory diagnostic tests are medically necessary during a prenatal visit, the laboratory test may be billed.

**9. What is the appropriate code to use when billing for a purified protein derivative (PPD)?**

The appropriate code to use when billing for PPD is 86580, which includes providing an explanation of the procedure, injection of the antigen, reading the test and following up to assure that it is read. A separate service may NOT be billed for reading the skin test if it was negative. However, if the test is positive and additional follow-up, scheduling of a chest x-ray, initiation of medications, etc. is required, a CPT procedure code for an Evaluation and Management (E/M) visit or Y2012 may be billed. Laboratory services are included in Y2012 and separate reimbursement is not allowed.

**10. Can a local health department bill for completing a Record of Tuberculosis Screening report (DHHS-3405)?**

No. Medicaid does not reimburse separately for completing a Record of Tuberculosis Screening report.

**11. Please clarify the definitions of “new” and “established” related to Evaluation and Management (E/M) procedure codes.**

In this context, “new” means a patient who has not been seen in the agency for a billed visit for at least three years. This is identified by selecting the appropriate CPT code that specifies a new or established patient.

Example: A family planning visit for a 19-year-old patient who meets this definition of new would be billed using 99385 (the new patient code for an individual of that age); an established patient of the same age is billed using 99395.

Example: Ms. R, age 24, is seen at a family planning clinic following delivery. She receives her prenatal care from the health department. On the encounter screen a “1” is entered in the field for “patient type” to indicate that she is new to the family planning program. However, an established patient visit is billed to procedure code 99395, because they have been seen in the agency within the past three years.

**12. Can procedure code 99211 be billed even if the physician, nurse practitioner or physician assistant sees the patient?**

Bill procedure code 99211 when an established patient, who may not require the presence of a physician, is seen in a local health department. If a physician, nurse practitioner or physician assistant sees the patient and provides all the services of a higher level E/M visit, bill the appropriate procedure code (99201 through 99205 or 99211 through 99215). It is not appropriate to bill 99211 and a higher level E/M visit for the same date of service unless the two visits were both medically necessary and completely unrelated.

**13. Is procedure code 99211 the only code that can be billed if a registered nurse sees the patient, even if the physician or nurse practitioner or physician assistant is on-site?**

Yes. Local health departments can bill 99211 when the recipient is seen only by a registered nurse and not seen by the physician. The services provided to the recipient would be covered under the “incident to” Medicaid policy.

**14. Please clarify how to bill for family planning; the May 2000 Special Bulletin indicates on page 18 that the “FP” modifier is used only to bill for service to patients only through age 20.**

All initial or annual family planning exams are now billed using the appropriate preventive medicine code (99383, 99384, 99385, 99386, 99393, 99394, 99395, 99396 – based on new vs. established and the patient’s age) and the FP modifier. This guidance, provided in a Public Health memo dated July 7, 2000, supersedes the information in the May 2000 Special Bulletin. A diagnosis code in the V25.xx series is REQUIRED when billing this service.

**15. If a patient is seen in a family planning clinic and is found to be pregnant, how should that visit be coded?**

The services provided to the recipient during the visit determines which procedure code is billed.

If only general information is provided during the visit and the patient is scheduled to be seen in the future at the maternity clinic, the correct E/M procedure code to bill is 99211.

If the patient is seen by a physician, nurse practitioner or physician assistant during the visit, bill the procedure code for the appropriate level of E/M visit.

**16. When a patient on Depo is seen after a 3-month lapse to be restarted on Depo, should the diagnosis code be V25.09 (prescription/initiation of other method) or V25.49 (surveillance of previously prescribed contraceptive method)?**

The correct diagnosis is based on the provider's determination of the extent to which the person needs re-education on the prescribed contraceptive method.

**17. If a patient is seen for an initial or annual family planning visit and returns two weeks later for IUD insertion, can the health department bill a preventive medicine code for first visit and an IUD insertion on the second visit?**

Yes.

**18. Can agencies continue to bill Maternity Care Coordinator and Child Service Coordinator services?**

Yes. These services can continue to be billed using state-created Y codes. They are billed using the last day of the month as the service date.

**19. If a family planning patient comes in for a problem-focused visit, and based on the health history the provider decides to do a GC culture, can the GC culture be billed to Medicaid?**

Yes. When the provider determines additional laboratory diagnostic tests are medically necessary, they may be billed to Medicaid.

**20. Can local health departments bill Medicaid recipients for services not covered in the Sexually Transmitted Disease (STD) package code, Y2013?**

As stated in administrative rule 15NCAC 19A.0204, local health departments shall provide control measures for STD services upon request and at no charge to the patient. These measures include preventive services, diagnosis, testing, treatment, and follow-up services for:

- syphilis
- gonorrhea
- chlamydia
- nongonococcal urethritis
- mucopurulent cervicitis
- chancroid
- lymphogranuloma venereum
- granuloma inguinale

When a health departments renders services that are not included in Y2013, it is appropriate to bill the Medicaid recipient for those services. As stated in 10NCAC 26K.0106, providers may only bill a Medicaid recipient:

- for the allowable deductible, coinsurance, or co-payments as specified in 10NCAC 26C.0003; or
- if the provider has informed the recipient that they may be billed for a service (as specified in 10NCAC 26B, 26C, and 26D) that is not covered by Medicaid; or
- the recipient has failed to supply a Medicaid number as proof of coverage; or
- the recipient is no longer eligible for Medicaid as defined in 10 NCAC 50B.

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

### Attention: All Prescribers

## Conversion from UPIN Numbers to DEA Numbers on Pharmacy Prescriptions and Claims

The Division of Medical Assistance (DMA) is now requiring DEA numbers on all recipient pharmacy claims instead of UPIN numbers. Providers must have their DEA registration number on file. Failure to do so may result in denied claims. If a prescriber does not have a DEA number and needs to issue prescriptions to recipients served by the Medicaid program, the prescriber should contact the DUR Section at 919-733-3590.

