Number 8 *August 2001*

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.

Attention: Health Departments, Developmental Evaluation Centers, Federally Qualified Health Centers, and Rural Health Clinics

Use of Codes Y2351 and Y2041 – Correction and Addition to June 2001 Bulletin Article

The table listing the primary diagnosis codes for billing medical nutritional therapy for recipients 21 years of age and older should also include the diagnosis codes **V23.3** and **V24.2**.

The following table replaces the table printed in the June 2001 general Medicaid bulletin.

V22.0	V22.1	V22.2	V23.0	V23.1	V23.2	**V23.3**	V23.4	V23.5
V23.7	V23.81	V23.82	V23.83	V23.84	V23.89	V23.9	**V24.2**	

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

Attention: All Providers

Laboratory Codes and Modifiers 76 and 77

When billing for an analyte, regardless of whether it is measured in multiple sessions from different sources or in specimens that are obtained at different times, the analyte is reported separately for each source and for each specimen. Modifiers 76 and 77 have been removed from the following codes to allow for separate billing of the analyte:

82016	82131	82261	82784	83080	83903	83918	84377
82017	82136	82379	82787	83788	83904	83919	84378
82042	82139	82492	82926	83789	83905	84150	84379
82127	82172	82657	82928	83883	83906	84182	
82128	82190	82658	82952	83901	83898	84376	

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

Attention: All Providers

Denials on Sterilization and Abortion Procedures

Claims with a diagnosis related to an abortion, hysterectomy or sterilization procedure are subject to all federal guidelines related to the processing of these procedures. Therefore, the appropriate consent statement must meet federally mandated requirements before any related claims (such as laboratory or anesthesia services) can be reimbursed. Although the responsibility for obtaining the appropriate consent statement rests with the primary physician or surgeon, related claims will deny until the appropriate consent statement meets federally mandated requirements and is on file at EDS. The provider billing the related service should contact the attending physician's billing office or EDS through the Automated Voice Response system at 1-800-723-4337 or Provider Services at 1-800 688-6696 to determine if the consent statement has been filed and is valid.

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

DMA and EDS Telephone Contact List

Topic/Reason For Call	Call	Telephone Number
Accident-Related Issues	DMA Third Party Recovery	1-919-733-6294
Automatic Deposits	EDS Finance Unit	1-800-688-6696 or 1-919-851-8888
Billing Issues	EDS Provider Services	1-800-688-6696 or 1-919-851-8888
Carolina ACCESS	DMA Managed Care	1-888-245-0179 or 1-919-857-4022
Checkwrite Information	AVR System	1-800-723-4337
Claims Status	AVR System	1-800-723-4337
Coverage Issues	EDS Provider Services	1-800-688-6696 or 1-919-851-8888
Denials (eligibility)	DMA Claims Analysis	1-919-857-4018
Denials (other than eligibility)	EDS Provider Services	1-800-688-6696 or 1-919-851-8888
Drug Use Review	DMA Program Integrity	1-919-733-3590
Eligibility Information (current day)	AVR System	1-800-723-4337
Fee Schedules	DMA Financial Operations	1-919-857-4015
Forms (information and orders)	EDS Provider Services	1-800-688-6696 or 1-919-851-8888
Fraud and Program Abuse	DMA Program Integrity	1-919-733-6681
Health Check	DMA Managed Care	1-888-245-0179 or 1-919-857-4022
HMO Risk Contracting	DMA Managed Care	1-888-245-0179 or 1-919-857-4022
Manuals/Bulletins	EDS Provider Services	1-800-688-6696
Medicare Crossovers	EDS Provider Services	1-800-688-6696 or 1-919-851-8888
Prior Approval	EDS Prior Approval Unit	1-800-688-6696 or 1-919-851-8888
Private Insurance	DMA Third Party Recovery	1-919-733-6294
Procedure Code Pricing	AVR System	1-800-723-4337
Provider Enrollment – Managed Care	DMA Managed Care	1-888-245-0179 or 1-919-857-4022
Provider Enrollment – MQB	EDS Provider Services	1-800-688-6696 or 1-919-851-8888
Provider Enrollment – All Others	DMA Provider Services	1-919-857-4017
Third Party Insurance Code Book	DMA Third Party Recovery	1-919-733-6294 FAX: 1-919-715-4725

