Number 1 *January 2002*

North Carolina Medicaid Bulletin

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

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

In This Issue…… ***Page #***

In This Issue…… ***Page #***

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

Attention: All Providers

Holiday Observance

The Division of Medical Assistance (DMA) and EDS will be closed on Tuesday, January 1, 2002 in observance of New Year's Day, and on Monday, January 21, 2002 in observance of Dr. Martin Luther King, Jr.'s Birthday.

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

Attention: All Providers

Current Procedural Terminology Update for 2002

The annual review of the 2002 Current Procedural Terminology (CPT) codes has not been completed. The codes that are covered for 2001 must be utilized until the Division of Medical Assistance provides further directions for filing the 2002 codes. Providers will be notified concerning coverage of new codes in future general Medicaid bulletins.

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

Attention: Adult Care Home Providers

Reimbursement Rate Increase for Adult Care Home Providers

Effective with date of service October 1, 2001, the per diem rates paid by the N.C. Medicaid program for Adult Care Home personal care services are:

Description	Revenue Code	HCPCS Code	Maximum Reimbursement Rate
Basic ACH/PC (Facility Beds 1 to 30)	599	W8251	$ 13.03
Basic ACH/PC (Facility Beds 31 and above)	599	W8258	14.43
Therapeutic Leave (TL) (Facility Beds 1 to 30)	183	W8251	13.03
Therapeutic Leave (TL) (Facility Beds 31 and above)	183	W8258	14.43
Enhanced ACH/PC (Eating)	599	W8256	10.33
Enhanced ACH/PC (Toileting)	599	W8257	3.69
Enhanced ACH/PC (Eating and Toileting)	599	W8259	14.02
Enhanced ACH/PC (Ambulation/Locomotion)	599	W8255	2.64

The transportation rate (RC 229) has increased to $.60 per Medicaid resident per day. Providers must bill their usual and customary charges. Adjustments will not be made to previously processed claims.

Jackie Burnette, Financial Operations
DMA, 919-857-4015

Attention: Hospital Providers

Reimbursement Rates for Lower Level of Care, Ventilator Dependent Care, and Swing Bed

Effective with date of service October 1, 2001, the hospital lower level of care, ventilator dependent care, and swing bed rates per patient day are:

Level of Care	Maximum Reimbursement Rate
Intermediate Care	$ 96.22
Skilled Nursing Care	126.36
Ventilator Dependent Care	359.70

Adjustments will not be made to previously processed claims.

Carolyn Brown, Financial Operations
DMA, 919-857-4015

Attention: All Providers

Referrals and Service Coordination for the Community Alternatives Program for Disabled Adults

The Community Alternatives Program for Disabled Adults (CAP/DA) provides a variety of home and community services as an alternative to nursing facility care. The program serves disabled adults and the elderly. Each county has designated a lead administrative agency to oversee the day-to-day operation of the program at the local level. In most counties, the lead agency is the entry point for the program and provides the case management for program participants. There are a few counties in which the lead agency has arranged for another agency to handle these functions. Each year the Division of Medical Assistance publishes a list of the local primary contacts for CAP/DA in the general Medicaid bulletin. This year's list (see page 4) shows the name, location, and phone number of the primary CAP/DA case management agency for each county. If the case management agency is not the lead agency, the name of the lead agency is shown in parentheses.

Providers of Medicaid home care services should refer to the list to coordinate with the client's CAP/DA case manager any services that they provide to a CAP/DA client. CAP/DA case managers need to be aware when home health services, personal care services, durable medical equipment, home infusion therapy, private duty nursing or hospice are being considered or provided to a CAP/DA client. A "CI" or "CS" in the CAP block of the Medicaid identification card identifies CAP/DA clients.

CAP/DA Lead Agency List

County	Lead Agency	City	Phone #
Alamance	Alamance County DSS	Burlington	(336) 229-3187
Alexander	Alexander County DSS	Taylorsville	(828) 632-1080
Alleghany	Alleghany Memorial Hospital	Sparta	(336) 372-4464
Anson	Anson Community Hospital	Wadesboro	(704) 695-3409
Ashe	Ashe Services for Aging, Inc.	West Jefferson	(336) 246-2461
Avery	Sloop CAP	Newland	(828) 733-1062
Beaufort	Beaufort County DSS	Washington	(252) 975-5500
Bertie	University Home Care – Cashie (Lead Agency - East Carolina Health-Bertie)	Windsor	(252) 794-2622
Bladen	Bladen County Health Dept.	Elizabethtown	(910) 862-6221
Brunswick	Brunswick County DSS	Bolivia	(910) 253-2077
Buncombe	Buncombe County DSS	Asheville	(828) 250-5814
Burke	Burke County DSS	Morganton	(828) 439-2000
Cabarrus	Cabarrus County DSS	Kannapolis	(704) 920-1400
Caldwell	Caldwell County DSS	Lenoir	(828) 757-1180
Camden	Albemarle Regional Health Services	Elizabeth City	(252) 338-4066
Carteret	Carteret County DSS	Beaufort	(252) 728-3181
Caswell	Caswell County Health Dept.	Yanceyville	(336) 694-9592
Catawba	Catawba County DSS	Hickory	(828) 695-5600
Chatham	Chatham County Health Dept.	Pittsboro	(919) 542-8220
Cherokee	District Memorial Hospital	Andrews	(828) 321-4113
Chowan	Chowan Hospital Home Care	Edenton	(252) 482-6322
Clay	Clay County Health Dept.	Hayesville	(828) 389-1444
Cleveland	Cleveland Regional Medical Center Care Solutions	Shelby	(704) 487-0968
Columbus	Columbus County Dept. of Aging	Whiteville	(910) 640-6602
Craven	Craven Regional Medical Center	New Bern	(252) 633-8240
Cumberland	Cape Fear Valley Health System, Inc.	Fayetteville	(910) 829-1720
Currituck	Albemarle Regional Health Services	Elizabeth City	(252) 338-4066
Dare	Dare County DSS	Manteo	(252) 473-1471
Davidson	Davidson County Senior Services	Thomasville	(336) 474-2754
Davie	Davie County Hospital	Mocksville	(336) 751-8340
Duplin	Duplin Home Care and Hospice (Lead Agency - Duplin General Hospital)	Kenansville	(910) 296-0819
Durham	Durham County DSS	Durham	(919) 560-8659
Edgecombe	Edgecombe Home Care and Hospice	Tarboro	(252) 641-7518

