



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

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

Bold, italicized material is excerpted from the American Medical Association Current Procedural Terminology CPT Codes. Descriptions and other data only are copyrighted 2001 American Medical Association. All rights reserved.

Attention: All Providers**Carolina ACCESS Provider Application Available on the Internet**

The Carolina ACCESS Provider Application for Participation and the instructions for completing it are now available on the Division of Medical Assistance's website at <http://www.dhhs.state.nc.us/dma> under the heading "Provider Enrollment Applications."

It is extremely important that the information on file with DMA for all Carolina ACCESS (CA) practices remains current and accurate to avoid potential claim denials or contract sanctions. Providers are responsible for ensuring that information on file with the **Medicaid** program for their practice or facility remains up-to-date. The Carolina ACCESS Provider Information Change form is available on DMA's website under the heading "Forms." (Refer to the article entitled *Reporting Changes in Provider Status to Medicaid* in the October 2001 general Medicaid bulletin for information on notifying Medicaid of changes within your practice.)

Questions about participating with the CA program or general questions about CA should be directed to the regional Managed Care Consultant (refer to the January 2002 general Medicaid bulletin) or DMA Managed Care at 919-857-4022.

Provider Services
DMA, 919-857-4017

Attention: Durable Medical Equipment Providers**HCPCS Code Changes**

The following code changes are effective with date of service April 1, 2002:

Old Code	New Code	Description	Quantity Limitation	Maximum Reimbursement Rate
W4063	A4215	Needle only, sterile, any size	200 per month	\$.14 new purchase
W4050	E1390	Oxygen concentrator, capable of delivering 85 percent or greater oxygen concentration at the prescribed rate	N/A	\$223.30 monthly rental
W4142	K0031	Safety belt/pelvic strap	1 per 2 years	\$ 4.03 monthly rental \$ 40.30 new purchase \$ 30.24 used purchase
W4149	K0107	Wheelchair tray	1 per 2 years	\$ 10.12 monthly rental \$101.03 new purchase \$ 75.58 used purchase

Only code E1390 requires prior approval. However, as with all durable medical equipment, a Certificate of Medical Necessity and Prior Approval form must be completed.

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

Attention: Independent Practitioner Program Providers, Local Education Agencies, All Providers of Outpatient Occupational, Physical, Speech, and Respiratory Therapy Services, Home Health Agencies, and Physicians

Prior Approval Process

Effective with dates of service June 1, 2002, a prior approval process will be utilized for all outpatient occupational, physical, speech, and respiratory therapy services regardless of provider or setting. A contract is being initiated with Medical Review of North Carolina (MRNC) to review these services and authorize care at designated trigger points. After these trigger points have been reached, claims will not process without prior approval.

Workshops regarding the prior approval process and billing are scheduled for the third week of May 2002. Please read your May general Medicaid bulletin promptly. The registration form and a list of the workshop locations will be included in the May general Medicaid bulletin.

Nora Poisella, Behavioral Health Services
Carol Robertson, Behavioral Health Services
DMA, 919-857-4020

Attention: Health Departments

Provision of Psychological Services in Health Departments

Effective July 1, 2002, health departments and school-based health centers sponsored by health departments may bill the following Current Procedural Terminology (CPT) codes for psychological services for the under 21 population.

90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814 and 90846, 90847 and 90853

Psychological services must be provided by a Licensed Clinical Social Worker (LCSW), an Advanced Practice Psychiatric Clinical Nurse Specialist (CNS), Advanced Practice Psychiatric Nurse Practitioner (NP) or Licensed Psychologist. All providers must function within the scope and practice of their state license and certification.

One of the following ICD-9-CM diagnosis codes must be present for the claim to process:

295.0 through 304.9	307.54	V15.41 and V15.42
305.0	307.9	V40 through V40.9
305.2 through 305.9	308 through 309.9	V62.81, V62.82, and V62.83
307.50	311 through 314.9	V70.1 and V70.2
307.51	V11.0 through V11.9	

The CPT codes are subject to prior approval from ValueOptions prior to the 27th visit in any calendar year.

