North Carolina Medicaid Bulletin

An Information Service of the Division of Medical Assistance

Published by EDS, fiscal agent for the North Carolina Medicaid Program

Number 2 ***February 1998***

Attention: Independent Laboratories

Billing Laboratory Services Related to Abortions, Hysterectomies and Sterilization Procedures

The February 1997 Bulletin informed providers that effective with date of service April, 1, 1997, claims billed with laboratory procedure codes submitted by independent laboratories were no longer allowed to use diagnosis V726, "laboratory examination." Claims with V726 are denied instructing providers to refile with an appropriate diagnosis.

Laboratory claims are subject to the same billing limitations as other providers. If an independent lab submits a claim with a diagnosis related to an abortion, hysterectomy or sterilization procedure performed on a Medicaid recipient, all Federal guidelines must be met before any related claim can be paid. When the appropriate consent/statement does not meet federally mandated requirements and/or is not on file at EDS, all related claims will deny.

Laboratories can contact either the attending physician's billing office or EDS provider services to determine if the consent/statement has been filed.

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

Attention: Personal Care Services (PCS) Providers

Reminder: PCS UB-92 Claim Form Instructions

This is to remind PCS providers of new instructions given in the November 1997 ***Medicaid Special Bulletin*** for preparing the UB-92 claim form.

Effective with claims processed beginning March 1, 1998, enter the ICD-9-CM code in Form Locator 67 for the principle diagnosis related to provision of PCS services to the patient. In Form Locator 68-75, enter the ICD-9-CM codes for any secondary diagnosis(es). This replaces the current procedure of entering V700 in Form Locator 67. A principle diagnosis code with a V prefix will be denied.

Note: *You may use these new instructions to file claims to be processed prior to March 1, 1998. You do not have to wait until March 1 to make the change. This option gives you some flexibility in implementing this requirement. Remember, the effective date is the date the claim is processed by EDS.*

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

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

Index

Attention: All Providers

Clarification to Billing Pap Smears with Correct Type of Treatment

The January, 1998 article is being reprinted with definitions of the terms "professional", "technical" and "complete" as they relate to billing Pap smear components.

Professional (type of treatment 4): Refers to the professional interpretation of the slide.

Technical (type of treatment T): Refers to the equipment and/or cutting of the slide.

Complete (type of treatment 5): Refers to both the professional and technical being performed by the same provider.

There is no separate fee for the collection of the pap smear. The collection of the smear is included as part of the office visit.

Effective with date of service January 1, 1998, Medicaid will cover three different types of Pap smears. Reference the 1998 CPT book for the complete definition of each procedure code:

- 88142-Thin prep
- 88150-88155-Non-Bethesda
- 88156-88158-Bethesda

Effective with date of service January 1, 1998 procedure code 88141, which represents the professional component can only be billed when any one code (88142-88158) is billed as the technical component.

The following table illustrates how the procedure code(s) can be billed and the relationship between the type of treatment and type of service. Note 88142-88158 can be billed as either T **or** 5, but not both.

Procedure Code	Type of treatment on HCFA-1500 box 24C	Type of Service reported on RA	Place of Service
88142-88158	T (technical)	T	Inpatient, Outpatient, and Office
88142-88158	5 (complete)	3	Inpatient, Outpatient, and Office

Remember, when any of the procedure codes 88142-88158 is billed as the complete component, 88141 will deny.

Procedure Code	Type of Treatment on HCFA-1500 Box 24C	Type of Service Reported on RA	Place of Service
88141	4 (professional)	5	Inpatient, Outpatient, and Office

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

Attention: Physician Office Labs

Clinical Laboratory Improvements Amendment (CLIA) Certification Numbers Required

To meet Federal requirements Clinical Laboratory Improvements Amendment (CLIA) has mandated that all laboratories, including physician office laboratories (POLS), have a CLIA certificate in order to receive reimbursement from Federal programs. HCFA has undertaken an initiative to monitor CLIA compliance for all laboratories.

North Carolina Medicaid requires all providers performing any laboratory tests by CLIA to have their CLIA number on file. Physician Office Labs (POLS) have until June 1, 1998 to ensure this requirement is met. Claims submitted after June 1, 1998 for laboratory services provided through a POL will deny if the CLIA number is not on file. Return this completed form and a copy of your CLIA certificate to this address:

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

(cut and return form with copy of CLIA certificate)

CLIA Certification Information

Provider Name: _____Provider Number:_____

Street Address _____

City _____ State _____Zip _____ Phone Number_____

Contact Person _____

CLIA Number_____

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

Attention: Ambulance Providers

Individual Visits

EDS is offering individual provider visits for all Ambulance providers. If there are any questions regarding general Medicaid guidelines, policy changes, billing information, or claims follow-up procedures, please complete and return the form below. An EDS Provider Representative will contact you to schedule a visit.

