Number 1 *January 2003*

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: http://www.dhhs.state.nc.us/dma

Attention: All Providers

Holiday Observance

The Division of Medical Assistance (DMA) and EDS will be closed on Wednesday, January 1, 2003 in observance of New Year's Day, and on Monday, January 20, 2003 in observance of Dr. Martin Luther King, Jr.'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 Providers

Proposed Medical Coverage Policies

In accordance with Session Law 2001-424, Senate Bill 1005, proposed new or amended Medicaid medical coverage policies are available for review and comment on DMA's website at http://www.dhhs.state.nc.us/dma/prov.htm. To submit a comment related to a policy, refer to the instructions on the website. Providers without Internet access can submit written comments to the address listed below.

Darlene Creech
Medical Policy Section
Division of Medical Assistance
2511 Mail Service Center
Raleigh, NC 27699-2511

The initial comment period for each proposed policy is 45 days. An additional 15-day comment period will follow if a proposed policy is revised as a result of the initial comment period.

Darlene Creech, Medical Policy Section
DMA, 919-857-4020

Attention: All Providers

CPT Update for 2003

The annual review of the new Current Procedural Terminology (CPT) codes has not been completed. Providers must bill the 2002 covered codes until the Division of Medical Assistance (DMA) provides directions for filing the 2003 codes. Providers will be notified of covered 2003 CPT codes in future general Medicaid bulletins. Bulletins are available on DMA's website at http://www.dhhs.state.nc.us/dma/bulletin.htm.

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

Attention: All Providers

HIPAA Implementation Training Seminars

Seminars on the implementation of the Health Insurance Portability and Accountability Act (HIPAA) transaction sets are scheduled for Spring 2003. Dates and site locations for the seminars will be published in the March general Medicaid bulletin.

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

Attention: All Providers

Corrected 1099 Requests – Action Required by March 1, 2003

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, 2003. The 1099 MISC tax form reflects the tax information on file with Medicaid as of the last Medicaid checkwrite cycle date, December 27, 2002.

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 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, 2003** and must be accompanied by the following documentation:

- a copy of the original 1099 MISC
- a signed and completed IRS W-9 form clearly indicating the correct tax identification number and tax name. (Additional instructions for completing the W-9 form can be obtained at 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
4905 Waters Edge Drive
Raleigh, NC 27606
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 are 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: All Providers

Endoscopy CPT Base Codes and Their Related Procedures

The following table represents an updated list of covered base and related endoscopy codes as designated in the 2002 Resource Based Relative Value System (RBRVS). **Group 1** reflects a new base code of 29805, effective with dates of service January 1, 2002. Existing codes previously omitted were added to the related side for groups **9** and **25**.

Endoscopy Base and Related Code Group

Group	Base Code	Related Codes	Comments
1	**29805**	29819 - 29826	Effective 01/01/02 new "base" code added from 2002 RBRVS
2	29830	29834 - 29838	
3	29840	29843 - 29847	
4	29860	29861 - 29863	
5	29870	29871, 29874 - 29877, 29879 - 29887	
6	31505	31510 - 31513	
7	31525	31527 - 31530, 31535, 31540, 31560, 31570	
8	31526	31531, 31536, 31541, 31561, 31571	
9	31622	**31623**, **31624,** 31625, 31628-31631, 31635, 31640 - 31641, 31645	Existing procedure codes added from 2002 RBRVS
10	43200	43202, 43204 - 43205, 43215 - 43217, 43219 - 43220, 43226 - 43228	
11	43235	43231 - 43232, 43239, 43241 - 43247, 43249 - 43251, 43255 - 43256, 43258 - 43259	
12	43260	43240, 43261 - 43265, 43267 - 43269, 43271 - 43272	
13	44360	44361, 44363 - 44366, 44369, 44370, 44372-44373	
14	44376	44377 - 44379	
15	44388	44389 - 44394, 44397	
16	45300	45303, 45305, 45307 - 45309, 45315, 45317, 45320 - 45321, 45327	
17	45330	45331 - 45334, 45337 - 45339, 45345	
18	45378	45379 - 45380, 45382 - 45385, 45387	
19	46600	46604, 46606, 46608, 46610 - 46612, 4661 -46615	
20	47552	47553 - 47556	
21	50551	50555, 50557, 50559, 50561	
22	50570	50572, 50574-50576, 50578, 50580	