Carol Robertson, Behavioral Health Services
DMA, 919-857-4020

Attention: Nursing Facility Providers

Tracking Forms for the Preadmission Screening and Annual Resident Review Process

Because providers continue to neglect to forward a Tracking Form to First Health (FH) for new admissions, the following article is reprinted from the January 2001 general Medicaid bulletin. Facilities that do not have the Level I and, if appropriate, Level II information as part of the medical record will be out of compliance with the Preadmission Screening and Annual Resident Review (PASARR) regulations and subject to penalty.

To assure compliance with the federally mandated PASARR requirements, all Medicaid certified nursing facilities **must complete the PASARR Tracking Form** for every admission, regardless of pay source, and forward it to FH, the Division of Medical Assistance's contractor for the PASARR program. The information documented on the **Tracking Form** communicates to FH the name of the admitting facility and assures that the facility will receive a copy of the Level I and, if appropriate, Level II screening results.

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

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

Tracking Forms must be completed for the following:

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

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

Attention: Nursing Facility Providers

Requests for Retroactive Prior Approval

Because providers continue to request retroactive prior approval for time periods exceeding the maximum 90 days allowed, the following article is reprinted from the January 2001 general Medicaid bulletin.

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

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

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

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

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

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

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

Attention: All Providers

Changes to the Initial Hemoglobin or Hematocrit Health Check Screening Component

Effective April 1, 2002, hemoglobin or hematocrit levels must initially be measured in infants between the ages of 9 to 12 months as recommended in the American Academy of Pediatrics (AAP) guidelines. Previously, Health Check policy required that hemoglobin or hematocrit levels initially be measured between the ages of 1 to 9 months of age.

This change allows providers to perform hemoglobin or hematocrit screenings at the same time as the initial lead screenings performed at 12 months of age. As a reminder, federal regulations require lead screenings be performed at 12 and 24 months of age.

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

Attention: All Providers

CPT Code Bundling

Over the next several months, the Division of Medical Assistance will be implementing bundling of Current Procedural Terminology (CPT) codes according to version 7.3 and 8.0 of the Correct Coding Initiative (CCI). The CCI was developed by the Centers for Medicare and Medicaid Services (CMS) when the Resource-Based Relative Value System (RBRVS) fee schedule for physician payment was implemented. Additional information about the CCI can be found online at <http://www.hcfa.gov/medlearn/ncci.htm>.

Since procedures should be billed using the most comprehensive code to describe the service performed, the CCI bundles the component procedures of the service into the comprehensive code. Only the comprehensive code is paid.

Providers will receive an Explanation of Benefits (EOB) denial code if a component code is billed with the comprehensive code. The EOB indicates that the component code cannot be billed in addition to the comprehensive code.

Modifiers that define a separately identifiable service, such as modifier 59, will allow some coding pairs to unbundle. Medical records documenting the appropriate use of the modifier must be kept on file for at least five years to allow for post-payment reviews.

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

Attention: Physicians

Case Conference for Sexually Abused Children

Effective with date of service April 1, 2002, procedure code W8241 will be end-dated to comply with the implementation of national procedure codes mandated by the Health Insurance Portability and Accountability Act.

Effective with date of service, April 1, 2002, Current Procedural Terminology (CPT) procedure code 99361 or 99362 should be billed to report a **face-to-face** case conference by a physician with health professionals or community agency representatives to coordinate patient care for sexually abused children.

99361 *Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient not present); approximately 30 minutes*

99362 *approximately 60 minutes*

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

Attention: Hospital Providers

Revenue Code Changes

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all health care providers to comply with the implementation of standardized national code sets. Therefore, the N.C. Medicaid program has revised definitions for the revenue codes (RC) listed below effective February 1, 2002.