(cut and return request form only)

Ambulance Provider Visit Request Form
(No Fee)

Provider Name _____ Provider Number _____

Address _____ Contact Person _____

City, Zip Code _____ County _____

Telephone Number _____ Date_____

List any specific concerns you would like us to address in the space provided below:

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

Attention: All Providers

New EDS Claims Processing Procedures for Carolina Alternatives

Since the beginning of Carolina Alternatives, the Division of Medical Assistance (DMA) and the Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS) jointly have been manually reviewing claims that inappropriately denied with an Explanation of Benefits (EOB) of 611 indicating that Carolina Alternatives was responsible for payment. New edits are now in place that correct this problem. The range of ICD-9-CM diagnoses for Carolina Alternatives for reimbursement is V110 thru V119, V400 thru V409, 290.0 thru 298.9, 299.8 thru 306.99, 307.1 thru 307.54 and 307.6 thru 314.9. The following claims processing procedures are being utilized:

1. If any service was rendered by a psychiatric provider type, the claim will deny for Carolina Alternatives with an EOB of 611.
2. If a non-psychiatric provider is billing one of the diagnosis codes included in the acceptable range listed above and if the claim is billed with Revenue Center Code 90X thru 919, 944, 945, 961 or 513, the detail will be denied with EOB 611 and should be billed to the appropriate Area Mental Health Center. This is also true for CPT 80178 with the above diagnosis codes and/or Revenue Center Codes. If billed to EDS, the detail will deny with an EOB of 611.
3. If a non-psychiatric provider is billing for procedure code 80101 (drug screen) or 80102 (drug confirmation) and the diagnosis codes include any codes from 303 thru 305.99, the procedure will deny with EOB 611.
4. If the provider is a non-psychiatric provider and the Revenue Center codes are 90X thru 919, 944, 945, 961 or 513, regardless of diagnosis,those line items will deny with an EOB of 611.

The new edits are expected to improve processing time for claims and alleviate the cumbersome manual review process.

Carol Robertson, RN, Medical Policy
DMA, 919-733-2833

Attention: Physicians and Podiatrists

Routine Foot Care - Trimming of Nondystrophic Nails, Any Number, CPT 11719

Section 1862(a) (13) (c) of the Social Security Act prohibits payment for routine foot care, including the cutting or removal of corns and calluses, the trimming of toenails, any debridement of nonmycotic nails, and other hygienic care. The only circumstances in which the coverage of these otherwise excluded services can be permitted under the Medicaid program are services that are a necessary and integral part of otherwise covered services (such as plantar warts), the presence of certain systemic conditions, and mycotic nails.

Effective with date of service April 30, 1998, routine foot care for patients diagnosed with metabolic disease, peripheral vascular disease, and/or neuropathy currently under the active treatment of the condition by a doctor of medicine or osteopathy must be billed using CPT 11719. The diagnosis must be listed on the claim.

Documentation in the medical record must indicate when the recipient last saw the medical doctor or doctor of osteopathy for treatment of the severe peripheral complication and the referring physician's name.

Claims submitted with CPT 11720-11721 (debridement of mycotic nails) for routine foot care, meeting diagnosis criteria, will be accepted until date of processing April 30, 1998. Beginning May 1, 1998, surgery codes 11720-11721 and 11040, 11050-11052 (debridement of skin/hyperkeratosis) can not be used for routine foot care.

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

Attention: All Providers

Managed Care Update

DMA has instituted several managed care initiatives to improve access to health care, ensure quality, and control the rate of growth of costs. The Managed Care Unit now administers these programs which are in varying stages of development. Below are overviews of each program, accompanied by an overview map and the Directory of Managed Care Representatives (MCRs) for each participating county.

- **Carolina ACCESS**, operative since 1991, is the Medicaid fee-for-service reimbursement program which links each recipient to their own Primary Care Physician (PCP). It is designed to enhance recipient access to quality primary care and to coordinate other health services. This Primary Care Case Management (PCCM) program now operates in 65 counties with approximately 350,000 recipients and is scheduled to expand to 99 counties (Mecklenburg excluded) by the end of 1999. See ACCESS II below.

- **HealthCare Connection** (previously the Mecklenburg project), operative only in Mecklenburg County since 1996, provides certain medical services to most Medicaid recipients through HMOs on a full risk capitated basis. HealthCare Connection coordinates the care of over 32,000 recipients through five HMOs and one federally-qualified health center in Mecklenburg County. A unique feature is the use of an independent Health Benefit Advisor to help recipients select and enroll in their HMO plan, educate the recipient, and perform some liaison functions.

- **HMO Risk-Contracting**, began in 1986 with one HMO (Kaiser Permanente) serving Mecklenburg and three Triangle counties. Risk-Contracting, combined with Carolina ACCESS, also began in Gaston County in 1997. This system will further expand to six-county Triangle and Triad areas (see map below) in February and August, 1998, respectively. HMO Risk-Contracting counties will allow Medicaid recipients to choose between a DMA-approved HMO or a Carolina ACCESS Primary Care Physician. DMA will reimburse HMOs on a per member/month basis and PCPs on a fee-for-service basis.

ACCESS II, is a demonstration program building upon the principles and infrastructure of the Carolina ACCESS program. The goal of the program is to promote a health care system that retains dollars in the local delivery of services, while assisting local providers to develop organized managed care systems that coordinate a full continuum of care with processes to influence cost and quality of care. The two models included in ACCESS II are the enhanced care management model and the community care network model.