CAP/DA Lead Agency List, continued

County	Lead Agency	City	Phone #
Forsyth	Senior Services, Inc. (Lead Agency - Forsyth County Health Dept.)	Winston Salem	(336) 725-0907
Franklin	Franklin County DSS	Louisburg	(919) 496-5721
Gaston	Gaston County DSS	Gastonia	(704) 862-7540
Gates	Chowan Hospital Home Care (Lead Agency - Gates County DSS)	Gatesville	(252) 357-1117
Graham	Graham County Health Dept.	Robbinsville	(828) 479-4201
Granville	Granville Medical Center	Oxford	(919) 690-3242
Greene	Greene County DSS	Snow Hill	(252) 747-5932
Guilford	Guilford County Health Dept.	Greensboro	(336) 641-3331
Halifax	Halifax County DSS	Halifax	(252) 536-6537
Harnett	Harnett County Dept. on Aging	Lillington	(910) 893-7596
Haywood	Haywood County Council on Aging	Waynesville	(828) 452-2370
Henderson	Margaret R. Pardee Hospital	Hendersonville	(828) 696-1000
Hertford	Hertford County DSS	Winton	(252) 358-7830
Hoke	Duke / St Joseph Home Health (Lead Agency – Hoke County DSS)	Raeford	(910) 875-8198
Hyde	Hyde County DSS	Swan Quarter	(252) 926-3371
Iredell	Iredell County DSS	Statesville	(704) 878-5086
Jackson	Harris Regional Hospital	Sylva	(828) 586-7410
Johnston	Johnston County DSS	Smithfield	(919) 989-5300
Jones	Jones County DSS	Trenton	(252) 448-2581
Lee	Lee County DSS	Sanford	(919) 718-4690
Lenoir	Lenoir Memorial Hospital	Kinston	(252) 522-7947
Lincoln	Lincoln County DSS	Lincolnton	(704) 732-1969
Macon	Macon County DSS	Franklin	(828) 349-2124
Madison	Madison County Dept. of Community Services	Marshall	(828) 649-2722
Martin	Martin County DSS	Williamston	(252) 809-6403
McDowell	McDowell County DSS	Marion	(828) 652-3355
Mecklenburg	Mecklenburg County Health Dept.	Charlotte	(704) 336-4700
Mitchell	Mitchell County DSS	Bakersville	(828) 688-2175
Montgomery	Montgomery County DSS	Troy	(910) 576-6531
Moore	FirstHealth Home Care (Lead Agency - Moore County DSS)	West End	(910) 295-2211
Nash	Nash County Health Dept.	Rocky Mount	(252) 446-1777
New Hanover	New Hanover Health Network	Wilmington	(910) 343-7711
Northampton	Northampton County DSS	Jackson	(252) 534-5811
Onslow	Onslow Council on Aging	Jacksonville	(910) 455-2747

CAP/DA Lead Agency List, continued

County	Lead Agency	City	Phone #
Orange	Orange County DSS	Hillsborough	(919) 245-2882
Pamlico	Pamlico County Senior Services	Alliance	(252) 745-7196
Pasquotank	Albemarle Regional Health Services	Elizabeth City	(252) 338-4066
Pender	Pender Adult Services	Burgaw	(910) 259-9119
Perquimans	Albemarle Regional Health Services	Elizabeth City	(252) 338-4066
Person	Person County DSS	Roxboro	(336) 599-8361
Pitt	Pitt County DSS	Greenville	(252) 413-1101
Polk	St. Luke's Hospital	Columbus	(828) 894-0564
Randolph	Randolph Hospital	Asheboro	(336) 625-5151
Richmond	FirstHealth Richmond	Rockingham	(910) 997-5800
Robeson	Southeastern Regional Medical Center	Lumberton	(910) 618-9405
Rockingham	Rockingham County Council on Aging, Inc.	Reidsville	(336) 349-2343
Rowan	CapCare Rowan Regional Medical Center	Salisbury	(704) 210-5626
Rutherford	Rutherford Hospital, Inc.	Forest City	(828) 245-3575
Sampson	Sampson County Dept. of Aging and In-Home Services	Clinton	(910) 592-4653
Scotland	Scotland Home Health (Lead Agency - Scotland County Health Dept.)	Laurinburg	(910) 277-2484
Stanly	Stanly County DSS	Albemarle	(704) 982-6100
Stokes	Stokes County DSS	Danbury	(336) 593-2861
Surry	Surry County Friends of Seniors	Mount Airy	(336) 401-8500
Swain	Swain County Health Dept.	Bryson City	(828) 488-3792
Transylvania	Transylvania Community Hospital	Brevard	(828) 883-5473
Tyrrell	Tyrrell County DSS	Columbia	(252) 796-3421
Union	Union County DSS	Monroe	(704) 296-4300
Vance	Vance County DSS	Henderson	(252) 492-5001
Wake	Resources for Seniors, Inc.	Raleigh	(919) 872-7933
Warren	Warren County DSS	Warrenton	(252) 257-5974
Washington	Washington County Center for Human Services	Plymouth	(252) 793-4041
Watauga	Watauga County Project on Aging	Boone	(828) 265-8090
Wayne	Wayne Memorial Hospital, Inc.	Goldsboro	(919) 731-6314
Wilkes	Home Care of Wilkes Regional Medical Center	North Wilkesboro	(336) 903-7700
Wilson	WilMed Home Care	Wilson	(252) 399-8228
Yadkin	Yadkin County DSS	Yadkinville	(336) 679-3385
Yancey	Yancey County Health Dept.	Burnsville	(828) 682-7967