Revenue Code	Old Definition	New Definition
RC 206	Intensive Care Post – ICU	Intensive Care: Intermediate ICU
RC 214	Coronary Care Post – CCU	Coronary Care: Intermediate ICU
RC 254	Drugs Less Than Effective	Pharmacy: Drugs Incident to Other Diagnostic Services
RC 274	Supplies and Solutions for Nutritional Therapy	Medical /Surgical Supplies and Devices: Prosthetic/Orthotic Devices
RC 780	Teleconsult Spoke Visit	Telemedicine: General Classification
RC 829	Facility Retrain Fee Per Session: Hemodialysis	Hemodialysis - Outpatient or Home: Other Outpatient Hemodialysis
RC 839	Facility Retraining Session: Peritoneal	Peritoneal Dialysis - Outpatient or Home: Other Outpatient Peritoneal Dialysis
RC 882	Miscellaneous Dialysis –Ultrafiltration	Miscellaneous Dialysis: Home Dialysis Aide Visit
RC 911	Not Defined	Psychiatric/Psychological Services: Rehabilitation
RC 912	Psychiatric/Psychological Service – Day Care	Psychiatric/Psychological Services: Partial Hospitalization - Less Intensive
RC 913	Psychiatric/Psychological Services – Night Care	Psychiatric/Psychological Services: Partial Hospitalization - Intensive

The following obsolete revenue codes were discontinued effective October 2001:

Revenue Code	Definition
RC 175	Nursery Neonatal – ICU
RC 701	Cast Room – Other
RC 890	Other – Donor Bank – General
RC 891	Other – Donor Bank – Bone
RC 892	Other – Donor Bank - Organ (Other Than Kidney)
RC 893	Other – Donor Bank – Skin
RC 899	Other – Donor Bank – Other

Ann H. Kimbrell, R.N., Institutional Services
DMA, 919-857-4020

Attention: All Providers

CPT Codes End-Dated for 2002

Effective with date of service April 1, 2002, N.C. Medicaid providers can no longer bill procedure codes deleted from the 2002 Current Procedural Terminology (CPT) by the American Medical Association (AMA). Claims submitted with covered, deleted procedure codes for dates of service prior to April 1, 2002 will be accepted for processing. The following table lists the deleted codes that are currently covered:

Deleted Code	Description
00857	<i>Neuraxial analgesia/anesthesia for labor ending in cesarean delivery</i>
00955	<i>Neuraxial analgesia/anesthesia for labor ending in a vaginal delivery</i>
26585	<i>Repair bifid digit</i>
26597	<i>Release of scar contracture, flexor or extensor, with skin grafts, rearrangement flaps, or Z-plasties, hand and/or finger</i>
29815	<i>Arthroscopy, shoulder, diagnostic, with or without synovial biopsy</i>
29909	<i>Unlisted procedure, arthroscopy</i>
53443	<i>Urethroplasty with tubularization of posterior urethra and/or lower bladder for incontinence</i>
54510	<i>Excision of local lesion of testis</i>
80072	<i>Arthritis panel</i>
85095	<i>Bone marrow; aspiration only</i>
85102	<i>Bone marrow biopsy, needle or trocar</i>
85535	<i>Iron stain (RBC or bone marrow smears)</i>
88170	<i>Fine needle aspiration; superficial tissue</i>
88171	<i>Fine needle aspiration; deep tissue under radiologic guidance</i>
93536	<i>Percutaneous insertion of intra-aortic balloon catheter</i>
93607	<i>Left ventricular recording</i>
93737	<i>Electronic analysis of single or dual chamber pacing cardioverter-defibrillator only; without reprogramming</i>
93738	<i>Electronic analysis of single or dual chamber pacing cardioverter-defibrillator only; with reprogramming</i>

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

Attention: All Providers

CPT Code Update 2002

Effective with date of service January 1, 2002, N.C. Medicaid providers may bill the following Current Procedural Terminology (CPT) codes, which replace codes deleted by the American Medical Association (AMA) for 2002:

Deleted Code	New Code	Description
00955	01967	<i>Neuraxial labor analgesia/anesthesia for planned vaginal delivery</i>
00857	01968	<i>Cesarean delivery following neuraxial labor analgesia/anesthesia</i>
00857	01969	<i>Cesarean hysterectomy following neuraxial labor analgesia/anesthesia</i>
88170	10021	<i>Fine needle aspiration, without imaging guidance</i>
88171	10022	<i>Fine needle aspiration, without imaging guidance with imaging guidance</i>
29815	29805	<i>Arthroscopy, shoulder, diagnostic, with or without synovial biopsy</i>
93536	33967	<i>Insertion of intra-aortic balloon assist device, percutaneous</i>
85095	38220	<i>Bone marrow aspiration</i>
85102	38221	<i>Bone marrow biopsy, needle or trocar</i>
53443	53431	<i>Urethroplasty with tubularization of posterior urethra and/or lower bladder for incontinence</i>

Claims submitted for dates of service January 1, 2002 through March 31, 2002 with deleted codes will be accepted for processing. Claims for dates of service on or after April 1, 2002 must be filed using the 2002 CPT codes listed in the table above.