An identification number (ID) will be issued in lieu of the DEA number. The ID number, following the same format as the DEA number, will always begin with a Z (for example, ZF1234567). Prescribers will need to enter this number on their Medicaid prescriptions. This number is referred to as a MEDICAID IDENTIFICATION NUMBER only and should not be referred to as a DEA number.

If EDS Provider Enrollment does not have your updated information, please copy, complete, and return the following form for each prescriber in your practice. Please send the information to the following address:

EDS Provider Enrollment Unit  
P.O. Box 300009  
Raleigh, North Carolina 27622

FAX, 919-851-4014

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

-----  
**DEA NUMBER:**

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

Medicaid Provider Number \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

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

DEA Number \_\_\_\_\_

Or

Medicaid Identification Number \_\_\_\_\_

**Sharman Leinwand, DUR Coordinator, Program Integrity  
DMA, 919-733-3590 ext. 229**

## Attention: All Providers

# Renovation of the MMIS System – Identification Tracking Measurement Enhancement (ITME) Project

The Division of Medical Assistance (DMA) is upgrading and enhancing the Medicaid Management Information System (MMIS). The goals of the renovation, as noted in the April, 2000 Bulletin, are:

- more efficient claims processing
- improved flexibility to administer special programs and experiment with new methods for program oversight
- begin use of web-based technologies

The enhancements will include minimal changes to the Remittance and Status Advice (RA), submission of adjustment requests, prior approval, and voice response and eligibility verification systems.

Changes to the following parts are detailed in the Provider Impact section of this article.

### **Part I - Remittance and Status Advice**

### **Part II - Adjustment Requests – NEW FORM**

### **Part III - Prior Approval (PA)**

### **Part IV - Automated Voice Response (AVR) System and Eligibility Verification System (EVS)**

## **Implementation Schedule**

**Updated Implementation Date:** The implementation of system changes for the ITME project has been extended to February 9, 2001. The revised date of February 9, 2001 supercedes the original implementation date reflected in the September and October, 2000 ITME bulletin articles. Please note that all references to effective dates in the remainder of this article have been revised to reflect the extended date of February 9, 2001.

The RA will reflect the changes noted in Part I beginning February 9, 2001. Part II reflects the new N.C. Medicaid adjustment form. Use of this form is required as of February 9, 2001. Part III provides new instructions for submitting services that have been prior approved. Part IV addresses changes to the AVR System and EVS resulting from this enhancement.

## **Provider Impact**

### **Part I: Remittance and Status Advice (RA) - See Example 1**

RA modifications/format changes will be kept to only those that are necessary in conjunction with the ITME project. Overall, the RA will look very similar to the current format. Please note the format changes on the RA sample following this article (Example 1).

### Addition of Financial Payer Code

A financial payer code follows the claim internal control number (ICN) in the first line of the claim data reflected on the RA. This financial payer code denotes the entity responsible for payment of the claims listed on the RA. Upon implementation, N.C. Medicaid will be the only financially responsible payer; therefore, the N.C. Medicaid payer code of NCXIX (five characters) will be reflected.

Addition of Population Group Payer Code

The RA reflects the population payer code for each claim detail. The population payer code is printed at the beginning of each claim detail line on the RA. The population payer code denotes the special program/population group from which a recipient is receiving Medicaid benefits. Examples of population payer codes are as follows:

<b>Code</b>	<b>Name</b>	<b>Description</b>
CA-I	Carolina ACCESS	All recipients enrolled in Medicaid's Carolina ACCESS program
CA-II	ACCESS II	All recipients enrolled in Medicaid's ACCESS II program
CAB	ACCESS III – Cabarrus County	All recipients enrolled in Medicaid's ACCESS III program for Cabarrus County
PITT	ACCESS III – Pitt County	All recipients enrolled in Medicaid's ACCESS III program for Pitt County
HMOM	Health Management Organization (HMO)	All recipients enrolled in Medicaid's HMO program
NCXIX	Medicaid	All recipients not enrolled in any of the above noted population payer programs. Any recipient not identified with Carolina ACCESS, ACCESS II, ACCESS III, or HMO will be assigned the NCXIX population payer code to identify them with the Medicaid fee-for-service program.

Other population payers may be designated by DMA in the future.

Addition of new totals following the current claim total line

An additional line is added following each claim total line of the paid and denied claim sections of the RA for the following claim types: Medical (J), Dental (K), Home Health, Hospice and Personal Care (Q), Medical Vendor (P), Outpatient (M), and Professional Crossover (O). This additional line reflects original claim billed amount, original claim detail count, and total number of financial payers. Upon implementation in February, 2001, N.C. Medicaid will be the only financial payer; these new totals will reflect the submitted claim totals.

These additional totals do not appear for claim types Drug (D), Inpatient (S), Nursing Home (T), and Medicare Crossover (W) since they are not processed at the claim detail level and will not have multiple financial payers assigned, based on current N.C. Medicaid billing policy.

Addition of a new summary page at end of RA

For each Medicaid population payer identified on the paper RA, a new summary page showing total payments by population payer is provided at the end of the RA. This provides population payer detail information for tracking and informational purposes.

New specifications for Tape RA

Updated specifications have been mailed to all Tape RA Providers. If you are currently receiving a Tape RA and have not received the updated specifications, or have questions regarding the changes, please contact Glenda Raynor, Manager of EDS Electronic Commerce Services, at 919-851-8888 extension 5-3099.

**Part II: Adjustment Requests – NEW FORM (Example 2)**

The N.C. Medicaid program will begin using a new RA format in February, 2001. This new format affects the way adjustment request forms are completed by the provider and processed by EDS. The appropriate “financial payer” information found on the new RA will be required on all adjustment request forms after February 9, 2001. DMA and EDS have implemented a new adjustment request form to help with these changes. One of the predominant changes is in the “claim number” field. This area is now identified with twenty boxes, each box for one number of the referenced claim number. Until February 9, 2001, there will be five empty boxes at the end of the claim number. After the February 9, 2001 implementation of the MMIS enhancements, these spaces will be used for the financial payer code information. Providers may begin using this new adjustment request form now if it facilitates implementing these changes. (Refer to example of claim field below.) Please contact EDS Provider Services with questions about the new format and processing of an adjustment request.