Barbara Schwab, CAP/DA Administrative Officer
DMA, 919-857-4021

Attention: Prescribers

Synagis Policy Revision

Synagis is a covered benefit reimbursable through the pharmacy program for FY 2001/2002. It has been approved for the prevention of respiratory syncytial virus (RSV) infections in high-risk children determined eligible by age and risk factors at the beginning of the RSV season. The drug is approved for administration once monthly during RSV season, which has been identified in North Carolina as October 1, 2001 through March 31, 2002 and will be reimbursable only during that period.

The following guidelines and procedures should be used in determining appropriate candidates for Synagis. **Eligibility guidelines** are based on the 1998 American Academy of Pediatrics recommendations as published in *Pediatrics*.

1. Chronic Lung Disease and Less Than Two Years of Age – Synagis prophylaxis should be considered for infants and children younger than two years of age with chronic lung disease (CLD) who have required medical therapy for their CLD within six months before the anticipated RSV season.
2. History of Premature Birth – Infants born at 32 weeks gestation or earlier, without CLD, may benefit from RSV prophylaxis.
    a. Infants born at 28 weeks of gestation or earlier may benefit from RSV prophylaxis up to 12 months of age.
    b. Infants born at 29 to 32 weeks of gestation may benefit most from prophylaxis up to six months of age.
    c. Infants born from **32 to 35 weeks of gestation with additional risk factors** may be considered for prophylaxis up to six months of age. Risk factors include underlying conditions that predispose to respiratory complication (e.g., neurologic disease in very low birth weight infants), number of young siblings, child care center attendance, exposure to tobacco smoke in the home, anticipated cardiac surgery, and distance to and availability of hospital care for severe respiratory illness.
3. Synagis is not recommended for children with cyanotic congenital heart disease.

When prescribing Synagis, the physician is required to write in his or her own handwriting on the face of the prescription: the birth weight, gestational age, and date of birth of the child.

Sharman Leinwand, MPH, RPH, Pharmacy Program Manager
DMA, 919-857-4034

Attention: Ambulance Services Providers

Reimbursement Rate Increase for Ambulance Services

Effective with date of service July 1, 2001, the maximum reimbursement rates for ambulance services were increased.

Procedure Code	Description	Maximum Reimbursement Rate
A0320	Ambulance service, BLS, non-emergency transport	$ 63.72
A0322	Ambulance service, BLS, emergency transport	63.72
A0324	Ambulance service, ALS, non-emergency transport, base rate one way	63.72
A0326	Ambulance service, ALS, non-emergency, special services rendered	83.61
A0330	Ambulance service, ALS, emergency transport	112.51
A0380	BLS ground mileage, outside base area, one way	2.10
A0390	ALS ground mileage, outside base area, one way	2.10
A0090	Non-emergency mileage outside base area, one way	2.10
Y0001	Non-emergency transport round trip	70.47
Y0002	State-to-state placement, base rate one way, prior approval required	63.72
A0040	Helicopter, lift off	422.91
Y0050	Helicopter, nautical mile	11.26
Y0060	Fixed wing, lift off	422.91
Y0070	Fixed wing, per nautical mile	3.52
Y0003	Fixed wing, lift off, state-to-state placement, prior approval require	422.91
Y0004	Helicopter, lift off, state-to-state placement, prior approval required	422.91

Providers are reminded to bill their usual and customary charges. Adjustments will not be made to previously processed claims.

Janet Choplin, Financial Operations
DMA, 919-857-4015

Attention: Physicians, Nurse Practitioners, and Dialysis Treatment Facilities

Ferrlecit (Sodium Ferric Gluconate Complex, HCPCS Code J2915, 625 mg.) Coverage Criteria

Effective with date of service July 1, 2001, the N.C. Medicaid program covers Ferrlecit (sodium ferric gluconate complex in sucrose injection, 62.5 mg.) for the treatment of patients with iron deficiency anemia who are undergoing chronic hemodialysis. Dialysis treatment facilities will be reimbursed for Ferrlecit in addition to the dialysis composite rate. Administration supply costs are included in the dialysis composite rate. Providers must bill their usual and customary charges. The maximum reimbursement rate for Ferrlecit is $38.70 per unit.

Ferrlecit is covered for recipients under the following conditions:

- The recipient has a diagnosis of chronic renal failure (ICD-9-CM **585**), **or** anemia in end-stage renal disease (ICD-9-CM **285.21**), **and**
- The recipient has one of the following ICD-9-CM diagnoses: **280.0 – 280.1; 280.8 – 280.9; or 284.0 – 285.9; and**
- The recipient is receiving erythropoietin therapy, **and**
- The recipient is undergoing chronic hemodialysis.

Billing Requirements for Physicians:

- File the claim using the HCFA-1500 claim form.
- Enter ICD-9-CM diagnosis code **585 or 285.21**, **and** one of the following diagnosis codes in block 21: **280.0 – 280.1; 280.8 – 280.9; or 284.0 – 285.9.**
- Enter the date of service in block 24A.
- Enter the place of service in block 24B.
- Enter HCPCS code J2915 in block 24D.
- Enter the total charges in block 24F.
- Enter the units given in block 24G (62.5 mg/5 ml ampule = 1 unit).