Attention: Carolina ACCESS Primary Care Providers

Referral Policy for Specialty Care

Referrals and consultations are at the discretion and control of the Carolina ACCESS (CA) primary care provider (PCP). Referrals can be made by phone or in writing. An enrollee can seek some specialty services without a referral. These services are defined as out-of-plan and are listed in the Basic Medicaid handout and in the Carolina ACCESS Overview.

When referring CA enrollees for specialty care (except mental health referrals for children under the age of 21), the PCP defines the scope of the referral. This includes the number of visits being authorized and the diagnostic evaluation needed to effectively evaluate the patient. To facilitate continuity of care for CA enrollees, any further diagnosis, evaluation or treatment of the patient not identified in the original referral is the responsibility of the PCP.

PCP referrals for children under the age of 21 to Licensed Psychologists, Licensed Clinical Social Workers, Advanced Practice Psychiatric Clinical Nurse Specialists, and Advanced Practice Psychiatric Nurse Practitioners are valid for up to 26 visits per calendar year. It is not a requirement for the PCP to limit the referral to a certain number of visits. Mental health providers are educated to communicate at regular intervals with the referring provider in order to ensure continuity of care and appropriate treatment planning.

The PCP may make referrals or authorize payment of medical services at other medical sites for their CA enrollees who have not contacted them for the purpose of establishing a patient/provider relationship.

PCPs are required to schedule appointments for enrollees to make an initial visit and to be established as a patient. The appointment(s) must be available in a timely manner based on the standards outlined in the Carolina ACCESS provider application packet.

PCPs must document all patient referrals in the patient record. The Division of Medical Assistance (DMA) sends a monthly referral report to each PCP so they can check the validity and accuracy of the referrals. Any inappropriate referrals should be reported to the county managed care representative (MCR) for follow-up. The MCR coordinates with DMA managed care staff to research, investigate, and resolve any discrepancy between authorized referrals and the referral report.

NOTE: PCP referrals do not replace prior approval when required.

If you have any questions or comments, contact your county MCR.

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

Attention: Physicians

Radiopharmaceuticals Used in Myocardial Perfusion Imaging and Echocardiography

The N.C. Medicaid program covers the following agents when used to perform diagnostic myocardial perfusion imaging and echocardiography.

HCPCS Code	Description	Effective Date of Service
A9500	Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m sestamibi, per dose	June 1, 2000
A9505	Supply of radiopharmaceutical diagnostic imaging agent, thallous chloride TL – 201, per mCi	June 1, 2000
A9700	Supply of injectable contrast material for use in echocardiography, per study	January 1, 2001

HCPCS code A9700 will be reimbursed only when used in echocardiography services within CPT code range 93303 through 93350. CPT code 78990, *Provision of diagnostic radiopharmaceuticals*, may not be billed with codes A9500, A9505, and A9700.

Providers must bill the appropriate HCPCS code on the HCFA-1500 claim form and attach an invoice for reimbursement. Bill the usual and customary charges.

Italicized material is excerpted from the *American Medical Association 2001 Current Procedural Terminology*.

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

Attention: Physicians

Reduction Mammaplasty

The N.C. Medicaid program covers reduction mammaplasty when a recipient is suffering from debilitating symptoms due solely to breast enlargement. Reduction mammaplasty requires prior approval.

The recipient must meet all of the following criteria:

1. The recipient must be 19 years of age or older.
2. The recipient must not be pregnant.
3. The recipient must not have delivered a child within the past 12 months.
4. The recipient's weight for body configuration must not be more than 25 percent over the ideal weight according to the Metropolitan Life Insurance tables.
5. Debilitating symptoms are solely due to the breast enlargement.