Endoscopy Base and Related Code Group, continued

Group	Base Code	Related Codes	Comments
23	50951	50953, 50955, 50957, 50959, 50961	
24	50970	50974, 50976	
25	52000	52007, **52010**, 52204, 52214, 52224, 52250, 52260, 52265, 52270, 52275 - 52277, 52281 -52283, 52285, 52290, 52300 - 52301, 52305, 52310, 52315, 52317 - 52318	Existing procedure code added from 2002 RBRVS
26	52005	52320, 52325, 52327, 52330, 52332, 52334, 52341 - 52344	
27	52335	52336-52339	End-dated due to 2001 CPT update
28	56300	56301 - 56309, 56311, 56343 - 56344, 56314	End-dated due to 2000 CPT update
29	56350	56351 - 56356	End-dated due to 2000 CPT update
30	57452	57454, 57460	
31	49320	38570, 49321 - 49323, 58550 - 58551, 58660 - 58662, 58670 - 58671	
32	58555	58558 - 58563	
33	52351	52345 - 52346, 52352 - 52355	
34	31575	31576 - 31579	

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

Attention: All Providers

Anesthesia – Billing CPT Anesthesia Codes Instead of Surgical Codes

Effective with date of service June 1, 2003, providers must bill CPT anesthesia codes for anesthesia services instead of billing the CPT surgical codes with modifier YA or QS. The Division of Medical Assistance (DMA) is making this conversion in order to comply with the implementation of national code sets mandated by the Health Insurance Portability and Accountability Act (HIPAA). Local state-created modifier YA will not be accepted, effective with date of service June 1, 2003. Instead, providers must bill the appropriate CPT anesthesia code with no modifier or with modifier QS to designate monitored anesthesia care. Units will remain calculated as 1 unit = 1 minute.

DMA will schedule seminars to discuss these changes. A list of dates and locations for these seminars will be published in future general Medicaid bulletins.

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

Attention: All Providers

Performance Bonds

The N.C. General Assembly has approved legislation that requires the purchase of performance bonds or a validly executed letter of credit as a condition for Medicaid payment to enrolled providers. The legislation also authorized the Department of Health and Human Services to waive or limit the requirement based on the provider's dollar amount of monthly billings or the length of time the provider has been licensed to provide services in the State. The Division of Medical Assistance (DMA) and the Office of the Attorney General are developing administrative rules and procedures to implement this requirement. The requirement will be phased in by provider type. We anticipate that the first phase will be implemented during Spring 2003. Providers enrolled for Personal Care Services and Durable Medical Equipment will be the first phase. No specific information about procedures is available at this time. DMA will publish updated information in the general Medicaid bulletin on DMA's website as it becomes available.

The authorizing legislation can be found on the N.C. General Assembly website at http://www.ncleg.net/html2001/Bills/allversions/senate/s1115vc.html. The relevant text reads as follows:

> Payment is limited to Medicaid enrolled providers that purchase a performance bond in an amount not to exceed one hundred thousand dollars ($100,000) naming as beneficiary the Department of Health and Human Services, Division of Medical Assistance, or provide to the Department a validly executed letter of credit or other financial instrument issued by a financial institution or agency honoring a demand for payment in an equivalent amount. The Department may waive or limit the requirements of this paragraph for one or more classes of Medicaid enrolled providers based on the provider's dollar amount of monthly billings to Medicaid or the length of time the provider has been licensed in this State to provide services. In waiving or limiting requirements of this paragraph the Department shall take into consideration the potential fiscal impact of the waiver or limitation on the State Medicaid Program.