Example:

21 Diagnosis	24A Date(s) of Service	24B Place of Service	24D Procedures, Services or Supplies	24F Charges	24G Days or Units
585 280.8	08142001	11	J2915	$	2

Note: Physicians cannot bill an Evaluation and Management code in addition to an injection administration code, CPT 90782. This drug should be added to the list of injectable drugs published in the November 2000 general Medicaid bulletin.

Billing Requirements for Dialysis Treatment Facilities:

- File the claim using the UB-92 claim form.
- Enter revenue code 250 in form locator 42.
- Enter the description of the drug in form locator 43.
- Enter HCPCS code J2915 in form locator 44.
- Enter the date of service in form locator 45.
- Enter the units given in form locator 46 (62.5 mg/5ml ampule = 1 unit).
- Enter the total charges in form locator 47.
- Enter diagnosis code **585** or **285.21** in form locator 67, **and**
- Enter a diagnosis code from the following list in form locators 68 through 75: **280.0 – 280.1; 280.8 – 280.9; 284.0 – 285.9**.

Example:

42 Rev Code	43 Description	44 HCPCS/Rate	45 Serv Date	46 Serv Units	47 Total Charges
250	Ferrlecit 62.5 mg.	J2915	08142001	2	$

67 Prin Diag Cd	68 Code	69 Code	70 Code	71 Code	72 Code	73 Code	74 Code	75 Code
585	280.1							

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

Attention: All Providers

Medicaid Identification Cards

In June 2001, to increase efficiency and improve security, Medicaid recipients were issued blue Medicaid identification (MID) cards printed on laser paper. Effective January 2002, the pink MID card, received by most Medicaid-eligible pregnant women, and the buff (or brown) MID card, received by Medicare-Aid recipients, will also be produced on laser paper.

The new MID cards will be printed on 8½" x 11" watermarked laser paper. The lighter weight paper is more pliable and will be perforated, allowing the recipient to detach the card. However, the card is still valid if it is not detached. The new cards also include a postal bar code, which is expected to improve delivery.

There is no change to the way recipients will use the MID cards. On occasion, Medicaid recipients may receive blue, pink or buff cards printed on the heavier stock paper. These cards are still valid.

Andy Wilson, Medicaid Eligibility Unit
DMA, 919-857-4019

Attention: Hospice Providers

Reimbursement Rate Increase for Hospice Services

Effective with date of service January 1, 2002, the maximum allowable rate for the following hospice services increased. The 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	$ 97.28	$ 23.65	$ 103.77	$ 432.94	$ 93.64	$ 124.44
Charlotte	41	101.38	24.64	107.29	449.91	93.64	124.44
Fayetteville	42	94.37	22.94	101.28	420.91	93.64	124.44
Greensboro/ Winston-Salem/ High Point	43	98.42	23.92	104.75	437.67	93.64	124.44
Hickory	44	98.98	24.06	105.23	439.99	93.64	124.44
Jacksonville	45	89.58	21.77	97.18	401.07	93.64	124.44
Raleigh/Durham	46	102.21	24.84	108.00	453.36	93.64	124.44
Wilmington	47	103.42	25.14	109.04	458.38	93.64	124.44
Rural	53	92.84	22.57	99.97	414.56	93.64	124.44
Goldsboro	105	93.17	22.65	100.25	415.92	93.64	124.44
Greenville	106	101.88	24.76	107.72	452.00	93.64	124.44
Norfolk Currituck County	107	93.96	22.84	100.94	419.23	93.64	124.44
Rocky Mount	108	96.16	23.37	102.82	428.33	93.64	124.44

Note: Providers must bill their usual and customary charges. Adjustments will not be made to previously processed claims.

Key to Hospice Rate Table:

SC = Specialty Code

RC = Revenue Code

1. A minimum of eight hours of continuous home care per day 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 respite and general inpatient days 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 must be billed instead of the inpatient care rate unless the recipient expires while 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 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 8-12, of the *N.C. Medicaid Community Care Manual* for details.

Debbie Barnes, Financial Operations
DMA, 919-857-4015

Attention: All Providers

Medicare Crossovers

The N.C. Medicaid program collaborates with several Medicare carriers to negotiate and execute Trading Partner Agreements, which establish a crossover relationship between Medicaid and a particular Medicare carriers. The agreement enables Medicare claims for recipients who also have Medicaid coverage secondary to Medicare to cross over to Medicaid for payment.

In order to process these crossover claims, providers must submit a Medicare Crossover Reference Request form (see page 13), which allows EDS to cross reference the provider's Medicare number with their Medicaid number and process the claim. Without this information, EDS cannot identify the provider's Medicaid number and cannot process Medicare crossover claims.

Providers must complete the Medicare Crossover Reference Request form if they file Medicare claims with any of the Medicare carriers listed on the form to ensure that the claim will cross over to Medicaid for payment.

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

MEDICARE CROSSOVER REFERENCE REQUEST

Provider Name: _____

Contact Person (required): _____ Telephone (required): _____

Select the appropriate *Medicare Carrier/Intermediary/DMERC* from the following listing, 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.