The recipient must have enlarged breasts and at least two of the following conditions must be documented:

1. Symptomatic kyphosis and osteoarthritis of the cervical spine as documented on x-ray.
2. Documented scoliosis of the thoracic spine greater than 15 degrees.
3. A history of chronic back, shoulder or chest pain, which incapacitates her ability to perform any work or personal duties.
4. Chronic intertrigo with or without pigmentation changes, which is recurrent or is unresponsive to antibiotic and antifungal therapy.
5. An axillary inlet syndrome with numbness and tingling that is specifically related to the enlarged breasts.

All of the following information must be submitted on the prior approval form (additional information may also be submitted):

1. Height (in inches), weight (in pounds), age, body frame size, and bra size.
2. The measurement (in centimeters) from the suprasternal notch to each nipple. (Ptosis is one consideration in determination of medical necessity.)
3. Unclothed preoperative photographs from chin to waist (or lowest extent of breasts, if lower) including standing frontal and side views with arms straight down at the sides.
4. Documentation of debilitating symptoms. For example, certification of inability to perform activities of daily living, interference with employment or employability or inability to perform household tasks (including documentation of compensatory arrangements when unable to perform such tasks).
5. Evidence of exclusion of other medical problems that may cause or contribute to head, neck, shoulder or back pain (emotional/psychological, endocrinological, neurological or musculoskeletal).
6. Medical documentation, such as progress notes, of prior conservative management including physical therapy, medications, weight reduction, etc.
7. Evidence or certification of objective signs of medical necessity (e.g., kyphosis, lordosis, scoliosis, arthritis, intertrigo, axillary inlet syndrome, etc.).
8. A list and chronology of subjective symptoms.

9. A certification statement on the prior approval form by the requesting surgeon that the recipient has been informed that breast reduction may interfere with breast feeding in the future, destroy or impair sexual sensitivity of the breasts and nipples, and may cause other surgical complications such as necrosis of the nipple, hypertrophic scarring, and hematoma.
10. A certification statement on the prior approval form by the requesting surgeon of the intent to remove at least 500 grams of tissue from each breast. Pathology reports, including the weight in grams removed from each breast, may be requested in support of claims at the option of the reviewer.

Reduction mammaplasty for breast hypertrophy not meeting the above criteria is not covered. Repeat reduction mammaplasty is not covered.

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

You Can Now Access The Following Medicaid Provider Manuals Online

Adult Care Home Services
Ambulance Services
Community Care Services
Dental Services
Durable Medical Equipment
Hospital Services
Nursing Facility Services
Pharmacy Services

www.dhhs.state.nc.us/dma

Attention: Local Education Agencies, Head Start Programs, and the Independent Practitioners Program

Change to Procedures for Health-Related Therapy Services Provided to Children Ages Birth through 20

Effective September 1, 2001, the Division of Medical Assistance will make the following changes in procedure reference codes for Local Education Agencies (LEAs), Head Start, and Independent Practitioners (IP) programs indicated below.

Code	Description
Y2401	Audiology assessment
Y2402	Audiology treatment
Y2403	Speech/language assessment
Y2404	Speech/language treatment – individual student
Y2405	Occupational therapy assessment
Y2406	Occupational therapy treatment
Y2407	Physical therapy assessment
Y2408	Physical therapy treatment
Y2409	Psychological assessment
Y2410	Psychological treatment
Y2411	Speech/language treatment – group of two students
Y2412	Speech/language treatment – group of three students
Y2413	Speech/language treatment – group of four students
Y2415	Respiratory therapy assessment
Y2416	Respiratory therapy treatment

If more than one speech/language therapy service (Y2404 and Y2411 through Y2413) is provided to a recipient on the same day of service (DOS), the claim will deny.