Claim # field on Adjustment form from RA prior to February 9, 2001:

Claim #: 

#	#	#	#	#	#	#	#	#	#	#	#	#	#	#					
---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	--	--	--	--	--

Claim # field on Adjustment form from RA after February 9, 2001:

Claim #: 

#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	N	C	X	I	X
---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---

**Part III: Prior Approval (PA)**

Effective February 9, 2001, entering the prior approval number on the claim form by the provider to receive payment for services rendered will no longer be required. This holds true for all prior approved Medicaid services, regardless of the entity giving the prior approval.

Prior approval requirements and the criteria for approval of services have not changed. Those services that previously required prior approval before the implementation of the enhanced MMIS will continue to require prior approval. If a service was approved prior to February 9, 2001 but was not provided or billed until after February 9, 2001, the original prior approval is still valid. The MMIS will verify that prior approval was obtained before claims payment can occur. If the services being submitted on the claim form require prior approval, and approval has not been obtained, that claim will be denied. The only change is that the input of the prior approval number is no longer required on the claim form by the provider as of February 9, 2001.

**Part IV: Automated Voice Response (AVR) System and Eligibility Verification System (EVS)**

These systems will be enhanced with new messages that will explain under which special Medicaid program or programs a recipient is enrolled as a participant. Additional information regarding these system enhancements will be provided in subsequent bulletin articles.

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

EXAMPLE 1

**NORTH CAROLINA MEDICAID  
REMITTANCE AND STATUS REPORT**

XYZ CORPORATION  
ACCOUNTS RECEIVABLE DEPT  
P O BOX 1111  
ANYWHERE NC 22222

PROVIDER NUMBER		8900000		REPORT SEQ. NUMBER		21		DATE		10/27/1999		PAGE		1		280767		
NAME	SERVICE DATES		DAYS	PROCEDURE/ACCOMMODATION/DRUG		TOTAL	NON	TOTAL	PAYABLE	PAYABLE	OTHER	PAYED	EXPLANA-					
RECIPIENT ID	FROM	TO	OR	CODE AND DESCRIPTION		BILLED	ALLOWED	ALLOWED	CUTBACK	CHARGE	DEDUCTED	AMOUNT	TION					
POPULATION GROUP	MM	DD	CCYY	MM	DD	CCYY	UNITS				CHARGES		CODES					
<b>PAID CLAIMS</b>																		
<b>MEDICAL</b>																		
JONES MARY	D CO=81 RCC=			CLAIM NUMBER=101999165181580NCXIX														
988888888A	06011999 06011999		1 3	99244 OUTPT. CONSULT, SEVERE- PHY		23000	11029	11971	00	11971	00	11971	534					
NCXIX	06011999 06011999		1 3	93526 COMB RT HEART CATHETERIZATI		130000	00	130000	00	130000	00	130000	99					
NCXIX	06011999 06011999		1 3	93543 INJECTION FOR HEART X-RAY		25100	22328	2772	00	2772	00	2772	98					
NCXIX	06011999 06011999		1 3	93545 INJECTION FOR HEART X-RAY		42500	39585	2915	00	2915	00	2915	98					
NCXIX	06011999 06011999		1 5	93555 IMAGING SUPERVISION, INTERP		26000	22581	3419	00	3419	00	3419	98					
NCXIX	06011999 06011999		1 5	93556 IMAGING SUPERVISION, INTERP		36500	32438	4062	00	4062	00	4062	98					
DEDUCTIBLE=		.00	PAT LIAB=		.00	CO PAY=		.00	TPL=		.00	283100	127961	155139	00	155139	00	155139
ORIGINAL BILLED AMOUNT=			2831.00			ORIGINAL DETAIL COUNT=		6	TOTAL FINANCIAL PAYERS=		1							
MOORE JOE	D CO=77 RCC=			CLAIM NUMBER=101999170192650NCXIX														
999777777A	05311999 05311999		4 3	84520 UREA NITROGEN; QUANTITATIVE		2000	1061	939	00	939	00	939	2955					
NCXIX	05311999 05311999		1 3	82565 CREATININE; BLOOD		2300	2300	00	00	00	00	00	2954					
NCXIX	05311999 05311999		1 3	84132 POTASSIUM SERUM		2000	2000	00	00	00	00	00	2954					
NCXIX	05311999 05311999		1 3	85014 BLOOD COUNT; OTHER THAN SPU		1400	1073	327	00	327	00	327	98					
NCXIX	05311999 05311999		1 3	85018 HEMOGLOBIN		1800	1473	327	00	327	00	327	98					
NCXIX	06011999 06011999		1 3	93010 ELECTROCARDIOGRAM REPORT		3500	2491	1009	00	1009	00	1009	534					
DEDUCTIBLE=		.00	PAT LIAB=		.00	CO PAY=		.00	TPL=		.00	13000	10398	2602	00	2602	00	2602
ORIGINAL BILLED AMOUNT=			130.00			ORIGINAL DETAIL COUNT=		6	TOTAL FINANCIAL PAYERS=		1							
2 CLAIMS		15		MEDICAL		*****		296100	138359	157741	00	157741	157741					
****-->	TOTAL PAID CLAIMS		2 CLAIMS		296100	138359	157741	00	157741	00	157741	157741						

EXAMPLE 1

**NORTH CAROLINA MEDICAID  
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XYZ CORPORATION  
ACCOUNTS RECEIVABLE DEPT  
P O BOX 1111  
ANYWHERE NC 22222