The annual review of new CPT codes is ongoing. Providers will be notified concerning coverage of other new codes in future general Medicaid bulletins.

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

Attention: Health Departments

Dibabetes Outpatient Self-Management Training: Supervision Clarification

Diabetes outpatient self-management training performed in health departments should be provided by or under the overall direction and supervision of a physician or other individuals approved to perform medical acts, tasks or functions (nurse practitioner, certified nurse midwives, physician assistants). The supervising practitioner may be employed by or under contract with the health department.

The health department provider number should be used when billing the service. Refer to the November 1999 general Medicaid bulletin for additional coverage information.

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

Attention: All Providers

Copayment Amounts for Recipients

The following copayments apply to all Medicaid recipients except those specifically exempted by law from copayment:

Service	Copayment
Chiropractic	\$1.00 per visit
Dental	\$3.00 per visit
Prescription Drugs and Insulin	
Generic	\$1.00 per prescription
Brand	\$3.00 per prescription
Ophthalmologist	\$3.00 per visit
Optical Supplies and Services	\$2.00 per visit
Optometrist	\$2.00 per visit
Outpatient	\$3.00 per visit
Physician	\$3.00 per visit
Podiatrist	\$1.00 per visit

Providers may not charge copayments for the following services:

- Hospital emergency department services including physician services delivered in the emergency department
- Family planning services
- Services in state-owned psychiatric hospitals
- Services covered by both Medicare and Medicaid
- Services to persons under the age of 21
- Services related to pregnancy
- Services provided to residents of nursing facilities (NF), intermediate care facilities for mental retardation (ICF-MR), and psychiatric hospitals
- Health Check (EPSDT) related services
- Services provided to participants in the Community Alternatives Program (CAP)
- Services to enrollees of prepaid plans (HMOs) except services not covered under the HMO's plan such as prescriptions and dental services
- Rural Health Clinic (RHC) core services
- Federally Qualified Health Center (FQHC) core services
- Nonhospital dialysis facility services
- Hospital inpatient services (inpatient physician services are not exempt)
- Home health services
- Hearing aid services
- Ambulance services
- Mental health clinic services
- Hospice services
- Durable medical equipment (DME)
- Private duty nursing (PDN) services
- Home infusion therapy

Providers may bill the patient for applicable copayment amounts, but may not refuse services for inability to pay the copayment. **Do not enter copayment as a prior payment on the Medicaid claim.** The copayment will be deducted automatically when the claim is processed.

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

Attention: All Providers

Health Insurance Portability and Accountability Act Compliance Survey

The N.C. Medicaid program plans to offer seminars focusing on how the implementation of the Health Insurance Portability and Accountability Act (HIPAA) will specifically impact electronic Medicaid claims processing. (Upcoming general Medicaid bulletins will list the dates and site locations for the HIPAA seminars along with the registration form.) Provider participation in the following survey will assist the N.C. Medicaid program in the development of the HIPAA seminars.

Additional information regarding HIPAA can be found on the Division of Medical Assistance’s website at <http://www.dhhs.state.nc.us/dma>.

- 1. On what date will your billing office be HIPAA compliant?
2. Will your claims filing software be upgraded to comply with HIPAA transaction standards?
3. Did you purchase the claims filing software from a vendor? If yes, has HIPAA compliant software been offered by this vendor? If yes, when will it be available? If no, do you plan to obtain HIPAA compliant software from a different vendor or file claims on paper?
4. Do you file your claims directly to EDS or through a clearinghouse/billing agent?
5. If you file claims to Medicaid through a clearinghouse/billing agent, what is the name of the clearinghouse/billing agent? Is the clearinghouse/billing agent HIPAA compliant now? If not, on what date will they be compliant?
6. With what insurance carriers or professional associations are you associated? What information have they provided regarding HIPAA?
7. Do you plan on attending any HIPAA training other than training sponsored specifically for Medicaid? If yes, who is sponsoring the training, what is the subject of the training, and when will the training occur?
8. What percentage of your claims is filed on paper?
9. If you are currently submitting claims electronically, which of these HIPAA-related functions do you plan to use in the future? (circle either YES or NO for EACH transaction)
• Health care claims (837 transaction) Yes or No
• Health care payments and remittance advices (835 transaction) Yes or No
• Eligibility inquiry and response (270 and 271 transactions) Yes or No
• Pharmacy billing (NCPDP transaction) Yes or No
• Prior approval (278 transaction) Yes or No
• Claim status request and response (276 and 277 transactions) Yes or No