Medicare Part A Intermediaries

- ☐ Riverbend GBA Medicare Part A (Tennessee); http://www.riverbendgba.com
- ☐ Palmetto GBA Medicare Part A. Effective November 1, 2001, Palmetto GBA assumed the role of North Carolina Part A intermediary from Blue Cross/Blue Shield of NC. (North Carolina); http://www.palmettogba.com
- ☐ Trailblazer Medicare Part A (Colorado, New Mexico and Texas); http://www.the-medicare.com
- ☐ United Government Services Medicare Part A (Wisconsin); http://www.ugsmedicare.com
- ☐ Palmetto Medicare Part A (South Carolina) http://www.palmettogba.com*
- ☐ AdminaStar Medicare Part A (Illinois, Indiana, Ohio, and Kentucky); http://www.astar-federal.com*
- ☐ Carefirst of Maryland Medicare Part A (Maryland) http://www.marylandmedicare.com*
- ☐ Veritus Medicare Part A (Pennsylvania) http://www.veritusmedicare.com*
- ☐ First Coast Service Options Medicare Part A, subsidiary of BCBS of Florida (Florida) http://www.floridamedicare.com*

Medicare Part B Carrier

- ☐ CIGNA Medicare Part B (Tennessee, North Carolina, and Idaho) http://www.cignamedicare.com
- ☐ AdminaStar Medicare Part B (Indiana and Kentucky) http://www.astar-federal.com*
- ☐ Palmetto Medicare Part B (South Carolina) http://www.palmettogba.com*

Medicare Regional DMERC

- ☐ Palmetto Region C DMERC (Alabama, Arkansas, Colorado, Florida, Georgia, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas and the Virgin Islands); http://www.palmettogba.com

*Trading Partners currently in testing phase.

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: _____

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

Attention: All Providers

Breast and Cervical Cancer Control Program Guidelines

The federal Breast and Cervical Cancer Prevention and Treatment Act of 2000 (BCCPTA) gave States the option to provide full Medicaid benefits to women who:

- have been enrolled and screened under the North Carolina Breast and Cervical Cancer Control Program (NCBCCCP) and found to need treatment for breast and cervical cancer including pre-cancerous conditions and early stage cancer; and
- are uninsured (have no major medical coverage including Medicaid and Medicare); and
- are 18 through 64 years of age; and
- meet Medicaid citizenship requirements and other general eligibility requirements for Medicaid.

The N.C. General Assembly approved funding for this option in Senate Bill 1005. The NCBCCCP operates through local health departments, some community health centers, and other medical facilities that are contracted to participate as screening providers and coordinators for the program.

Effective January 1, 2002, NCBCCCP screening providers will complete a Medicaid eligibility application for women who have been screened through the NCBCCCP and found to need treatment for either breast or cervical cancer or pre-cancerous conditions.

Providers may refer women who meet the criteria listed above to their local health department to be screened under the NCBCCCP. The NCBCCCP screening program has specific age and income requirements. Contact the local health department for these requirements.

The period of Medicaid eligibility is based on the individual's course of treatment for cancer established by a statement from her physician. The certification period ends when the course of treatment ends. Women in this new coverage group will receive a blue Medicaid identification card, which entitles them to all Medicaid covered services during the breast or cervical cancer treatment period.

Denise Rogers, Medicaid Eligibility Unit
DMA, 919-857-4019

Attention: Mecklenburg County Providers

Managed Care Update

Effective February 1, 2002, Carolina ACCESS/ACCESS II will be a managed care enrollment option for Medicaid recipients in Mecklenburg County. This option will be offered in addition to the two health maintenance organizations, United Healthcare and Southcare, currently providing Medicaid services in Mecklenburg County.

Julia McCollum, Managed Care Section
Darryl Frazier, Managed Care Section
DMA, 919-857-4022

Attention: Hospital Providers

ICD-9-CM Diagnosis Codes – Additions and Changes

The following list of ICD-9-CM diagnosis codes are new or have been revised by federal mandate. These codes are listed in the August 1, 2001 *Federal Register*, pages 400063 through 400066, and are effective on date of service October 1, 2001.

New Diagnosis Codes

Code	Description
256.31	Premature menopause
256.39	Other ovarian failure
277.7	Dysmetabolic Syndrome X
464.00	Acute laryngitis, without mention of obstruction
464.01	Acute laryngitis, with obstruction
464.50	Unspecified supraglottitis, without mention of obstruction
464.51	Unspecified supraglottitis, with obstruction
521.00	Unspecified dental caries
521.01	Dental caries limited to enamel
521.02	Dental caries extending into dentine
521.03	Dental caries extending into pulp
521.04	Arrested dental caries
521.05	Odontoclasia
521.09	Other dental caries
525.10	Unspecified acquired absence of teeth
525.11	Loss of teeth due to trauma
525.12	Loss of teeth due to periodontal disease
525.13	Loss of teeth due to caries
525.19	Other loss of teeth
530.12	Acute esophagitis
564.00	Unspecified constipation
564.01	Slow transit constipation
564.02	Outlet dysfunction constipation
564.09	Other constipation
602.3	Dysplasia of prostate
608.82	Hematospermia

New Diagnosis Codes, continued

Code	Description
608.87	Retrograde ejaculation
692.76	Sunburn of second degree
692.77	Sunburn of third degree
718.70	Developmental dislocation of joint, site unspecified
718.71	Developmental dislocation of joint, shoulder region
718.72	Developmental dislocation of joint, upper arm
718.73	Developmental dislocation of joint, forearm
718.74	Developmental dislocation of joint, hand
718.75	Developmental dislocation of joint, pelvic region and thigh
718.76	Developmental dislocation of joint, lower leg
718.77	Developmental dislocation joint, ankle and foot
718.78	Developmental dislocation of joint, other specified sites
718.79	Developmental dislocation of joint, multiple sites
733.93	Stress fracture of tibia or fibula
733.94	Stress fracture of the metatarsals
733.95	Stress fracture of other bone
772.10	Intraventricular hemorrhage, unspecified grade
772.11	Intraventricular hemorrhage, Grade I
772.12	Intraventricular hemorrhage, Grade II
772.13	Intraventricular hemorrhage, Grade III
772.14	Intraventricular hemorrhage, Grade IV
779.7	Perventricular leukomalacia
793.80	Unspecified abnormal mammogram
793.81	Mammographic microcalcification
793.89	Other abnormal findings on radiological examination breast
840.7	Superior glenoid labrum lesions (SLAP)
997.71	Vascular complications of mesenteric artery
997.72	Vascular complications of renal artery
997.79	Vascular complications of other vessels
V10.53	Personal history of malignant neoplasm, renal pelvis
V45.84	Dental restoration status
V49.82	Dental sealant status
V83.01	Asymptomatic hemophilia A carrier
V83.02	Symptomatic hemophilia A carrier

Codes Requiring Further Subdivision

The following diagnosis codes have been further subdivided with new codes found in the above table. Therefore, effective with date of service October 1, 2001, these codes should not be used.