Barbara Brooks, Recipient and Provider Services Section
DMA, 919-857-4019

Attention: Hospital Providers

Cochlear Implant Device – Billing Clarification

When billing for an FDA-approved cochlear implant device, use Revenue Code 278. N.C. Medicaid coverage of the cochlear implant device is limited to pre-linguistically and post-linguistically deafened children ages birth to 21 who meet medical necessity criteria.

Debbie Garrett, RNC, Hospital Consultant
Medical Policy Section
DMA, 919-857-4020

Attention: All Providers

Zoledronic Acid, 1 mg (Zometa, J3487) – Billing Guidelines Update

Effective with date of service January 1, 2003, the N.C. Medicaid program covers Zometa for use in the Physician's Drug Program when billed with HCPCS code J3487. Providers may no longer bill J3490 for Zometa. For Medicaid billing, one unit of coverage is now 1 mg. The maximum reimbursement rate for one unit is $192.69. An invoice is no longer required for dates of service on or after January 1, 2003.

Only the following ICD-9-CM diagnoses are covered:

- One of the following diagnoses (stand alone) can either be the primary or a secondary diagnosis:
  a. Hypercalcemia - 275.42
  b. Secondary malignant neoplasm of bone and bone marrow - 198.5
  c. Multiple myeloma - 203.00 or 203.01
- For the following indications, a primary **and** a secondary diagnosis is required in order for the claim to be processed:
  a. Prostate cancer – 185 primary with 198.5 secondary
  b. Non-small-cell lung cancer – 162.0 through 162.9 primary with 198.5 secondary
  c. Breast cancer (female) – 174.0 through 174.9 primary with 198.5 secondary
  d. Breast cancer (male) – 175.0 through 175.9 primary with 198.5 secondary

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

Attention: Nursing Facility Providers

Medicaid Nursing Facility Payments

In accordance with Session Law 2002-126, Senate Bill 1115, residents of nursing facilities who are eligible for Medicare coverage of nursing facility services must be placed in a Medicare-certified bed. Effective with dates of service December 1, 2002, Medicaid considers reimbursement for nursing facility services only after the appropriate services have been billed to Medicare. Nursing facility providers have until April 30, 2003 to certify additional Medicare beds if necessary. If beds have not been certified by April 30, 2003, reimbursement may be affected. Providers should contact the Division of Facility Services at 919-733-7461 to request Medicare certification of additional beds.

Lloyd Pattison, Institutional Services Section
DMA, 919-857-4020

Attention: Licensed Psychologists, Licensed Clinical Social Workers, Psychiatric Clinical Nurse Specialists, Psychiatric Nurse Practitioners, and Mental Health Multi-Specialty Groups

Mental Health Services for HMO Enrollees Provided by Direct-Enrolled Mental Health Providers

Beginning with dates of service on or after February 1, 2003, direct-enrolled mental health providers may begin to bill Medicaid for services rendered to HMO-enrolled recipients without a referral from the Area Mental Health Authority. Currently, HMO enrollment is restricted to Mecklenburg County with Southcare as the sole HMO option. Affected providers include licensed psychologists, licensed clinical social workers, psychiatric clinical nurse specialists, psychiatric nurse practitioners, and mental health multi-specialty groups. Mental health services are limited to Medicaid recipients under the age of 21.