Provider Name _____ Provider Number _____
Address _____ Contact Person _____
City, Zip Code _____ Telephone Number _____

Please return the completed survey by fax (919-816-3192) or mail to: EDS (Attention: HIPAA Survey)
P.O. Box 300009
Raleigh, NC 27622

Attention: Physicians and Nurse Practitioners

Apligraf HCPCS Code Change

Apligraf is indicated for the treatment of noninfected partial and full-thickness skin ulcers due to venous insufficiency or neuropathic diabetic foot ulcers. The HCPCS code that is currently used to bill apligraf, Q0185, has been deleted as of 2002. The new HCPCS code is **J7340**. Reimbursement will be per unit. One unit equals one square centimeter. Bill the appropriate code according to the dates of service listed below:

Date of Service	Code	Description
November 1, 2000 through March 31, 2002	Q0185	Dermal and epidermal tissue, of human origin, with or without bioengineered or processed elements, with metabolically active elements, per square centimeter
April 1, 2002 and after	J7340	Dermal and epidermal tissue, of human origin, with or without bioengineered or processed elements, with metabolically active elements, per square centimeter

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

Attention: Area Mental Health Center and Residential Treatment Facility Providers for Levels II through IV

Completion of the Residential Authorization Form

Effective May 1, 2002, Area Mental Health Centers must use only the most recent version (12/21/01) of the Residential Authorization Form (RAF). A copy of the form can be obtained on the Division of Medical Assistance's website at <http://www.dhhs.state.nc.us/dma>. Information submitted for admission or changes during the initial 120-day period for Levels II and III or the initial 30-day period for Level IV will not be accepted if providers use the older version of the RAF.

It is the responsibility of the Area Mental Health Center to submit the **completed** RAF to ValueOptions and EDS. The Area Mental Health Center may submit the completed RAF to ValueOptions either by fax at 919-941-0433 or by e-mail at nmedicaid@valueoptions.com. A copy must also be submitted to EDS by fax at 919-233-6832.

Residential Treatment Facility providers for Levels II through IV are encouraged to obtain a copy of the RAF for their records for each and every child admitted to their facilities through the Area Mental Health Center, and to verify that the dates of admission and other information are accurate. Medicaid reimbursement will not occur until the RAF has been received and processed. In order to ensure that the RAF is received, the Residential Treatment Facility providers for Levels II through IV may also submit a copy of the RAF to ValueOptions and EDS.

Reba Hamm, Behavioral Health Services
DMA, 919-857-4020

NC MEDICAID Residential Authorization Form

Authorizing Area Program _____

Area Program Designee for Initial Clinical Information _____

Phone # (____) _____

Case Manager at the AP _____

Phone # (____) _____

Child's Name _____ DOB _____

Medicaid ID _____

Medicaid Eligibility Date _____

Social Security # _____

Child's Legal Guardian _____

Address _____

Phone # (____) _____

Date of Admission _____ through _____ # Days authorized _____

Initial Admit _____ Transfer _____ Date discharged from previous program _____

Level of Residential Care _____

Residential Program _____

Address _____

Phone # (____) _____ Medicaid Provider # _____

Contact Person/Title _____

Signature of Authorizing Area Program Representative

ValueOptions will confirm receipt with the Area Program no later than 1 business day from the receipt of this form. If confirmation is not received, please contact 888-510-1150 ext. 5367

ValueOptions Fax (919) 941-0433 **AND** EDS Fax (919) 233-6834

Attention: Psychiatric Residential Treatment Facility Providers

Denials Relative to Patient Monthly Liability

Psychiatric treatment in a Psychiatric Residential Treatment Facility (PRTF) is considered an inpatient service for Medicaid recipients. Because of this status, a monthly patient liability (PML) must be determined for recipients beginning the first of the month following the thirtieth (30th) day from the date of admission. The PRTF is responsible for informing the county department of social services (DSS) of the recipient's admission.