Code	Description
256.3	Other ovarian failure
464.0	Acute laryngitis
521.0	Dental caries
525.1	Loss of teeth due to accident, extraction, or local periodontal disease
564.0	Constipation
772.1	Intraventricular hemorrhage
793.8	Nonspecific abnormal findings on radiological and other examinations of body structure, breast

Revised Diagnosis Code Titles

Code	Current Description	Revised Description
411.81	Coronary occlusion without myocardial infarction	Acute coronary occlusion without myocardial infarction
493.00	Extrinsic asthma without mention of status asthmaticus	Extrinsic asthma without mention of status asthmaticus or acute exacerbation or unspecified
493.10	Intrinsic asthma without mention of status asthmaticus	Intrinsic asthma without mention of status asthmaticus or acute exacerbation or unspecified
493.20	Chronic obstructive asthma without mention of status asthmaticus	Chronic obstructive asthma without mention of status asthmaticus or acute exacerbation or unspecified
493.90	Asthma, unspecified without mention of status asthmaticus	Asthma, unspecified without mention of status asthmaticus or acute exacerbation or unspecified
V70.7	Examination for normal comparison or control in clinical research	Examination of participant in clinical trial

Ann H. Kimbrell, R.N., Institutional Services
DMA, 919-857-4022

Attention: Personal Care Services Providers and Home Health Agencies

Questions and Answers Regarding Personal Care Services (in Private Residences)

The following questions were asked during the August 2001 workshops for agencies providing Personal Care Services (PCS) in private residences. This article is part of a continuing effort to educate providers regarding Medicaid guidelines for providing services in the home.

1. **Is there a limit on the amount of time that the aide can spend on "incidental services" such as meal preparation and housekeeping?**

   No, but remember that PCS is based on the client's need for personal care, not home management, and the purpose of each visit must be to meet the client's personal care needs. Guidelines do not address the amount of time that can be spent on incidental services. The incidental services covered under PCS are housekeeping and home management tasks essential, though secondary, to the personal care needs of the patient. The time allotted on the PCS plan of care for all the personal care and home management tasks to be accomplished during a visit must be reasonable and necessary to complete the tasks. The plan of care must document the specific tasks and the total time needed to complete all of the tasks on a given day. Daily records must be kept to support the services provided. Appropriate revisions to the plan of care must be made to reflect any permanent change in amount of time or task.

2. **Is meal preparation considered an "incidental service" or a "personal care" service? It is listed under "Personal Care" in section 30 of the DMA 3000 but under "Home Management" on page 6-3 of the *N.C. Medicaid Community Care Manual*.**

   Preparation of "simple meals" is considered an "incidental" housekeeping and home management task, as indicated on page 6-3 of the *N.C. Medicaid Community Care Manual*. The meal preparation could qualify as a Level III Personal Care task if the physician orders a specific diet requiring careful menu planning or specialized preparation. Aides performing menu planning and preparation of more complex diets must meet the N.C. Board of Nursing's competency requirements and be registered as a Nurse Aide I or II in the N.C. Nurse Aide Registry with the Division of Facility Services (DFS).

3. **What does "medically stable" mean?**

   "Medically stable" means that the patient's medical condition is at maintenance level and without constant changes that would require monitoring and evaluation. Keep in mind that PCS is a paraprofessional service and does not include skilled medical care.

4. **Is bathing or assistance with bathing a requirement to get PCS services?**

   Medicaid guidelines do not indicate the need for a specific personal care task as a requirement for services. PCS guidelines indicate that the patient must need at least one of the In-Home Aide Level II or III Personal Care tasks listed on pages 6-2 and 6-3 of the *N.C. Medicaid Community Care Manual*, due to a medical condition, to be appropriate for the program. Keep in mind that PCS must be the most cost-effective and appropriate form of care and should not replace other care available.

5. Please review levels of care that require a certified versus a non-certified aide.

The qualifications of the aide needed are determined by the tasks identified and in accordance with rules set forth by the N.C. Board of Nursing. The tasks included under PCS correspond to personal care tasks in the "In-Home Aide Level II and Level III Personal Care" of the DHHS In-Home Aide Service Plan. Aides performing Level III Personal Care tasks must meet the N.C. Board of Nursing's competency requirements and be registered as a Nurse Aide I or II in the N.C. Nurse Aide Registry with DFS. Level II Personal Care tasks can be performed by an aide meeting in-home aide qualifications in the Home Care Licensure Rules. A full explanation of these requirements is covered on pages 6-2 and 6-3 of the *N.C. Medicaid Community Care Manual*.

6. **Please provide clarification and updated guidelines for dually eligible Medicare/Medicaid patients getting skilled services under the Medicare Prospective Payment System (PPS).**

As noted in the May 2001 general Medicaid bulletin, the home health agency is responsible for providing all covered home health needs under Medicare PPS during an open episode of care. The services are reimbursed as a package (bundled) and can either be provided directly by the home health agency or under arrangement with another entity. While Medicaid does not have a policy directly prohibiting a patient from receiving PCS and home health aide services – as long as the services are not provided on the same day – Medicaid would question why PCS was being provided since both services cover the same tasks.