Therapy services provided by LEAs, Head Start, and IP programs can only be provided to children ages birth through 20. Claims submitted for services, including psychological assessment (code Y2409) and psychological treatment services (code Y2410) will deny if the recipient is over 20 years of age. **Note:** IP programs cannot bill for psychological assessment (code Y2409) and psychological treatment (code Y2410) services.

Jency Abrams, RN, BSN, MS, Medical Policy Section
DMA, 919-857-4020

Attention: Physicians

Apligraf Coverage Criteria

The N.C. Medicaid program began covering Apligraf effective with date of service November 1, 2000. Apligraf is supplied as a bi-layered skin substitute and is indicated for the treatment of noninfected partial and full-thickness skin ulcers due to venous insufficiency or neuropathic diabetic foot ulcers.

Coverage Criteria
The Division of Medical Assistance (DMA) follows the same criteria as Medicare on indications for the use of Apligraf. Reimbursement may be made when all of the following conditions are met and documented in the recipient's health record:

Venous stasis ulcers

- Ulcers of more than three months duration.
- Ulcers that have failed to respond to documented conservative measures used for more than two months duration (failed to decrease the ulcer by 50 percent).
- Partial or full-thickness ulcers.
- Measurement must be made of the initial ulcer size, the ulcer size following cessation of conservative management, and the size at the beginning of skin substitute treatment.

Neuropathic diabetic ulcers

- Ulcers of more than four weeks duration.
- Ulcers that have failed to respond to documented conservative measures used for greater than one-month duration (failed to decrease the ulcer by 50 percent).
- Partial or full-thickness ulcers.
- Measurement must be made of the initial ulcer size, the ulcer size following cessation of conservative management, and the size at the beginning of skin substitute treatment.
- Appropriate steps to off-load pressure during treatment must be taken.

In all cases, the ulcer must be free of infection and underlying osteomyelitis, and the treatment of the underlying disease must be provided and documented in conjunction with bilaminate skin substitute treatment.

Limitations
Coverage is limited to three separate applications to any given ulcer.

Venous Stasis Ulcers	**Neuropathic Diabetic Foot Ulcers**
No fewer than six weeks between applications.	No fewer than three weeks between applications.
Two applications of skin substitute are indicated. A third application of skin substitute will be considered for coverage if a 50 percent or greater improvement is noted and documented. Documentation must be submitted.	Reapplication of the skin substitute is not recommended after three applications when satisfactory healing progress is not noted (i.e., a 50 percent or greater improvement). Other treatment modalities should be considered.
Retreatment within one year of the date of initial treatment is not covered.	

ICD-9-CM Codes
The following ICD-9-CM diagnosis codes must be used to support medical necessity:

Code	Description
250.80 – 250.83	Diabetes, with other specified manifestations. (Use additional code to identify manifestation 707.10 – 707.19.)
454.0	Varicose veins of lower extremities, with ulcer.
454.2	Varicose veins of lower extremities, with ulcer and inflammation.
707.10 - 707.19	Ulcer of lower limb, except decubitus. (ICD-9-CM codes 250.80 – 250.83 must also be reported with these codes.)

The use of Apligraf is not covered for the following diagnoses and conditions:

- infected ulcer
- osteomyelitis
- allergy to bovine collagen
- arterial disease with an ankle brachial index (ABI) of less than 6.5 in the case of venous stasis ulcers and a lack of pedal pulses in the case of neuropathic diabetic foot ulcers
- uncontrolled diabetes (for purposes of this policy "controlled" diabetes is based on documentation in the medical record)
- active Charot's arthropathy of the ulcer extremity
- vasculitis
- uncontrolled rheumatoid arthritis and or rheumatoid ulcers
- other uncontrolled collagen vascular disease
- patients under treatment with high-dose corticosteroids or immunosuppressants
- patients who have undergone radiation and/or chemotherapy within the month immediately preceding proposed skin substitute treatment

Documentation
The medical record must show that the listed criteria have been met. The ulcer must be measured at the beginning of conservative treatment, following cessation of conservative treatment, and at the beginning of the skin substitute treatment. The record must document that wound treatment by this method is accompanied by appropriate wound dressing during the healing period, by appropriate compressive dressings during follow-up, and, for neuropathic diabetic foot ulcers, appropriate steps to off-load wound pressure during follow-up.