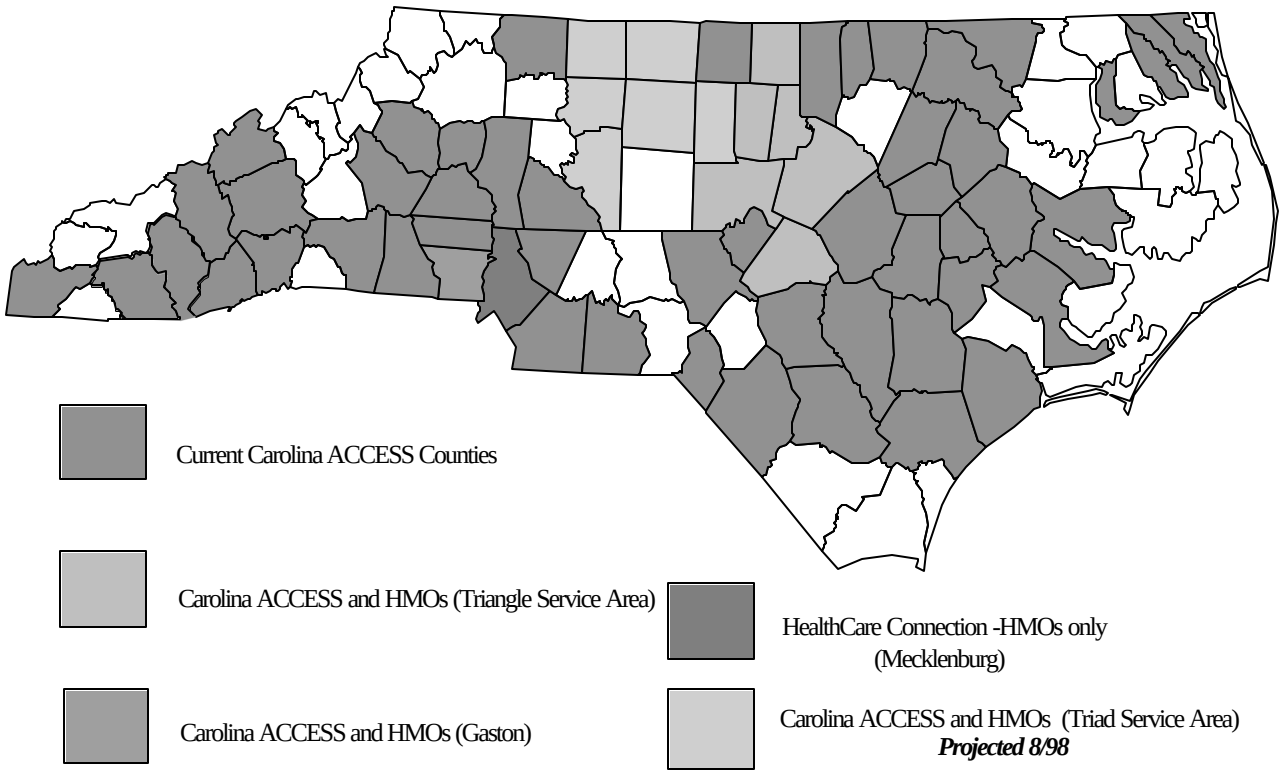
The enhanced care management model involves working with those Carolina ACCESS providers with 2,000 or more current enrollees to set up selected demonstration sites across the state. These demonstration sites will develop managed care strategies that can be used in these practices.

The community care network model involves a county-wide approach to addressing the needs of the Medicaid population in a particular county. Pitt and Cabarrus counties have been selected as feasibility study sites for this model.

ACCESS II is being developed by the N.C. Foundation for Alternative Health Programs, Inc. in concert with DMA and is funded, in part, by the Kate B. Reynolds Health Care Trust. Questions about the program should be addressed to the Foundation at 919-821-0485.

Medicaid Managed Care

February 1998



County Managed Care Representatives

County	Managed Care Representative	Phone #
Alamance	Betty London	910-229-2949
Alexander	Martha Boyle	704-632-1080
Anson	Mary Beth Gaddy	704-694-9351
Beaufort	Mary Jo Guthrie	919-975-4456
Bladen	Janice Ussery	910-862-6831
Buncombe	Marty Phillips	704-255-5696
Burke	Mary Anna Cooper	704-439-2000
Cabarrus	Vickie Carpenter	704-786-7141
Caldwell	Deborah Dlugos	704-757-1444
Camden	Beth Sawyer	919-331-4787
Caswell	Lois Williamson	910-694-4141
Catawba	Melanie Whitener	704-326-5655
Chatham	Cindy Moore	919-542-2759
Cherokee	Mary Ann Measmer	704-837-7455
Chowan	Robin Hughes	919-482-7441
Cleveland	Karen Sweezy	704-487-0661
Craven	Mark Mehan	919-636-4900

Currituck	Yvette Combs	919-232-3983
Davidson	Vickie Hedrick	910-242-2579
Duplin	Karen Tyndall	910-296-2200
Durham	Gwen Tilley	919-560-8767
Edgecombe	Yvonne Parker	919-641-7646
Forsyth	Cynthia Brammer	336-727-8349
	Dona Ayers	336-727-8376
Gaston	Brian Robinson	704-866-3084
	Stephanie Lilley	704-866-3454
Granville	Gerald Hamilton	919-693-1511
Greene	Sherry Askew	919-747-5932
Guilford/Greensboro	Christine Chaplik	910-333-6061
	Scott Vestal	336-333-6986
Guilford/High Point	Ellen Bishop	910-884-7694
Halifax	Cathey Ralph	919-536-6411
Harnett	Diena Burton	910-893-7500
Haywood	Renee Cable	704-452-6620
Henderson	Judith Pittillo	704-698-5618
Iredell	Krista McMillan	704-873-5631
Jackson	Mickey Luker	704-586-5546
Johnston	Melony Gupton	919-989-5462
Lee	Sandra Hall	919-774-4955
Lenoir	Elaine Harris	919-559-6340
Lincoln	Donna Corriher	704-732-0738
Macon	Sharon Bradham	704-349-2141
	Sharon Moslet	704-349-2161
Madison	Debbie Robinson	704-649-2711
Moore	Paulette Chisesi	910-947-2436
Nash	Shirley Cobb	919-459-1415
Northampton	Debby Gay	919-534-5811
Onslow	Pat Lamb	910-938-5513
Orange	Rose Minton	919-732-8181
Pamilco	Sandy McCotter	919-745-4086
Pasquotank	Jo Ellen Smith	919-338-2126
Pender	Sherese Smith	910-259-1341
Person	Betty Reeves	910-599-8361
Pitt	Cheryl Nelson	919-413-1129
Robeson	Nancy Thompson	910-671-3208
	Shannon Raney	910-737-5006
Rockingham	Debra Griffin	910-342-1394
Rutherford	Susan Street	704-287-6270
Sampson	Erma Thornton	910-592-7131
Scotland	Sandy Lockey	910-277-3120
Stokes	Ann Vance	910-593-2861
Surry	Libbie Inman	910-401-8718
Transylvania	Carla Owens	704-884-3174
Union	Carolyn Phillips	704-282-0253
Wake	Alice Wilkerson	919-212-7817
Warren	Maurine King	919-257-1283
Wayne	Lyn Perry	919-731-1293
Wilson	Katrina Barnes	919-206-4000