7. As a PCS provider, what do I need to know about an "open episode" and how does it affect my provision of PCS?

"Open episode" is Medicare terminology that describes when the home health agency is responsible for care to the patient. As a PCS provider, the key information to obtain from the home health agency is the start date and end date for the open episode. After the episode closes, PCS may be considered. (Medicare's website at http://www.hcfa.gov/medicare/hhqanda.htm also contains information about home health PPS.)

8. Will the PCS plan of care need to match the Home Health plan of care if services are resumed after Medicare-covered skilled service ends? Will Medicaid question the amount of time spent by the PCS aide verses the Home Health aide?

The PCS plan of care does not need to match the Home Health plan of care. The PCS provider must develop a PCS plan that accurately reflects the client's situation and needs according to Section 6 of the *N.C. Medicaid Community Care Manual*. The RN assessment and the PCS plan of care must document the need for PCS and support the amount of time spent by the PCS aide.

Adelle Kingsberry, Hospice/PCS Program Consultant
DMA, 919-857-4021

Attention: Carolina ACCESS Primary Care Providers

Carolina ACCESS Primary Care Provider Manual Available Online

The revised *Carolina ACCESS Primary Care Provider Manual* is now available on DMA's website at http://www.dhhs.state.nc.us/dma. Providers without Internet access should contact their Regional Managed Care Consultant for assistance. Please refer to the below list.

Regional Managed Care Consultants

Jerry Law 252-321-1806	**Rosemary Long 919-477-3362**	**Lisa Gibson 919-319-0301**	**Julia McCollum 919-857-4219**	**Daryl Frazier 919-857-4233**	**Lisa Catron 828-683-8812**
Beaufort	Bladen	Alamance	Chatham	Cabarrus	Alexander
Bertie	Brunswick	Anson	Durham	Gaston	Alleghany
Camden	Carteret	Caswell	Franklin	Iredell	Ashe
Chowan	Columbus	Davie	Granville	Lincoln	Avery
Currituck	Craven	Davidson	Orange	Mecklenburg	Buncombe
Dare	Cumberland	Forsyth	Vance	Union	Burke
Edgecombe	Duplin	Guilford	Wake		Caldwell
Gates	Greene	Lee			Catawba
Halifax	Harnett	Montgomery			Cherokee
Hertford	Hoke	Moore			Clay
Hyde	Johnston	Person			Cleveland
Martin	Jones	Randolph			Graham
Nash	Lenoir	Richmond			Haywood
Northhampton	New Hanover	Rockingham			Henderson
Pasquotank	Onslow	Rowan			Jackson
Perquimans	Pamlico	Stanley			Macon
Pitt	Pender	Stokes			Madison
Terrell	Robeson	Surry			McDowell
Warren	Sampson	Yadkin			Mitchell
Washington	Scotland				Polk
	Wayne				Rutherford
	Wilson				Swain
					Transylvania
					Watauga
					Wilkes
					Yancey

Laurie Giles, Managed Care Section
DMA, 919-857-4022

Attention: All Providers

Index to General and Special Medicaid Bulletins for 2001

All Providers

Rural Health Clinics
Immune Globulin (IgIV, Human, for Intravenous Use, CPT 90283) Coverage Clarification, 09/01, pg. 3
Use of Codes Y2351 and Y2041, 06/01, pg. 3
Use of Codes Y2351 and Y2041 – Correction and Addition to June 2001 Bulletin Article, 08/01, pg. 2

Surgical Sterilization Procedure Providers
New Procedures for Submitting Sterilization Consent Forms to EDS, 09/01, pg. 12

Therapy Providers
Clarification Regarding Therapy Services Provided to Medicaid HMO Enrollees, 07/01, pg. 3

Ventilator Long-term Care Providers
Authorized Persons to Sign Ventilator Addendum Form, 03/01, pg. 3
Time Constraints for Provider Notification of Ventilator Prior Approval, 03/01, pg. 3

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

Attention: All Providers

Electronic Funds Transfer Form – Fax Number Change for Submittals

Providers are instructed to use the following fax number when submitting Electronic Funds Transfer (EFT) forms to the EDS Financial Unit: 919-816-4399.

EDS offers EFT as an alternative to paper check issuance. Providers are required to complete and submit an EFT form to initiate the automatic deposit process. Providers must also complete and submit a new EFT form (see page 27) if they change banks or bank accounts.

A deposit slip or voided check confirming the account number and bank transit number must be attached to the EFT form. Completed forms may be mailed to EDS at the address listed below or they may be faxed to the EDS Financial Unit.

EDS
Attention: Financial Unit
P.O. Box 300011
Raleigh, NC 27622

Note: There is an interim time period of two checkwrites during which providers will receive a paper check before automatic deposit begins or resumes to a new bank account. The top left corner of the last page of the provider's Remittance and Status Report will indicate **EFT number** rather than **check number** when automatic deposit begins or resumes.

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

Attention: All Providers

Corrected 1099 Requests – Action Required by March 1, 2002

Providers receiving Medicaid payments of more than $600 annually receive a 1099 MISC tax form from EDS. The 1099 MISC tax form is generated as required by IRS guidelines. It will be mailed to each provider no later than January 31, 2002. The 1099 MISC tax form will reflect the tax information on file with Medicaid as of the last Medicaid checkwrite cycle date, December 27, 2001.

If the tax name or tax identification number on the annual 1099 MISC you receive is **incorrect**, a correction to the 1099 MISC must be requested. This 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 **30.5 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 to EDS by March 1, 2002** and must be accompanied by the following documentation:

- a copy of the original 1099 MISC
- a signed and completed IRS W-9 form (see page 29) clearly indicating the correct tax identification number and tax name. (Additional instructions for completing the W-9 form can be obtained at http://www.irs.gov under the link "Forms and Pubs.")