PROVIDER NUMBER		8900000		REPORT SEQ. NUMBER		21		DATE		10/27/1999		280767		PAGE		2	
NAME	SERVICE DATES		DAYS	PROCEDURE/ACCOMMODATION/DRUG	TOTAL	NON	TOTAL	PAYABLE	PAYABLE	OTHER	PAYED	EXPLANA-					
RECIPIENT ID	FROM	TO	OR	CODE AND DESCRIPTION	BILLED	ALLOWED	ALLOWED	CUTBACK	CHARGE	DEDUCTED	AMOUNT	TION					
POPULATION GROUP	MM	DD	CCYY	MM	DD	CCYY	UNITS			CHARGES		CODES					
<b>ADJUSTED CLAIMS PROFESSIONAL ADJUSTMENT</b>																	
BARNES LARRY	D CO=43 RCC=			CLAIM NUMBER=901999183001888NCXIX **ADJ**DEBIT TO 101998100300888NCXIX													
977788888A				PAID 12231998 ATTN PROV=													
NCXIX	08131998	08141998	2 3	99232 HOSP VISIT, MODERATE. PHYS	18200	8096	10104	8083	2021	00	2021	8926					
	86 ADJUSTMENT OF CLAIM NCXIX 101998100300888			MED REC=00009033333													
	21 DUPLICATE OF CLAIM NCXIX 1019990466666666			PAID 03011999													
NCXIX	08171998	08171998	1 3	99231 HOSP VISIT, STABLE. PHYS T	5900	2474	3426	2741	685	00	685	8926					
	86 ADJUSTMENT OF CLAIM NCXIX 101998100300888																
NCXIX	18181998	08181998	1 3	99232 HOSP VISIT, MODERATE. PHYS	9100	4048	5052	4042	1010	00	1010	8926					
	86 ADJUSTMENT OF CLAIM NCXIX 101998100300888																
NCXIX	08191998	08191998	1 3	99238 HOSPITAL DISCHARGE DAY MANA	10200	4227	5973	4778	1195	00	1195	8926					
	86 ADJUSTMENT OF CLAIM NCXIX 101998100300888																
DEDUCTIBLE= .00 PAT LIAB= .00 CO PAY= .00 TPL= .00					43400	18845	24555	19644	4911	00	4911						
1	CLAIMS		5	PROFESSIONAL ADJUSTMENT	43400	18845	24555	19644	4911	00	4911						
****->	TOTAL ADJUSTED CLAIMS		1	CLAIMS	43400	18845	24555	19644	4911	00	4911						

EXAMPLE 1

**NORTH CAROLINA MEDICAID  
REMITTANCE AND STATUS REPORT**

XYZ CORPORATION  
ACCOUNTS RECEIVABLE DEPT  
P O BOX 1111  
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PROVIDER NUMBER 8900000		REPORT SEQ. NUMBER 21		DATE 10/27/1999		PAGE 3						
NAME	SERVICE DATES		DAYS OR	PROCEDURE/ACCOMMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMOUNT	EXPLANATION CODES
RECIPIENT ID	FROM	TO										
POPULATION GROUP	MM	DD	CCYY	MM	DD	CCYY	UNITS					
<b>DENIED CLAIMS MEDICAL</b>												
JONES JERRY	D CO=77			CLAIM NUMBER=901999197050025NCXIX								
97777777A				MED REC= 00006100000					ATTN PROV= 8910000			
NCXIX	11091998	11091998	1 3	86316 TUMOR ANTIGEN IMMUNOASSAY	8200	5324	2876	00	00	00	00	21
21 DUPLICATE OF CLAIM NCXIX 10199904777777 PAID 0531999												
DEDUCTIBLE= .00 PAT LIAB= .00 CO PAY= .00 TPL= .00 8200 5324 2876 00 0 00 0												
ORIGINAL BILLED AMOUNT= 82.00 ORIGINAL DETAIL COUNT= 1 TOTAL FINANCIAL PAYERS= 1												
PERRY JOHNNY	A CO=48			CLAIM NUMBER=901999172168421NCXIX								
944444444B				MED REC= 10455555					ATTN PROV= 7924000			
NCXIX	06081999	06081999	1 3	99213 OV ESTAB. PT, MODERATE. PHYS	6200	6200	00	00	00	00	00	270
NCXIX	06081999	06081999	1 3	82962 BLOOD GLUCOSE BY MONITORING D Q4	1300	1300	00	00	00	00	00	270
DEDUCTIBLE= .00 PAT LIAB= .00 CO PAY= .00 TPL= .00 7500 7500 00 00 00 00 00												
ORIGINAL BILLED AMOUNT= 75.00 ORIGINAL DETAIL COUNT= 2 TOTAL FINANCIAL PAYERS= 1												
2 CLAIMS 3 MEDICAL ***** 15700 12824 2876 00 00 00												
****--> TOTAL DENIED CLAIMS 2 CLAIMS 15700 12824 2876 00 00 00												



EXAMPLE 1

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PROVIDER NUMBER 8900000				REPORT SEQ. NUMBER 21			DATE 10/27/1999		PAGE 5			
NAME	SERVICE DATES		DAYS OR UNITS	PROCEDURE/ACCOMMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMOUNT	EXPLANA- TION CODES
RECIPIENT ID	FROM	TO										
POPULATION GROUP	MM	DD	CCYY	MM	DD	CCYY						
<b>FINANCIAL ITEMS: ADJUSTMENTS (PRINCIPAL, PENALTY, INTEREST), REFUND, PAYOUT ACTIVITY</b>												
RECIPIENT NAME/ RECIPIENT ID	FROM DOS/ TXN DATES	REFUND CCN/ ORIGINAL CCN/ICN	AR CCN	REFUND AMOUNT (A)	BAL FROM PRIOR CYCLE (B)	\$ APPLIED THIS CYCLE (C)	ENDING BALANCE (B-C=E) (E)	EOB				
<b>REFUNDS</b>												
INMAN WILLI 246705500A	04/22/1998 05/03/1999	1999153000002NCXIX 101999109666666NCXIX		4359	4359	517	3842	2242				
ROPER JOE 246705500A	03/28/1998 02/01/1999	1999177400050NCXIX 101999204772555NCXIX		2755	2755	2755	00	2242				
TOTAL:				7114	7114	3272	3842					
(TOTAL OF COLUMN C=TO CREDIT AMOUNT ON CLAIMS PAYMENT SUMMARY PAGE)												
TOTAL FINANCIAL ITEMS				5	*****	60816	60816	56974				