Attention: Hospitals and Physicians

Supervision of Residents in Teaching Hospitals

The following states the supervision requirements of the Division of Medical Assistance. It is being added to hospital provider agreements.

> Hospitals must have current written policy that defines supervision requirements of residents and fellows by teaching physicians including a plan for compliance.
>
> Teaching physicians must use the "immediately available" standard in supervising residents and assume full responsibility for the health and safety of their patients.
>
> Board certified or eligible physicians with a valid medical license and a current Medicaid provider number may bill the North Carolina Program while concurrently pursuing fellowship in a subspecialty. Salary and other pertinent costs for these physicians can not be included in any hospital or other hospital cost reports submitted to federal or state programs.

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

Attention: All Providers

DMA Eligibility Toll-Free Number

Effective March 1, 1998, the Division of Medical Assistance (DMA) will change the method for providing eligibility information. The toll free number 1-800-662-7547 will be discontinued, but providers may obtain recipient eligibility through the following sources:

- EDS Voice Inquiry toll free number, 1-800-723-4337;
- Electronic Data Interchange (EDI) vendors (vendors listed below);
- Blue Cross network;
- Recipient's Medicaid ID Card.

Providers should attempt to obtain Medicaid information from the Medicaid recipient or responsible person by viewing the Medicaid identification card. When this is not possible, providers may call DMA at 919-733-4600 to obtain the Medicaid number only. Eligibility for dates of service must be verified on the EDS voice inquiry. Providers may verify eligibility for dates of service over 12 months old at 919-733-4600.

Approved EDI vendors are:

Envoy Corporation
Two Lakeview Place
15 Century Boulevard, Suite 600
Nashville, TN 37214
Contact: Marketing Department
1-800-366-5716

MediFAX, The Potomac Group
1283 Murphreesboro Road
Building II
Nashville, TN 37217
Contact: Galen LaBauve
1-800-444-4336

NDC Healthcare EDI Services
1854 Shackleford Ct. Suite 200
Norcross, GA 30093
Contact: Bill Johnson
1-800-882-0802

Healthcare Data Exchange Corp
101 Lindenwood Drive
Malvern, PA 19355
Contact: Steve Aylward
610-219-1784

Claims Analysis Unit
DMA, 919-733-4600

Attention: All Providers

New Laboratory Panels for Automated Tests

The American Medical Association (AMA) CPT Board approved new automated laboratory panels that comprise specific automated tests frequently performed in conjunction with one another. They were developed to facilitate ordering of common groupings of tests. The CPT codes for these new panels can only be used for date of service January 1, 1998 or after. CPT codes 80002 through 80019 for 2 through 19 nonspecified automated multi-channel tests and HCPCS codes G0058-G0060 for 19 or more tests have been replaced.

Although the AMA CPT has approved the new automated laboratory panels and eliminated CPT codes 80002-80019 for usage as of January 1, 1998, DMA will allow a three month grace period for users to implement these changes. During this grace period, which ends March 31, 1998, DMA encourages laboratories to begin using the new codes as quickly as possible. After March 31, 1998, the new panel codes are the only billing codes that can be used for groupings of automated tests. Claims for lab services performed after March 31, 1998 using codes 80002-80019 or G0058-G0060 will be denied.

The new CPT 1998 Panel Codes for automated tests replacing CPT 80002-80019 and G0058-G0060 are:

80049 Basic metabolic panel
This panel must include the following:
- Carbon dioxide (82374)
- Chloride (82435)
- Creatinine (82565)
- Glucose (82947)
- Potassium (84132)
- Urea Nitrogen (BUN) (84520)

80051 Electrolyte panel
This panel must include the following:
- Carbon dioxide (82374)
- Chloride (82435)
- Potassium (84132)
- Sodium (84295)

80054 Comprehensive metabolic panel
This must include the following:
- Albumin (82040)
- Bilirubin, total OR direct (82250)
- Calcium (82310)
- Chloride (82435)
- Creatinine (82565)
- Glucose (82947)
- Phosphatase, alkaline (84075)
- Potassium (84132)
- Protein, total (84155)
- Sodium (84295)
- Transferase, aspartate amino (AST)(SGOT)(84450)
- Urea Nitrogen (BUN)(84520)

Physicians should identify which of the following they wish to order and if the tests match a grouping, the panel should be billed. Any other tests not included in the grouping should be separately billed. However, unnecessary tests must not be added in order to match a panel. If the order does not match any panel, separately bill all tests on the claim.