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

Attention: Physicians, Hospitals, and Outpatient Clinics

Modifier YS for Teleconsults

Effective December 1, 2002, modifier YS, representing services provided during a teleconsult in the spoke site, was end-dated to comply with the implementation of national code sets mandated by the Health Insurance Portability and Accountability Act (HIPAA). This modifier is no longer available. Teleconsults should be billed by the consulting facility/physician with modifier GT, which states "Via interactive audio and video telecommunication systems." The following codes may be billed with modifier GT:

99201	99202	99203	99204	99205	99211
99212	99213	99214	99215	99221	99222
99223	99231	99232	99233	99241	99242
99243	99244	99245	99251	99252	99253
99254	99255	99261	99262	99263	99271
99272	99273	99274	99275		

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

Attention: Personal Care Services (in Private Residences) Providers, Home Health Agencies, Durable Medical Equipment Providers, Home Infusion Therapy Providers, Private Duty Nursing Providers, and Adult Care Home Providers

Implementation of Transfer of Assets Policy for Specified Home Care Services

Effective with date of service February 1, 2003, payments for specified home care services may be affected by a new transfer of assets policy that applies to certain Medicaid recipients. This policy is similar to the transfer of assets requirements currently in place for Medicaid recipients receiving nursing facility and ICF-MR care, as well as for those recipients participating in the Community Alternatives Programs.

Transfer of Assets Sanctions

If an applicant/recipient has transferred assets in a manner contrary to the policy, he will not qualify for payment for any of the specified services provided during the sanction period. Sanction periods are by calendar month. They may be retroactive as well as extend through the current time period. This policy does not apply to transfers prior to February 1, 2003; therefore, there will be no sanction periods that begin before that date.

Services Included in the Policy

The Medicaid services included in the policy are:

- Personal Care Services (PCS) in private residences
- Home Health Services, including the supplies provided by home health agencies
- Durable Medical Equipment (DME), including the supplies provided by DME providers
- Home Infusion Therapy
- The supplies on the Home Health fee schedule provided by Private Duty Nursing (PDN) providers to PDN patients (the nursing care is not included in the policy)

Medicaid Recipients Subject to the Policy

The policy applies to individuals in the following Medicaid eligibility categories:

- Medical Assistance for the Aged (MAA)
- Medical Assistance for the Disabled (MAD)
- Medical Assistance for the Blind (MAB)
- Medicare Aid (MQB-Q)

Adult care home providers should note that this policy does not apply to their residents receiving State/County Special Assistance. It does apply to a private pay adult care home resident if the individual is in one of the four eligibility categories (MAA, MAD, MAB, and MQB-Q).

MAA, MAD, and MAB recipients have a blue Medicaid identification (MID) card with the abbreviation listed under "Program" on the card. MQB-Q recipients have a buff card labeled as a "MEDICARE-AID ID CARD."

Community Alternatives Program (CAP) participants are not subject to a transfer of assets determination for the specified services. Providers may identify a CAP participant by the entry in the "CAP" block of the MID card.

Transfer of Assets Determination

The county department of social services will make a transfer of assets determination when it is aware that a recipient is seeking any of the specified services. The determination and any resulting sanction will apply to all of the services. A separate determination for each service is not required.

How the Policy Affects Payment

Payment for a date of service on and after February 1, 2003, depends on the information that is in the claims processing system.

1. **No Transfer of Assets Information in System –** If there is no transfer of assets information in the system, the claim will suspend for up to 60 days. The suspension will end before 60 days if transfer of assets information is received. (Refer to ***Current Service Recipients*** for information about individuals for whom Medicaid has paid for services in December 2002 and January 2003.)
   a. The provider will be notified on the Remittance and Status Report that the claim is suspended. The explanation of benefits statement will indicate that the claim is pended awaiting a transfer of asset assessment by the county department of social services (DSS). The provider may contact the recipient to request that the recipient contact the county DSS office. The provider should not resubmit the claim.
   b. The recipient's county DSS will be notified to contact the recipient and make a transfer of assets determination.
      - If a sanction period is imposed that includes a date of service on the claim, payment for the date of service will be denied. (Refer to ***Billing the Recipient***.)
      - If no sanction is imposed for the date(s) of service, the claim will continue to process for payment.
      - If the claims processing system does not receive information on the transfer of assets determination before the end of the 60-day period, the claim will deny. The provider may resubmit the claim after verifying that the recipient has cleared the transfer of assets requirement for the date(s) of service. (Refer to ***Transfer of Asset Information***.)
2. **Transfer of Assets Information in System –** If there is transfer of assets information in the system, the claim will process.
   - If a date of service is in a sanction period, payment for the date of service will be denied. (Refer to ***Billing the Recipient***.)
   - If the date of service is not in a sanction period, the claim will continue to process for payment.