Effective April 1, 2002, when a child is admitted to a PRTF bed, the DSS in the child's county of eligibility must be notified of the admission so the PML can be determined. The DSS will issue a Notification of Eligibility for Medicaid/Amount and Effective Date of Patient's Liability form (DMA-5016), which indicates the amount of PML to be entered on the claim. Continue to bill on the UB-92 claim form using Bill Type 891 in form locator 4 and Revenue Code 911 in form locator 42. The PML must be entered in form locator 39 with a Value Code of 23. Failure to enter the code and a PML amount (even if the amount is \$0.00) will result in denial of the claim.

Carolyn Wisner, Behavioral Health Services
DMA, 919-857-4020

Attention: All Providers

Carolina ACCESS Override Requests

Effective April 1, 2002, the procedure to request a Carolina ACCESS (CA) override for **past dates of service** has changed. When services have been rendered to a CA recipient without first obtaining a CA authorization number from the primary care provider (PCP), written request must be made using the attached Carolina ACCESS Override Request Form. EDS will respond to your written request by fax or phone.

The procedure to request an override **before a service is rendered** has not changed. Please continue to call the EDS Managed Care Unit at 1-800-688-6696 or 919-816-4321. Providers rendering medical care to a CA enrollee must contact the PCP for authorization. Providers must verify the PCP by viewing the recipient's current Medicaid identification card or calling the Automated Voice Response (AVR) system at 1-800-723-4337. **Overrides (verbal or written) will not be considered unless the PCP has been contacted and refused to authorize treatment.**

PCPs are contractually required to provide services **or** authorize another provider to provide services until the county department of social services changes the CA status of a recipient. EDS is authorized to issue CA overrides **only** when extenuating circumstances beyond the control of the responsible parties affect access to medical care and the PCP refused to authorize treatment.

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

Carolina ACCESS Override Request

Complete this form to request a Carolina ACCESS override when you have either received a denial for EOB 270 or 286 or the Primary Care Provider (PCP) has refused to authorize treatment for a **past** date(s) of service. Overrides will not be considered unless the PCP has been **contacted and refused** to authorize treatment. Attach any supporting documentation. Mail or FAX completed form to EDS. If your override request is approved, EDS will telephone or FAX your office with the override number to use for filing the claim. This form is also available in the PCP Provider Manual and on DMA's website (<http://www.dhhs.state.nc.us/dma>).

Mail To: CA Override
 EDS Provider Services
 PO Box 300009
 Raleigh, NC 27622

OR

Fax: CA Override
 919/851-4014

Recipient MID _____ Recipient Name _____

Date(s) of Service _____ Claim No. _____ RA Date _____

PCP on Recipient's Medicaid card _____

Name of Person contacted at PCP's office? _____

Date contacted? _____

Reason PCP would not authorize treatment _____

* If the PCP information on the recipient's Medicaid card is different than the PCP information on file with EDS, submit a copy of the Medicaid card with this form.

If recipient is linked with the incorrect PCP, who is the correct PCP? _____

Provider name _____ Provider number _____

Provider contact _____ Tel _____ Fax _____

Checkwrite Schedule

April 9, 2002
April 16, 2002
April 25, 2002

May 7, 2002
May 14, 2002
May 21, 2002
May 30, 2002

June 11, 2002
June 18, 2002
June 27, 2002

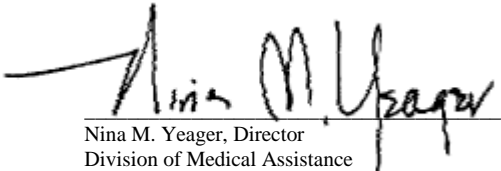
Electronic Cut-Off Schedule


April 5, 2002
April 12, 2002
April 19, 2002

May 3, 2002
May 10, 2002
May 17, 2002
May 24, 2002

June 7, 2002
June 14, 2002
June 21, 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

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