82040	Albumin
82250	Bilirubin, Direct or Total
82551	Bilirubin, Total & Direct
83210	Calcium
82374	Carbon Dioxide Content
	(SGOT)
82435	Chlorides
82465	Cholesterol
82550	CPK (Creative Phosphoskinase)
82565	Creatinine
82947	Glucose (Sugar, Fasting Blood)
82977	GGT (Gamma Glutamyl)
	(Transpeptidase)
83615	Lactic Dehydrogenase (LDH)
84075	Phosphatase, Alkaline
84100	Phosphorus
84132	Potassium
84155	Protein Total
84295	Sodium
84450	Transaminase, Glutamix Oxa Oacetic
84460	Transaminase, Glutamic Pyruvic (SGPT)
84478	Triglycerides
84520	Urea Nitrogen (BUN)
84550	Uric Acide

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

Attention: CAP MR/DD Providers

Code and Rate Changes

The Division of Medical Assistance and the Division of Mental Health/Developmental Disabilities/Substance Abuse have worked closely with CAP-MR program stakeholders to develop fair and reasonable rates. As a result of this study, effective with date of service January 1, 1998, the following changes were made:

W8155 Rate is $5.30

W8156 Description is changed to "Prevocational Services, Group,Level I" and the rate is $3.50.

W8187 New code: "Prevocational Services, Group, Level II", rate is $2.00 per 15 minute unit.

W8157 Rate is $7.25

W8177 Description changed to include "Individual" and the rate is $5.30 per 15 minute unit

W8186 New code: "Community Inclusion, group", rate is $3.50 per 15 minute

W8182 Description changed to include "Level 1", and the rate is $80.00 per day

W8183 New code: "Supported Living, Level 2, and the rate is $108.00 per day

W8184 New code: "Supported Living, Level 3, and the rate is $135.00 per day

W8185 New code: "Supported Living, Thomas S clients, and the rate is $150.00 per day

W8103 CAP MR/DD Case Management is end-dated effective 12-31-97

W8188 New Code: "CAP MR/DD Case Management, monthly" for use by Area Programs only. Payment is $509.00 per month per recipient. Area Programs are instructed to include on the case management claim the actual number of service units delivered in the applicable period.

W8163 Bill code at cost; do not include prior 10% overhead when billing

W8164 Bill code at cost; do not include prior 10% overhead when billing

W8165 Bill code at cost; do not include prior 10% overhead when billing

W8151 Bill code at cost; do not include prior 10% overhead when billing

W8153 Bill code at cost; do not include prior 10% overhead when billing

W8149 Bill code at cost; do not include prior 10% overhead when billing

W8180 Bill code at cost; do not include prior 10% overhead when billing

No adjustments will be made for claims already processed.

Providers are reminded to bill their usual and customary rates.

Jim Panton, Financial Operations
DMA, 919-733-6784

Attention: All Providers

New Advance Directive For Mental Health Treatment

This article summarizes some of the important elements of a new North Carolina law, effective January 1, 1998, entitled "An Act To Establish Advance Instruction For Mental Health Treatment" (see, North Carolina General Statutes §122C-71 through §122C-77). The purpose of the law is to create a method for an individual to exercise the right to consent to or refuse mental health treatment if the individual later becomes "incapable" (i.e., lacks the capacity or ability to make and communicate mental health treatment decisions). Any adult of sound mind can make an Advance Instruction for Mental Health Treatment (AIMHT). The instruction may include information and preferences regarding mental health treatment. The individual may appoint a competent adult as an "attorney-in-fact" who shall make the mental health treatment decisions on behalf of the individual only when the individual is incapable. Treatment decisions shall be consistent with desires the individual expressed in the AIMHT. The advance instruction will become effective when delivered to the individual's physician or mental health treatment provider, who then makes it part of the individual's medical record. It remains valid for two years unless revoked. The physician or mental health treatment provider shall act in accordance with the AIMHT, except in certain circumstances, when a physician or psychologist has determined the individual is incapable. An advance instruction for mental health treatment can be combined with, or incorporated into, a health care power of attorney or a general power of attorney. A copy of this new law (Senate Bill 757) which contains a statutory form, may be obtained from the Printed Bills office of the N.C. General Assembly (919-733-5648).

The issue of Advance Directives was addressed in the federal Patient Self-Determination Act (PSDA) which became effective December 1, 1991. The PSDA applies to hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, health maintenance organizations and health insuring organizations.

One provision of the federal law requires that the providers described above distribute the Division of Medical Assistance pamphlet summarizing the state law on advance directives to patients 18 years and older. The pamphlet is titled "Medical Care Decisions and Advance Directives - What You Should Know" and was originally distributed in the November 1991 Medicaid Special Bulletin. An updated version of this pamphlet, including information on the AIMHT, is included in this Bulletin. The document is two pages, should be photocopied on the front and back of one sheet of paper and folded in half to form a four-page pamphlet. Prior to distributing the pamphlet, the provider must indicate in the box on the last page of the pamphlet a contact for the patient to obtain more information. The name and/or number of the contact must be written, typed or stamped in the box. The contact must be within the provider's organization, but may either supply information to the patient or refer the patient to sources of information outside the provider's organization.

We expect providers to photocopy and distribute the pamphlet as is. Providers, however, may choose to alter the document graphically, but **may not** change or delete text, or the order of the paragraphs. In addition, a provider-published pamphlet must include the NC Department of Health and Human Services logo and the production statement on page four of the folded pamphlet.

Ann Hemmens, Medical Policy
DMA, 919-733-2833

advance instruction for mental health treatment while you are able to make and make known your decisions, by telling your doctor or other provider that you want to cancel it.

Whom should I talk to about an advance directive?