EXAMPLE 1

**NORTH CAROLINA MEDICAID  
REMITTANCE AND STATUS REPORT**

XYZ CORPORATION  
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PROVIDER NUMBER 8900000		REPORT SEQ NUMBER 21		DATE 10/27/1999		PAGE 6						
NAME	SERVICE DATES		DAYS OR	PROCEDURE/ACCOMMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMOUNT	EXPLANATION CODES
RECIPIENT ID	FROM	TO										
POPULATION GROUP	MMDDCCYY	MMDDCCYY	UNITS									
<b>CLAIMS PAYMENT SUMMARY</b> EFT NUMBER 123456												
	<b>CLAIMS PAID</b>	<b>PAID CLAIMS AMOUNT</b>	<b>WITHHELD AMOUNT(*)</b>	<b>NET PAY AMOUNT (A-B)</b>	<b>CREDIT AMOUNT</b>	<b>NET 1099 AMOUNT (C-D)</b>	<b>IRS WITHHELD AMOUNT</b>	<b>POS &amp; EDI</b>	<b>OTHER W/H</b>	<b>ADJUSTED (NET PAY (C-F-G-H))</b>		
CURRENT PROCESSED	5	1626.52	.00	1626.52	32.72	1593.80	.00	.00	.00	1626.52		
YEAR-TO-DATE TOTAL	12	5000.00	.00	5000.00	32.72	4967.28	.00	.00	.00	5000.00		
1099 INFORMATION 1099 - THIS INFORMATION IF BEING FURNISHED TO THE INTERNAL REVENUE SERVICE												
PROVIDER TAX ID : 62-2222222				PROVIDER TAX NAME : XYZ CORPORATION								
PAYER ID : ELECTRONIC DATA SYSTEMS CORPORATION, PO BOX 30968 RALEIGH, NC 27622 #75-2548211												
PLEASE VERIFY THE FOLLOWING IDENTIFICATION NUMBERS THAT HAVE BEEN ASSIGNED TO YOU. IF ANY OF THE NUMBERS ARE INCORRECT, PLEASE SEND CORRECTIONS TO:												
EDS PO BOX 300009 RALEIGH, NORTH CAROLINA 27622												
CLIA - NONE ASSIGNED UPIN - NONE ASSIGNED												
THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION CODES UTILIZED THROUGHOUT THE REPORT												
98 FEE ADJUSTED TO MAXIMUM PAYABLE												
99 PAID AS BILLED												
101 PENDING NORMAL IN-HOUSE PROCESSING												
102 PENDING IN-HOUSE REVIEW												
112 CHECK AMOUNT REDUCED BY RECOUPMENT AMOUNT												
270 BILLING PROVIDER IS NOT THE RECIPIENT'S CAROLINA ACCESS PCP. CONTACT THE PCP FOR AUTHORIZATION; PUT AUTHORIZATION NUMBER IN BLOCK 19 ON THE HCFA-1500 OR FORM LOCATOR 11 OF THE UB-92												
534 COPAY PREVIOUSLY DEDUCTED FOR THIS DATE OF SERVICE												
2242 REFUND APPLIED TO OUTSTANDING PRINCIPAL, PENALTY, AND INTEREST BALANCES (REFER TO WRITE-OFF EOB). 1099 CREDITED FOR RETURN OF MEDICAID PAYMENTS												
2954 REIMBURSEMENT WAS MADE ON PREVIOUSLY PAID DETAIL. PAYMENT IS DETERMINED BY # OF AUTOMATED TESTS BILLED. PAYMENT OF # OF UNITS ARE REFLECTED ON 1ST DETAIL. SEE 5/98 BULLETIN.												
2955 PAYMENT REDUCED TO EQUAL THE NUMBER OF AUTOMATED LAB TESTS BILLED FOR THIS RECIPIENT. ADDITIONAL PAYMENT WAS MADE ON A PREVIOUSLY PAID DETAIL. SEE 5/98 BULLETIN												
8926 ALLOWABLE REDUCED FOR OTHER INSURANCE PAYMENT												

EXAMPLE 1

**NORTH CAROLINA MEDICAID  
REMITTANCE AND STATUS REPORT**

XYZ CORPORATION  
ACCOUNTS RECEIVABLE DEPT  
P O BOX 1111  
ANYWHERE NC 22222

280767

PROVIDER NUMBER 8900000		REPORT SEQ. NUMBER 21		DATE 10/27/1999		PAGE 7						
NAME	SERVICE DATES		DAYS	PROCEDURE/ACCOMMODATION/DRUG	TOTAL	NON	TOTAL	PAYABLE	PAYABLE	OTHER	PAID	EXPLANA-
RECIPIENT ID	FROM	TO	OR	CODE AND DESCRIPTION	BILLED	ALLOWED	ALLOWED	CUTBACK	CHARGE	DEDUCTED	AMOUNT	TION
POPULATION GROUP	MM	DD	CCYY	MM	DD	CCYY	UNITS			CHARGES		CODES

\*\*\*\*\*  
 \* SPECIAL NOTE: IF YOUR REMITTANCE ADVICE IS TEN PAGES OR MORE AND YOU ARE DUE A PAPER CHECK FOR CLAIMS REIMBURSEMENT, YOUR \*  
 \* CHECK WILL BE MAILED IN A SEPARATE ENVELOPE. \*  
 \*\*\*\*\*