Billing
HCPCS code Q0185, dermal and epidermal tissue, of human origin, with or without bioengineered or processed elements, with metabolically active elements, per square centimeter, must be used when billing this material.

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

Date of Service	Code	Description
November 1, 2000 through December 31, 2000	G0170	application of tissue cultured skin graft, initial 25 sq cm
	G0171	application of tissue cultured skin graft, each additional 25 sq cm
January 1, 2001 or after	15000	*surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar; first 100 sq cm or one percent of body area of infants and children*
	15342	*application of bilaminate skin substitute/neodermis; initial 25 sq cm*
	15343	*application of bilaminate skin substitute/neodermis; each additional 25 sq cm*

Italicized material is excerpted from the *American Medical Association 2001 Current Procedural Terminology*.

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

Attention: All Providers

Automated Voice Response System Reminder

When accessing information from the Automated Voice Response (AVR) system (1-800-723-4337), callers are required to key information such as provider number, recipient MID, date of service, etc. Information entered by the provider's office is repeated to the caller for verification. To expedite a call, providers may press the number one (1) on the telephone keypad to bypass this verification process. However, by bypassing this process on the AVR, providers may inadvertently confirm inaccurate or miskeyed information.

Please refer to the July 2001 Special Bulletin II, *Automated Voice Response System Provider Inquiry Instructions* for additional information regarding the AVR system. A copy of this special bulletin can also be accessed from DMA's website at www.dhhs.state.nc.us/dma.

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

Attention: Physicians, Nurse Practitioners, and Psychologists

After Hours, Weekend Visits, and On-Call Services

The N.C. Medicaid program allows separate reimbursement for services provided outside normal office hours. Medicaid defines normal office hours as those hours when the office is routinely open and services are available to recipients. Providers with established weekend, evening or holiday office hours offering service **may not** receive this separate reimbursement in addition to the basic service furnished.

CPT procedure codes 99050 through 99058 are for services provided outside normal office hours. Only one of the procedure codes listed below is allowed in addition to the Evaluation and Management (E/M) level of care code billed.

- 99050 – After office hours in addition to basic service
- 99052 – Between 10:00 p.m. and 8:00 a.m. in addition to basic service
- 99054 – Sundays and holidays in addition to basic service
- 99058 – Office services provided on an emergency basis

No additional reimbursement is made for being "on-call." If, while on-call, a provider has an actual face-to-face encounter with a recipient, the provider may bill the appropriate E/M level of care procedure code in addition to one of the procedure codes listed above.

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

EDS Mailing Addresses

Correspondence sent to EDS should be addressed to the appropriate P.O. Box number listed below, Raleigh, NC 27622.

P.O. Box	30968	HCFA-1500 claim forms
P.O. Box	31188	Prior approval requests
P.O. Box	300001	Pharmacy claims
P.O. Box	300009	Correspondence, adjustments, and Medicare crossovers (indicate department on envelope)
P.O. Box	300010	UB-92 claim forms
P.O. Box	300011	Other claim types and returned checks
P.O. Box	300012	Sterilization/hysterectomy consent form/statements **(Do not send claims to this address)**

Correspondence mailed to EDS by certified mail, UPS, or Federal Express should be sent to:
EDS
4905 Waters Edge Drive
Raleigh, NC 27606

Attention: Providers of Community Alternatives Program for Disabled Adults

Seminars for the Community Alternatives Program for Disabled Adults

Seminars for the Community Alternatives Program for Disabled Adults (CAP/DA) are scheduled for October 2001. The September general Medicaid bulletin will have the registration form and a list of site locations for the seminars. Please list any issues you would like addressed at the seminars. Return form to:

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

_____

_____

_____

_____

_____

_____

_____

_____

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

Attention: All Providers

Basic Medicaid Seminar Schedule

Seminars for Basic Medicaid are scheduled for September 2001. The seminars are intended for providers who are new to the N.C. Medicaid program. Topics to be discussed will include, but are not limited to, provider enrollment requirements, billing instructions, eligibility issues, and Managed Care, including Carolina ACCESS and HMOs. Persons inexperienced in billing N.C. Medicaid are encouraged to attend.