You should talk to those closest to you about an advance directive and your feelings about the health care you would like to receive. Your doctor or health care provider can answer medical questions. A lawyer can answer questions about the law. Some people also discuss the decision with clergy or other trusted advisors.

Where should I keep my advance directive?

Keep a copy in a safe place where your family members can get it. Give copies to your family, your doctor or other health care provider, your health care agent, your attorney-in-fact and any close friends who might be asked about your care should you become unable to make decisions.

What if I have an advance directive from another state?

An advance directive from another state may not meet all of North Carolina's rules. To be sure about this, you may want to make an advance directive in North Carolina too. Or you could have your lawyer review the advance directive from the other state.

Where can I get more information?

Your health care provider can tell you how to get more information about advance directives by contacting:

This document has been developed by the North Carolina Division of Medical Assistance in cooperation with the Department of Human Resources Advisory Panel on Advance Directives 1991. Revised 1998.

Medical Care Decisions and Advance Directives
What You Should Know

What are My Rights?

Who decides about my medical care or treatment?

If you are 18 or older and mentally competent, you have the right to make decisions about your medical treatment. You should talk to your doctor or other health care provider about any treatment or procedure so that you understand what will be done and why. You have the right to say yes or no to treatments recommended by your doctor. If you want to control decisions about your health care even if you become unable to make or to express them yourself, you will need an "advance directive."

What is an "advance directive"?

An advance directive is a set of directions you give about the health care you want if you ever lose the ability to make decisions for yourself. North Carolina has three ways for you to make a formal advance directive. One way is called a "living will"; another is called a "health care power of attorney"; and another is called an "advance instruction for mental health treatment."

Do I have to have an advance directive and what happens if I don't?

Making a living will, a health care power of attorney or an advance instruction for mental health treatment is your choice. If you become unable to make your own decisions, and you have no living will or a person named to make medical decisions for you ("health care agent"), your doctor or health care provider will consult with someone close to you about your care. If you have no advance instruction for mental health treatment, or person named to make mental health treatment decisions for you ("attorney-in-fact"), then your doctor or mental health treatment provider will consult with someone close to you about your care.

Living Will

What is a living will?

In North Carolina, a living will is a document that tells others that you want to die a natural death if you are terminally and incurably sick or in a persistent vegetative state from which you will not recover. In a living will, you can direct your doctor not to use heroic treatments that would delay your dying, for example by using a breathing machine ("respirator" or "ventilator"), or to stop such treatments if they have been started. You can also direct your doctor not to begin or to stop giving you food and water through a tube ("artificial nutrition or hydration").

Health Care Power of Attorney

What is a health care power of attorney?

In North Carolina, you can name a person to make medical care decisions for you if you later become unable to decide yourself. This person is called your "health care agent." In the legal document you name who you want your agent to be. You can say what medical treatments you would want and what you would not want. Your health care agent then knows what choices you would make.

How should I choose a health care agent?

You should choose an adult you trust and discuss your wishes with the person before you put them in writing.

Advance Instruction for Mental Health Treatment

What is an advance instruction for mental health treatment?

In North Carolina, an advance instruction for mental health treatment is a legal document that tells doctors and health care providers what mental health treatments you would want and what treatments you would not want, if you later become unable to decide yourself. With this document, you can also choose someone to make these decisions for you when you are unable to make them. This person is called your "attorney-in-fact." This person does not have to be a lawyer.

How should I choose an attorney-in-fact for mental health treatment?

You should choose an adult you trust and discuss your wishes with that person. This person needs to sign the advance instruction for mental health treatment, agreeing to make these decisions for you.

Other Questions

How do I make an advance directive?

You must follow several rules when you make a formal living will, health care power of attorney or an advance instruction for mental health treatment. These rules are to protect you and ensure that your wishes are clear to the doctor or other provider who may be asked to carry them out. A living will, a health care power of attorney and an advance instruction for mental health treatment must be written and signed by you while you are still able to understand your condition and treatment choices and to make those choices known. All three types of advance directives must be witnessed by two qualified people. The living will and the health care power of attorney also must be notarized.

Are there forms I can use to make an advance directive?

Yes. There is a living will form, a health care power of attorney form and an advance instruction for mental health treatment form that you can use. These forms meet all of the rules for a formal advance directive. Using the special form is the best way to make sure that your wishes are carried out.

When does an advance directive go into effect?

A living will goes into effect when you are going to die soon and cannot be cured, or when you are in a persistent vegetative state. The powers granted by your health care power of attorney go into effect when your doctor states in writing that you are not able to make or to make known your health care choices. When you make a health care power of attorney, you can name the doctor you would want to make this decision. An advance instruction for mental health treatment goes into effect when it is given to your doctor. The doctor will follow the instructions you have put in the document, except in certain situations, after the doctor determines that you are not able to make and to make known your choices about mental health treatment. After a doctor determines this, if you have an attorney-in-fact that person may make treatment decisions for you. An advance instruction for mental health treatment expires after two years.

What happens if I change my mind?

You can cancel your living will anytime by informing your doctor that you want to cancel it and destroying all the copies of it. You can change your health care power of attorney while you are able to make and make known your decisions, by signing another one and telling your doctor and each health care agent you named of the change. You can cancel your

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Attention: Hospital and Nursing Facility Providers

Medicaid Credit Balance Reporting

Hospital and Nursing Facility providers of health care services participating in the Medicaid program are required to submit a **Quarterly Medicaid Credit Balance Report** (copy attached for your reproduction). The Division of Medical Assistance (DMA) does not furnish copies of this form.