EXAMPLE 1

**NORTH CAROLINA MEDICAID  
REMITTANCE AND STATUS REPORT**

XYZ CORPORATION  
ACCOUNTS RECEIVABLE DEPT  
P O BOX 1111  
ANYWHERE NC 22222

280767  
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PROVIDER NUMBER		8900000		REPORT SEQ. NUMBER		21		DATE		10/27/1999		PAGE		8	
NAME	SERVICE DATES		DAYS	PROCEDURE/ACCOMMODATION/DRUG CODE AND DESCRIPTION	TOTAL	NON	TOTAL	PAYABLE	PAYABLE	OTHER	PAYED	EXPLANA- TION CODES			
RECIPIENT ID	FROM	TO	OR		BILLED	ALLOWED	ALLOWED	CUTBACK	CHARGE	DEDUCTED	AMOUNT				
POPULATION GROUP	MM	DD	CCYY		MM	DD	CCYY	UNITS		CHARGES					
TOTALS BY POPULATION GROUPING:															
POPULATION	POPULATION	CURRENT		YTD											
GROUPING	GROUPING	PAID		PAID											
NUMBER	DESCRIPTION	AMOUNT		AMOUNT											
NCXIX	MEDICAID	1626.52		3000.00											
CA-I	CCN1	0		1100.00											
CA-II	CCN2	0		900.00											
TOTAL PAID		1626.52		5000.00											



## Attention: All Physicians

**C**overage of Apligraf, Q0185

Effective with date of service November 1, 2000, the N.C. Medicaid program covers Apligraf. HCPCS code Q0185, dermal and epidermal tissue of human origin, per square centimeter, must be used when billing this material. The code must be billed in conjunction with codes that describe application of the tissue and preparation of the site.

Use the following codes to bill the application of Apligraf and preparation of the site.

<b>Date of Service</b>	<b>Code</b>	<b>Description</b>
November 1, 2000 through December 31, 2000	<b><u>HCPCS Code</u></b> G0170	Application of tissue cultured skin graft, initial 25 sq cm
	G0171	Application of tissue cultured skin graft, each additional 25 sq cm
January 1, 2001 or after	<b><u>CPT Code</u></b> 15342	<i>Application of bilaminar skin substitute/neodermis; initial 25 sq cm</i>
	15343	<i>Application of bilaminar skin substitute/neodermis; each additional 25 sq cm</i>

Italicized material is excerpted from the American Medical Association *Current Procedural Terminology*. CPT codes, descriptions, and other data only are copyrighted 2000 American Medical Association. All rights reserved.

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

## Attention: Nursing Facility Providers

### Request for Retroactive Prior Approval

Effective January 1, 2001, nursing facilities may request consideration of retroactive prior approval for nursing facility (NF) level of care with the initial FL2 submission to EDS. If the retroactive request is within thirty (30) days from the telephone prior approval or FL2 criteria review, medical records may not be needed by EDS to make a level of care decision. If the retroactive request is for a time period exceeding thirty (30) days, medical record documentation will be required by EDS to support the retroactive request and level of care decision.

EDS will also consider retroactive prior approval requests in the following instances:

- The Medicaid applicant's eligibility was unknown when the nursing facility services were provided. When this situation occurs, a request for retroactive prior approval must be made in writing to EDS accompanied by documentation of Medicaid eligibility from the county DSS, including the Medicaid eligibility approval date(s), the Medicaid application date, and medical record documentation for the requested time period. EDS must have this information before retroactive prior approval and level of care can be authorized.

**Note: Retroactive prior approval will not be granted for time periods exceeding ninety (90) days from the date Medicaid eligibility was determined.**

- The Medicaid recipient's prior approval for service had not been obtained, but nursing facilities services were provided. In these situations, EDS will consider requests for retroactive prior approval and level of care. These requests must be made in writing to EDS with medical record documentation for the requested time period and a current signed and dated FL2.

**Note: Retroactive prior approval request in this category will not be granted for time periods exceeding ninety (90) days from the current request date.**

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

## Attention: Nursing Facility Providers

### Preadmission Screening and Annual Resident Review

Effective January 1, 2001, all nursing facility residents must have a First Health (formerly First Mental Health) PASARR number. Residents who were “grandfathered” in with PASARR forms used prior to February 1994, must be screened and receive a PASARR number from First Health (FH) by the effective date.

Tracking forms must be sent to FH for **all new admissions** in order for the receiving facility to obtain a copy of the Level I and, if appropriate, the Level II results. **Level I and Level II documentation must be kept in the resident’s medical record.**

FH authorization numbers end with an “alpha” character. The following is an explanation of the alpha characters:

- A** Nursing facility placement appropriate, does not meet target population for mental illness (MI), mental retardation (MR), or related condition (RC).
- B** Nursing facility placement appropriate, no specialized services required. An annual resident review is required.
- C** Nursing facility placement appropriate, specialized services required. An annual resident review is required.
- D** Represents 7-day time-limited approvals.
- E** Represents 30-day time-limited approvals.
- F** Represents 60-day time-limited approvals.
- H** Halted Level II review. Does not meet MI or MR definitions
- J** Residents approved for admission only to state psychiatric hospitals.
- Z** Denial for placement in a nursing facility.

**NOTE:** The D, E, and F alphas indicate time-limited stays and the prior approval (PA) number issued by EDS for level of care is also time-limited. Payment will be denied when the PA number is end-dated. Residents who have PASARR numbers with these alpha characters must be closely monitored. If a resident needs to remain in the facility beyond the specified time limit, a Level II screening must be initiated through FH. Payment will be denied for each day past the time-limited stay. For time-limited stays E and F, a new FL2 **must** be submitted to EDS as soon as the facility receives the new PASARR number.