Due to limited seating, preregistration is required and limited to two staff members per office. Unregistered providers are welcome to attend when reserved space is adequate to accommodate. Please select the most convenient site and return the completed registration form to EDS as soon as possible. Seminars begin at 10:00 a.m. and end at 1:00 p.m. Providers are encouraged to arrive by 9:45 a.m. to complete registration.

Directions are available on page 15 of this bulletin.

Tuesday, September 11, 2001
Coast Line Convention Center
501 Nutt Street
Wilmington, NC

Thursday, September 13, 2001
Catawba Valley Technical College
Highway 64-70
Hickory, NC

Wednesday, September 19, 2001
Blue Ridge Community College
College Drive
Flat Rock, NC

Wednesday, September 26, 2001
Wake Med
Andrews Conference Center
3000 New Bern Avenue
Raleigh, NC

(cut and return registration form only)

Basic Medicaid Seminar Registration Form
(No Fee)

Provider Name _____ Provider Number _____
Address _____ Contact Person _____
City, Zip Code _____ County _____
Telephone Number _____ Fax Number _____ E-mail Address _____
1 or **2** (circle one) person(s) will attend the seminar at _____ (location) on _____ (date)

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

Directions to the Basic Medicaid Seminars

The registration form for the Basic Medicaid Seminars is on page 14 of this bulletin.

WILMINGTON, NORTH CAROLINA

COAST LINE CONVENTION CENTER

Take I-40 east to Wilmington. Take the Highway 17 exit. Turn left onto Market Street. Travel approximately 4 or 5 miles to Water Street. Turn right onto Water Street. The Coast Line Inn is located one block from the Hilton on Nutt Street behind the Railroad Museum.

HICKORY, NORTH CAROLINA

CATAWBA VALLEY TECHNICAL COLLEGE

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

FLAT ROCK, NORTH CAROLINA

BLUE RIDGE COMMUNITY COLLEGE

Take I-40 to Asheville. Travel east on I-26 to exit 22. Turn right and then take the next right. Follow the signs to Blue Ridge Community College. Turn left at the large Blue Ridge Community College sign. The college is located on the right. Pass the college's main entrance and turn right into the college entrance past the pond. The parking lot is on the left. The Auditorium entrance is located to the right of the Patton Building main entrance.

RALEIGH, NORTH CAROLINA

WAKE MED ANDREWS CONFERENCE CENTER

Driving and Parking Directions

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

Parking is available at the former CCB Bank parking lot, a short walk to the conference facility. The entrance to the Conference Center is at the top of the stairs to Wake Med's Andrews Conference Center.

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

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

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

Checkwrite Schedule

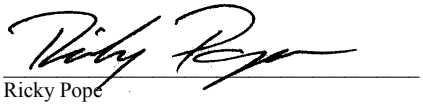
August 7, 2001	September 5, 2001	October 9, 2001
August 14, 2001	September 11, 2001	October 16, 2001
August 23, 2001	September 18, 2001	October 25, 2001
	September 27, 2001	

Electronic Cut-Off Schedule

August 3, 2001	September 7, 2001	October 5, 2001
August 10, 2001	September 14, 2001	October 12, 2001
August 17, 2001	September 21, 2001	October 19, 2001
August 31, 2001		

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

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



Ricky Pope
Executive Director
EDS

EDS

P.O. Box 300001
Raleigh, North Carolina 27622

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