Fax both documents to 919-816-4399, Attention: Corrected 1099 Request - Financial

Or

Mail both documents to:

EDS
P.O. Box 300011
Raleigh, NC 27622
Attention: Corrected 1099 Request - Financial

A copy of the corrected 1099 MISC will be mailed to you for your records. All corrected 1099 MISC requests will be reported to the IRS. In some cases, additional information may be required to ensure that the tax information on file with Medicaid is accurate. Providers will be notified by mail of any additional action that may be required to complete the correction to their tax information.

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

Form **W-9**
(Rev. December 2000)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Please print or type

Name (See **Specific Instructions** on page 2.)

Business name, if different from above. (See **Specific Instructions** on page 2.)

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ► .....

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

Part I **Taxpayer Identification Number (TIN)**

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). **However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 2.** For other entities, it is your employer identification number (EIN). If you do not have a number, see **How to get a TIN** on page 2.

Note: *If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.*

Social security number
			–			–		

or

Employer identification number
			–					

List account number(s) here (optional)

Part II **For U.S. Payees Exempt From Backup Withholding** (See the instructions on page 2.)

►

Part III **Certification**

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item **2** above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item **2** does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 2.)

Sign Here **Signature of U.S. person ►** **Date ►**

Purpose of Form

A person who is required to file an information return with the IRS must get your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to give your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

If you are a foreign person, use the appropriate Form W-8. See **Pub. 515,** Withholding of Tax on Nonresident Aliens and Foreign Corporations.

Note: *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

What is backup withholding? Persons making certain payments to you must withhold and pay to the IRS 31% of such payments under certain conditions. This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

If you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return, payments you receive will not be subject to backup withholding. **Payments you receive will be subject to backup withholding if:**

1. You do not furnish your TIN to the requester, or
2. You do not certify your TIN when required (see the Part III instructions on page 2 for details), or
3. The IRS tells the requester that you furnished an incorrect TIN, or
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the Part II instructions and the separate **Instructions for the Requester of Form W-9.**

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

Cat. No. 10231X Form **W-9** (Rev. 12-2000)

Specific Instructions

Name. If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first and then circle the name of the person or entity whose number you enter in Part I of the form.

Sole proprietor. Enter your **individual** name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, **enter the owner's name on the "Name" line.** Enter the LLC's name on the "Business name" line.

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Part I—Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box.

If you are a **resident alien** and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see **How to get a TIN** below.

If you are a **sole proprietor** and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are an **LLC** that is **disregarded as an entity** separate from its owner (see ***Limited liability company (LLC)*** above), and are owned by an individual, enter your SSN (or "pre-LLC" EIN, if desired). If the owner of a disregarded LLC is a corporation, partnership, etc., enter the owner's EIN.

Note: *See the chart on this page for further clarification of name and TIN combinations.*

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get **Form SS-5,** Application for a Social Security Card, from your local Social Security Administration office. Get **Form W-7,** Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN or **Form SS-4,** Application for Employer Identification Number, to apply for an EIN. You can get Forms W-7 and SS-4 from the IRS by calling 1-800-TAX-FORM (1-800-829-3676) or from the IRS's Internet Web Site at **www.irs.gov**.

If you do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: *Writing "Applied For" means that you have already applied for a TIN* ***or*** *that you intend to apply for one soon.*

Part II—For U.S. Payees Exempt From Backup Withholding

Individuals (including sole proprietors) are **not** exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends. For more information on exempt payees, see the separate Instructions for the Requester of Form W-9.

If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding. Enter your correct TIN in Part I, write "Exempt" in Part II, and sign and date the form.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

Part III—Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 3, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required).

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item **2** in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item **2** of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified state tuition program payments, IRA or MSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to give your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA or MSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 31% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Sole proprietorship	The owner [3]
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name, but you may also enter your business or "DBA" name. You may use either your SSN or EIN (if you have one).

[4] List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note: *If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.*

Attention: Home Health, Personal Care Services, and Private Duty Nursing Providers

Written Confirmation of Verbal Orders

Providers of Home Health Services, Personal Care Services (in private residences), and Private Duty Nursing may bill Medicaid for services provided under a physician's verbal order that is confirmed in writing and signed by the physician within 30 days. If the order is not signed within 30 days, the date of the physician's signature is considered to be the start date for billable services. Medicaid payments made for services prior to the start date are subject to recoupment.

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

Attention: Personal Care Services Providers (excluding Adult Care Homes)

Personal Care Services Seminars

Personal Care Services (PCS) seminars are scheduled for March 2002. The February general 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

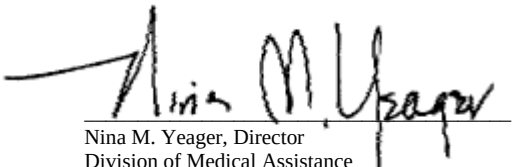
Checkwrite Schedule

January 15, 2002	February 12, 2002	March 5, 2002
January 23, 2002	February 19, 2002	March 12, 2002
January 30, 2002	February 27, 2002	March 19, 2002
		March 28, 2002

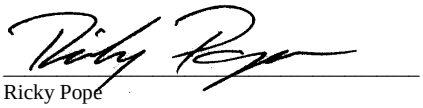
Electronic Cut-Off Schedule

January 11, 2002	February 8, 2002	March 1, 2002
January 18, 2002	February 15, 2002	March 8, 2002
January 25, 2002	February 22, 2002	March 15, 2002
		March 22, 2002

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.



Nina M. Yeager, Director
Division of Medical Assistance
Department of Health and Human Services



Ricky Pope
Executive Director
EDS

e

Presorted Standard
U.S. POSTAGE
PAID
Raleigh, N.C.
Permit No. 1087

P.O. Box 300001
Raleigh, North Carolina 27622