**Margaret O. Langston, RN, Institutional Services, Medical Policy Section  
DMA, 919-857-4020**

## Attention: All Providers

# Non-emergency Transportation by Nursing Facilities and Adult Care Homes

This article clarifies the responsibility that nursing facilities and adult care homes have when a Medicaid recipient requires medically necessary non-emergency transportation. This situation may arise, for example, when a Medicaid recipient needs to be transported to a physician's office or from an emergency department back to the facility.

According to the North Carolina Medicaid State Plan, since October 1, 1994, nursing facilities have been responsible for medically necessary non-emergency transportation for residents, unless ambulance transport is required. The cost of this service is reimbursed under the facility's direct rate, as written in the State Plan, Section 4.19 (d), Attachment 4.19-D .0102 (I):

“Effective October 1, 1994, nursing facilities are responsible for providing medically necessary transportation for residents, unless ambulance transportation is needed. The cost of this service shall be included with the facility's direct cost and therefore reimbursed under the facility's direct rate. Effective October 1, 1994, each facility's direct rate shall be increased for the estimated cost of this service. These costs shall be cost settled like all other direct care costs.”

This directive was most recently published for the nursing facility provider community in the N.C. Medicaid Nursing Facility provider manual issued June 1, 2000.

Adult care homes are responsible for assuring that residents are transported to necessary resources and activities, including transportation to the nearest appropriate health facilities, according to the licensure rules by which the home is licensed. These facilities are also reimbursed for this service under the adult care home transportation rate by the N.C. Medicaid program.

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

## Attention: Nursing Facility Providers

### **T**acking Forms: A Major Part of the Preadmission Screening and Annual Resident Review Process

To assure compliance with the federally mandated Preadmission Screening and Annual Resident Review Process (PASARR) requirements, all Medicaid-certified nursing facilities **must complete the PASARR Tracking form** for every admission, regardless of pay source, and forward it to First Health (FH), the Division of Medical Assistance's contractor for the PASARR process. The information documented on the **Tracking form** communicates to FH the name of the admitting facility and ensures that the facility will receive a copy of the Level I and, if appropriate, Level II screening results.

The requirements also mandate that when a screening has not been completed prior to admission or an annual review is not performed within the fourth quarter after the previous preadmission screen or annual resident review, Medicaid reimbursement must be denied. Once the Level I, and, if appropriate, the Level II screen is completed, Medicaid reimbursement will resume.

The Level I or Level II screening results **must** be kept in the resident's medical record to allow availability to the facility's care planning team and to federal and state auditors.

#### **Tracking forms must be completed for the following:**

1. All first time admissions in the Level I process:
  - Unless there is a significant change in status, no further contact with FH is required for Level I residents.
2. All first time admissions in the Level II process and if:
  - the Level II resident transfers to another Medicaid-certified nursing facility;
  - the Level II resident expires; or
  - the Level II resident is discharged from the nursing facility. (Discharge means that the resident no longer resides in a Medicaid-certified nursing facility.)

**Margaret O. Langston, RN, Institutional Services, Medical Policy Section  
DMA, 919-857-4020**

## Attention: Home Health Providers

# Home Health Seminar Schedule

Seminars for Home Health providers are scheduled for February 2001. Each provider is encouraged to send new or appropriate administrative, clinical, and clerical personnel. The primary topic will be the new guidelines for whether the service is medically necessary and appropriate in the home setting. The agenda will also include Program Integrity issues, commonly identified Home Health program errors, a review of procedures for filing home health claims, common billing errors, and follow-up procedures.

**Due to limited seating, preregistration is required. Unregistered providers 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 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. (The updated Community Care manual includes the January 1999 reprint, the October 1999 revision, and the October 2000 revision.)

Directions to the sites are available on page 45 of this bulletin.

**Thursday, February 1, 2001**

Four Points Sheraton  
5032 Market Street  
Wilmington, NC

**Tuesday, February 6, 2001**

Martin Community College  
Kehakee Park Road  
Williamston, NC  
Auditorium

**Tuesday, February 13, 2001**

Catawba Valley Technical College  
Highways 64-70  
Hickory, NC  
Auditorium

**Tuesday, February 20, 2001**

Holiday Inn Conference Center  
530 Jake Alexander Blvd., S.  
Salisbury, NC

**Tuesday, February 27, 2001**

WakeMed  
MEI Conference Center  
3000 New Bern Avenue  
Raleigh, NC

(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 (\_\_\_\_) \_\_\_\_\_ Fax Number (\_\_\_\_) \_\_\_\_\_ Date Mailed: \_\_\_\_\_  
 \_\_\_\_\_ persons will attend the seminar at \_\_\_\_\_ on \_\_\_\_\_  
 (location) (date)

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

## Directions to the Home Health Seminars

The registration form for the Home Health seminars is on page 44 of this bulletin.

### *WILMINGTON, NORTH CAROLINA*

#### **FOUR POINTS SHERATON**

Take I-40 East into Wilmington to Highway 17 – just off I-40. Turn left onto Market Street. The Four Points Sheraton is located approximately ½ mile on the left.

### *WILLIAMSTON, NORTH CAROLINA*

#### **MARTIN COMMUNITY COLLEGE**

Take Highway 64 into Williamston. Martin Community College is located approximately 1 to 2 miles west of Williamston. The Auditorium is located in Building 2.

### *HICKORY, NORTH CAROLINA*

#### **CATAWBA VALLEY TECHNICAL COLLEGE**

Take I-40 to exit 125. Travel approximately ½ mile to Highway 70. Travel east on Highway 70. The college is approximately 1½ miles on the right. Ample parking is available in the rear lower parking areas. The entrance to the Auditorium is between Student Services and the Maintenance Center. Follow sidewalk (toward satellite dish) and turn right to Auditorium Entrance.

### *SALISBURY, NORTH CAROLINA*

#### **HOLIDAY INN CONFERENCE CENTER**

##### 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.

### *RALEIGH, NORTH CAROLINA*

#### **WAKEMED MEI CONFERENCE CENTER**

##### Driving and Parking Directions

Take the I-440 Raleigh Beltline to New Bern Avenue, exit 13A (New Bern Avenue, Downtown). Travel toward WakeMed. Turn left onto Sunnybrook Road.