This report must include all OUTSTANDING Medicaid credit balances reflected in your accounting records as of the last day of each calendar quarter. The report is to be sent to DMA no later than 30 days following the end of the calendar quarter (March 31, June 30, September 30 and December 31). **A report is required even if a zero ($0.00) credit balance exists.**

The Medicaid Credit Balance Report is used to monitor and recover "credit balances" due the Medicaid program. A credit balance is defined as an improper or excess payment made to a provider as the result of recipient billing or claims processing errors. For example, if a provider is paid twice for the same services (e.g., by Medicaid and another insurer), a refund must be made to Medicaid.

For the purpose of completing the report, a Medicaid credit balance is an amount determined to be refundable to the Medicaid program. Generally, when a provider receives an improper or excess payment for a claim, it is reflected in their accounting records (patient accounts receivable) as a "credit." However, Medicaid credit balances include money due the program regardless of its classification in a provider's accounting records.

For example, if a provider maintains a credit balance account for a stipulated period, e.g., 90 days, and then transfers the account or writes it off to a holding account, this does not relieve the provider of its liability to the program. In these instances, the provider is responsible for identifying and repaying all of the monies due the Medicaid program.

The detail form requires specific information on each credit balance on a claim-by-claim basis. The detail form provides space for 15 claims but it may be reproduced as many times as necessary to accommodate all of the credit balances that are to be reported. Specific instructions for completing the report are on the reverse side of the reporting form.

Submit **ONLY** the completed Medicaid Credit Balance Report to:

Division of Medical Assistance
Third Party Recovery Section
Post Office Box 29551
Raleigh, NC 27626-0551

Send any refunds due or recoupment requests directly to EDS as you normally do with all necessary documentation to process the refund or recoupment. **DO NOT** send refunds or recoupment requests to DMA.

Failure to submit a Medicaid Credit Balance Report in a timely manner could result in the withholding of Medicaid payments until the report is received.

Third Party Recovery
DMA, 919-733-6294

MEDICAID CREDIT BALANCE REPORT

PROVIDER NAME: _____ CONTACT PERSON: _____

PROVIDER NUMBER: _____ TELEPHONE NUMBER: ( )_____

QUARTER ENDING:

(1) RECIPIENT'S NAME	(2) MEDICAID NUMBER	(3) FROM DATE OF SERVICE	(4) TO DATE OF SERVICE	(5) DATE MEDICAID PAID	(6) MEDICAID ICN	(7) AMOUNT OF CREDIT BALANCE	(8) REASON FOR CREDIT BALANCE
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							

(See back of form for instructions)

Instructions for Completing Medicaid Credit Balance Report

Complete the "Medicaid Credit Balance Report" as follows:

- Full name of facility as it appears on the Medicaid Records
- The facility's **Medicaid** provider number. If the facility has more than one provider number, use a separate sheet for each number. **DO NOT MIX**
- The month and year of the reporting quarter, e.g., September 1996
- The name and telephone number of the person completing the report. This is needed in the event DMA has any questions regarding some item in the report

Complete the data fields for each Medicaid credit balance by providing the following information:

Column 1 - The last name and first initial of the Medicaid recipient (e.g., Doe, J.)

Column 2 - The individual Medicaid identification (MID) number

Column 3 - The month, day, and year of beginning service (e.g., 12/05/95)

Column 4 - The month, day, and year of ending service (e.g., 12/10/95)

Column 5 - The R/A date of Medicaid payment (not your posting date)

Column 6 - The Medicaid ICN (claim) number

Column 7 - The amount of the credit balance

Column 8 - The reason for the credit balance by entering: "81" if it is a result of a Medicare payment; "83" if it is the result of a health insurance payment; "84" if it is the result of a casualty insurance/attorney payment or "00" if it is for another reason. Please explain "00" credit balances on the back of the form.

After this report is completed, total column 7 and mail to DMA.

Note: These instructions are printed on the back of the actual Credit Balance Report.

Attention: Dental Providers

Seminars

Dental seminars will be held in April 1998. The March Medicaid Bulletin will have the registration form for the seminars and a list of site locations. Please suggest topics you would like addressed at the seminars. List topics and issues and return to:

Provider Representative
EDS
P.O. Box 300009
Raleigh, NC 27622

Attention: All Providers

Seminars

General Medicaid seminars intended for new Medicaid providers will be held in April 1998. The March Medicaid Bulletin will have the registration form for the seminars and a list of site locations. Please suggest topics you would like addressed at the seminars. List topics and issues and return to:

Provider Representative
EDS
P.O. Box 300009
Raleigh, NC 27622

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Attention: Health Check Providers (Excluding Health Department)

Seminar Schedule

Seminars for Health Check providers will be held in March 1998. Medicaid billing supervisors, office managers, and billing personnel are encouraged to attend. This seminar will focus on program coverage, coding, claim form completion, free vaccine program, and follow-up on the most common identified denials.

Please select the most convenient site and return the completed registration form to EDS as soon as possible. Seminars begin at 10:00 a.m. and end at 1:00 p.m. Providers are encouraged to arrive by 9:45 a.m. to complete registration. **Preregistration is strongly recommended**.

Directions are available on page 23 of this bulletin.