If a transfer of assets sanction is entered into the claims processing system after payment is made for a date within the sanction period, the county DSS will pursue recoupment from the recipient. The payment will not be recouped from the provider agency.

Transfer of Asset Information

Providers may access the Automated Voice Response (AVR) system to get a recipient's transfer of assets status as of a specified date. The AVR response provides information that is in the claims processing system at the time of the inquiry. AVR information is not a guarantee of payment. Because a penalty period can be applied retroactively, transfer of assets information for a given date may change after the provider obtains the information.

To access transfer of assets information, the provider selects option 6 at the main menu for information about recipient eligibility. The call flow to get to transfer of assets information is as follows:

> **Provider Number Verification –** When the provider selects option 6 from the main menu, AVR prompts the provider to enter their N.C. Medicaid provider number for verification. After the provider number is verified, the prompt will allow a caller to go in either of two directions: Recipient Eligibility and Coordination of Benefits or Hospice Eligibility. Choose selection 1.

Recipient Access Method Prompt – To obtain recipient eligibility information, the provider must enter a valid recipient MID number **OR** a combination of the recipient's date of birth and social security number, **and** a "FROM" date of service. AVR prompts the provider to select a method for accessing the recipient data.

> **"Please select one of the following recipient identification options. To enter a recipient identification number, press 1. To enter a recipient date of birth and social security number, press 2."**

Date of Service Prompt – The provider must enter either a pound sign (#) only (for the current date) or a "FROM" date of service in a MMDDCCYY format.

Host Response – After receiving a valid provider number and recipient MID number, and "FROM" date of service, AVR determines whether or not the provider is authorized to access recipient eligibility information from the eligibility file.

Eligibility/Enrollment Prompt – The AVR will give the following response asking the provider to choose one of these two options:

> **"For eligibility information, press 1. For enrollment information, press 2."**

Choose selection 1 for eligibility information. Transfer of assets information will be the last information given. The provider will be told one of the following:

- The recipient has not been assessed. The provider should ask the recipient to contact the county DSS to begin a transfer of assets assessment.
- The recipient is in a penalty period for the given date of service and claims for the specified services will be denied.
- The recipient is not in a penalty period for the given date of service.

Providers also may verify the recipient's transfer of assets status by seeing the recipient's notice about the results of a transfer of assets determination. The county DSS will provide the recipient a notice indicating that transfer of assets has been reviewed and any penalty period assessed.

Current Service Recipients

Transfer of assets information will be entered into the claims processing system for recipients for whom Medicaid paid for any of the specified services during December 2002 and January 2003. While this will not capture all of the recipients of the specified services, it will reduce the number of claims suspended while awaiting a transfer of assets determination. The county department of social services will review transfer of assets for these recipients at their next eligibility review.

Billing the Recipient

A provider may bill the recipient if Medicaid payment is denied due to a transfer of assets sanction and the provider has advised the recipient of his responsibility for payment before the services are rendered. The provider should maintain documentation that the recipient was notified of and accepted the responsibility.

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Checkwrite Schedule

January 14, 2003	February 11, 2003	March 4, 2003
January 22, 2003	February 18, 2003	March 11, 2003
January 30, 2003	February 27, 2003	March 18, 2003
		March 27, 2003

Electronic Cut-Off Schedule

January 10, 2003	February 7, 2003	March 7, 2003
January 17, 2003	February 14, 2003	March 14, 2003
January 24, 2003	February 21, 2003	March 21, 2003
	February 28, 2003	

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

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