Parking is available at the former CCB Bank parking lot, a short walk to the conference facility. The entrance to the Conference Center is at the top of the stairs to WakeMed's Medical Education Institute.

Parking is also available on the **top two levels** of Parking Deck P3. To reach this deck, exit the I-440 Beltline at exit 13A. Proceed to the Emergency entrance of the hospital (on the left). Follow the access road up the hill to the gate for Parking Deck P3. After parking in P3, walk down the hill past the Medical Office Building and past the side of the Medical Education Institute. Turn right at the front entrance of the building and follow the sidewalk to the Conference Center entrance.

**Illegally parked vehicles will be towed.** Parking is **not** permitted at East Square Medical Plaza, Wake County Human Services, the P4 parking lot or in front of the Conference Center.

# Attention: Licensed Psychologists, Licensed Clinical Social Workers, Certified Child and Adolescent Psychiatric Nurse Practitioners, Certified Child and Adolescent Psychiatric Clinical Nurse Specialists Independent Mental Health Provider Seminars

Effective February 1, 2001, the Division of Medical Assistance will begin enrollment of Independent Mental Health providers in the N.C. Medicaid Program. This direct enrollment will be for independent providers in a solo or group practice for the provision of mental health services to Medicaid-eligible children ages birth through twenty.

Seminars for Independent Mental Health Providers are scheduled for February 2001. These seminars will focus on Medicaid guidelines for direct enrollment of Licensed Psychologists, Licensed Clinical Social Workers, Certified Child and Adolescent Psychiatric Nurse Practitioners, and Certified Child and Adolescent Psychiatric Clinical Nurse Specialists. Other topics will include covered services, reimbursement rates, and billing instructions.

**Due to seating limitations, registration for group practices is limited to one registrant per practice. Unregistered providers are welcome to attend when reserved space is adequate to accommodate.** 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.

Please select the most convenient site and return the completed registration form to EDS no later than January 22, 2001. Please be sure to complete all the blocks of the registration form to expedite registration. Should your chosen site no longer have available seating, you will be notified and offered registration at an alternate location.

Directions to the sites are available on page 47 of this bulletin.

**Thursday, February 8, 2001**  
A-B Technical College  
340 Victoria Road  
Asheville, NC

**Monday, February 12, 2001**  
Brody Science Building  
Brody Auditorium (Blue  
Section)  
Greenville, NC

**Thursday, February 15, 2001**  
Holiday Inn  
530 Jake Alexander Blvd., S.  
Salisbury, NC

**Monday, February 19, 2001**  
Coastline Convention Center  
501 Nutt Street  
Wilmington, NC

**Thursday, February 22, 2001**  
McKimmon Center  
Raleigh, NC

(cut and return registration form only)

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## Independent Mental Health Provider Seminar Registration Form (No Fee)

Provider Name \_\_\_\_\_ Provider Number \_\_\_\_\_ N/A  
Address \_\_\_\_\_ Contact Person \_\_\_\_\_  
City, Zip Code \_\_\_\_\_ County \_\_\_\_\_  
Telephone Number (\_\_\_\_) \_\_\_\_\_ Fax Number (\_\_\_\_) \_\_\_\_\_ Date Mailed: \_\_\_\_\_  
\_\_\_\_\_ persons will attend the seminar at \_\_\_\_\_ on \_\_\_\_\_  
(location) (date)

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

## Directions to the Independent Mental Health Provider Seminars

The registration form for the Independent Mental Health Provider Seminars is on page 46 of this bulletin.

### ***ASHEVILLE, NORTH CAROLINA***

#### **A-B TECHNICAL COLLEGE**

##### Directions to the College

Take I-40 to exit 50. Travel north on Hendersonville Road, which turns into Biltmore Avenue. Continue on Biltmore Avenue toward Memorial Mission Hospital. Turn left onto Victoria Road.

##### Campus

Stay on Victoria Road. Turn right between the Holly Building and the Simpson Building. The Laurel Building/Auditorium is located on the right, behind the Holly Building.

### ***SALISBURY, NORTH CAROLINA***

#### **HOLIDAY INN CONFERENCE CENTER**

##### Traveling South on I-85

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

### ***GREENVILLE, NORTH CAROLINA***

#### **BRODY MEDICAL SCIENCE BUILDING**

From Highway 264 (becomes Stantonsburg Road into Greenville), turn onto Moye Boulevard. Turn left onto North Campus Loop. The Brody Building is the nine-story complex. At the front entrance, walk through the lobby and take the first left to the auditorium.

### ***WILMINGTON, NORTH CAROLINA***

#### **COASTLINE CONVENTION CENTER**

Take I-40 until it ends in downtown Wilmington. Turn right onto Market Street. Travel approximately 4 or 5 miles to Water Street. Turn right onto Water Street. The Coast Line Inn is located one block from the Hilton on Nutt Street behind the Railroad Museum.

### ***RALEIGH, NORTH CAROLINA***

#### **MCKIMMON CENTER**

##### 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 between Avent Ferry Road 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 between Avent Ferry Road and Western Boulevard.

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## Checkwrite Schedule

January 9, 2001	February 6, 2001	March 6, 2001
January 17, 2001	February 13, 2001	March 13, 2001
January 25, 2001	February 22, 2001	March 20, 2001
		March 29, 2001

## Electronic Cut-Off Schedule

January 5, 2001	February 2, 2001	March 2, 2001
January 12, 2001	February 9, 2001	March 9, 2001
January 19, 2001	February 16, 2001	March 16, 2001
		March 23, 2001

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

\_\_\_\_\_  
John W. Tsikerdanos  
Executive Director  
EDS



P.O. Box 300001  
Raleigh, North Carolina 27622

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