Thursday, March 5, 1998
Catawba Valley Technical College
Highway 64-70
Hickory, NC
Auditorium

Wednesday, March 11, 1998
A-B Technical College
340 Victoria Road
Asheville, NC
Simpson Lecture Room

Tuesday, March 17, 1998
Wake MEI Conference Center
3000 New Bern Avenue
Raleigh, NC

Friday, March 20, 1998
Martin Community College
Kehakee Park Road
Williamston, NC
Auditorium

Wednesday, March 25, 1998
Holiday Inn
4903 Market Street
Wilmington, NC

Tuesday, March 31, 1998
Ramada Inn
I-85 & 62 South
2703 Ramada Road
Burlington, NC

(cut and return registration form only)

Health Check Provider Seminar Registration Form
(No Fee)

Provider Name _____ Provider Number _____

Address _____ Contact Person _____

City, Zip Code_____ County _____

Telephone Number_____ Date_____

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

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

Attention: Durable Medical Equipment Providers

Seminar Schedule

Seminars for Durable Medical Equipment (DME) providers will be held in March 1998. This seminar will focus on Medicaid guidelines for DME equipment and supplies, prior approval procedures, Certificate of Medical Necessity and Prior Approval form, claims filing, and post payment review.

Note: Providers are requested to bring the November 1997 North Carolina Durable Medical Equipment manual to the seminar as a reference source. Additional manuals will be available for purchase at $12.00.

Please select the most convenient site and return the completed registration form to EDS as soon as possible. Seminars begin at 10:00 a.m. and end at 1:00 p.m. Providers are encouraged to arrive by 9:45 a.m. to complete registration. **Preregistration is strongly recommended**.

Directions are available on page 23 of this bulletin.

Wednesday, March 4, 1998
Wake MEI Conference Center
3000 New Bern Avenue
Raleigh, NC

Thursday, March 5, 1998
Holiday Inn
4903 Market Street
Wilmington, NC

Tuesday, March 10, 1998
A-B Technical College
340 Victoria Road
Asheville, NC
Simpson Lecture Room

Friday, March 13, 1998
Ramada Inn Airport Central 1
515 Clanton Road
Charlotte, NC

Wednesday, March 18, 1998
Ramada Inn
3050 University Parkway
Winston-Salem, NC
Carnegie Dupont Room

Friday, March 27, 1998
Martin Community College
Kehakee Park Road
Williamston, NC
Auditorium

(cut and return registration form only)

DME Provider Seminar Registration Form
(No Fee)

Provider Name _____ Provider Number _____

Address _____ Contact Person _____

City, Zip Code_____ County _____

Telephone Number_____ Date_____

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

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

Attention: All Providers

Directions to the DME and Health Check Seminars

Registration forms for these workshops are on pages 21 and 22 of this bulletin.

Wake Medical MEI Conference Center, Raleigh

March 4, 1998 - DME Seminar

March 17, 1998 - Health Check Seminar

Take the I-440 Raleigh beltline to New Bern Avenue, Exit 13A. Go toward Wake Medical Center on New Bern Avenue and at the stoplight at Sunnybrook Road, turn left. Park in the medical office center parking lot. Parking is free. Walk back to New Bern Avenue up the sidewalk in front of the Wake County Department of Health and stay on the sidewalk until it leads you to the Medical Education Institute. Enter the building at the far left Conference Center Entrance and follow the signs to your classroom.

Holiday Inn, Wilmington

March 5, 1998 - DME Seminar

March 25, 1998 - Health Check

I-40 East into Wilmington to Highway 17 - just off of I-40. Turn left onto Market Street and Holiday Inn is located on the right.

A-B Technical College, Asheville

March 10, 1998 - DME Seminar

March 11, 1998 - Health Check Seminar

I-40 to Exit 50. Head North on Hendersonville Road to intersection with Route 25 (McDowell Street). Take a left on Route 25 to Intersection with Victoria Road. Take a left onto Victoria Road to the Administration Building.

Ramada Inn Airport Central, Charlotte

March 13, 1998 - DME Seminar

I-77 to exit 7. Ramada Inn is located right off I-77 on Clanton Road. Signs will be posted with room locations.

Ramada Inn Plaza, Winston-Salem

March 18, 1998 - DME Seminar

I-40 Business to Cherry Street Exit. Continue on Cherry Street for 2-3 miles. Get in the left hand turn lane and make a left at IHOP Restaurant. The Holiday Inn is located behind the IHOP Restaurant.

Martin Community College, Williamston

March 27, 1998 - DME Seminar

March 20, 1998 - Health Check Seminar

Take Highway 64 into Williamston. College is approximately 1-2 miles west of Williamston. The Auditorium is located in building 2.

Catawba Valley Technical College, Hickory

March 5, 1998 - Health Check Seminar

Take I-40 to exit 125 and go approximately 1/2 mile to Highway 70. Head East on Highway 70 and College is approximately 1.5 miles on the right.

Ramada Inn, Burlington

March 31, 1998 - Health Check Seminar

I-40 to Exit 143. At the first stoplight make a left on Ramada Road. The Ramada Inn is located at the top of the hill.

Checkwrite Schedule

February 3, 1998	March 3, 1998	April 7, 1998
February 10, 1998	March 10, 1998	April 14, 1998
February 19, 1998	March 17, 1998	April 23, 1998
	March 26, 1998	

Electronic Cut-Off Schedule *

January 30, 1998	February 27, 1998	April 3, 1998
February 6, 1998	March 6, 1998	April 9, 1998
February 13, 1998	March 13, 1998	April 17, 1998
	March 20, 1998	

* ***Electronic claims must be transmitted and completed by 5:00 p.m. EST on the cut-off date to be included in the next checkwrite as paid, denied, or pended. Any claims transmitted after 5:00 p.m. will be processed on the second checkwrite as paid, denied, or pended following the transmission date.***

Paul R. Perruzzi, Director	James R. Clayton
Division of Medical Assistance	Executive Director
Department of Health and Human Services	EDS

EDS

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