Number 9 *September 2000*

North Carolina Medicaid Bulletin

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

Attention: All Providers

Holiday Observance

The Division of Medical Assistance (DMA) and EDS will be closed Monday, September 4, in observance of Labor Day.

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

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

Attention: Health Departments

Questions from Health Department Workshops

1. **Are health departments required to bill non-Medicaid clients for services if they bill the same services to Medicaid for a Medicaid recipient?**
   Yes. Medicaid providers must bill all clients the usual and customary rate for services rendered whether or not the recipient is a Medicaid recipient. The CPT code conversion project did not change whether or not a provider chooses to use a sliding scale fee method to determine fees for clients.

2. **How much time should pass from the date of the last visit for a recipient to be considered a new patient?**
   A recipient is considered a new patient when three years from the last date of service have passed.

3. **How is nutritional therapy billed?**
   Medical nutritional therapy will continue to be billed with the appropriate state created Y code with a Type of Service (TOS) 3.

4. **What modifier or extended visit code is used when the Evaluation and Management (E/M) code does not sufficiently cover the visit?**
   The most comprehensive E/M code should be selected to meet the services rendered.

5. **When are dental codes effective?**
   October 1, 2000.

6. **What services can be performed or billed by an Enhanced Maternal Health Role (EMHR) nurse?**
   CPT conversion did not change the role of the EMHR nurse.

7. **Can enhanced-role nurses be used as a provider to bill adult preventive visits?**
   Enhanced-role nurses will not be given individual Medicaid provider numbers. Services will continue to be billed under the health department provider number. The manner in which health departments provide services did not change with CPT conversion. Refer to the "Supervision of Services Performed in Health Departments" on page 21 of this bulletin.

8. **Can Nurse's diagnosis codes be used for Health Check screen?**
   When a Health Check screening is performed, V20.2, routine infant or child Health Check, is always the primary diagnosis to be billed. Nursing diagnosis codes should continue to be listed as additional diagnosis codes. The Health Check program wants to continue to use these codes to collect information on the Health Check population.

9. **Can health departments bill Medicaid for STD's?**
   Health departments will continue to bill code Y2013, STD control treatment. When a recipient is eligible for Medicaid and all of the components of Y2013 have been provided, it is appropriate to bill Medicaid.

10. **If all components of a physical exam except pap smear are provided, and the recipient must return to the office for the pap, how should these visits be billed?**
    The visits for the physician exam and the return visit for the pap smear cannot be billed separately. The physical exam components are billed as a package and are included in the E/M code and the Adult Preventive Health code. The appropriate E/M or Adult Preventive Health code should be billed for the visit if all the components except the pap smear have been completed and nothing should be billed for the return visits for the pap smear.

11. **Nurses spend a lot of time "interpreting" pap smears, notifying patients of results and referring patients. Can nurse practitioners bill code 88141 for pap smear interpretation?**
    No. Nurses and nurse practitioners cannot bill code 88141.

12. **If a recipient receives prenatal services at a health department, but a private physician provides delivery and postpartum services, what should the health department bill when the recipient returns to the health department for birth control? Birth control was not included as part of the postpartum care by the private physician.**
    When all the components of family planning are provided, it is appropriate to bill the preventive code (99384-99387 or 99394-99397) appended with the Family Planning modifier, FP.

13. **How do health departments bill for a routine lead screening when performed in conjunction with a Health Check screening?**
    Lead screening is a required component of the Health Check screening. Health departments should bill one of the Health Check screening codes with V20.2 as the diagnosis code.

14. **Can a screening blood lead test collection be billed if the specimen is collected through the WIC office?**
    Yes.

15. **How do local health departments bill for a redraw when the blood lead screening performed as a component of the Health Check screening is elevated?**
    If a Medicaid recipient returns for a redraw because the screening was elevated, Medicaid will reimburse the venipuncture and specimen collection fee code, G0001.

16. **If blood lead collection is the only service performed (lead sent to state lab) and no Health Check visit is billed (W8010 or W8016), can the venipuncture code be billed?**
    Yes, it would be appropriate to bill G0001, venipuncture and specimen collection.

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

Correspondence sent to EDS by Certified mail, UPS, or Federal Express should be sent to:

EDS
4905 Waters Edge Drive
Raleigh, NC 27606

Attention: All Prescribers

Drug Utilization Review Section

The main emphasis of the Drug Utilization Review Section (DUR) at the Division of Medical Assistance (DMA) is to enhance the quality and appropriateness of patient care by educating prescribers and pharmacists about common drug therapy issues and disease management. The DUR Section receives guidance from a DUR Board consisting of pharmacists, physicians, and other health care experts. The three major interventions utilized are letters to prescribers and pharmacists, telephone contacts, and bulletin articles.

The ultimate goal of the DUR program is to promote patient safety by incorporating both retrospective and prospective reviews. The purpose is to ensure that outpatient drugs dispensed to Medicaid recipients are appropriate, medically necessary, and not likely to result in clinically significant adverse medical effects. The DUR Staff strives to improve the quality of health care, effectively identify and ultimately influence prescribing patterns, and conserve health care dollars while achieving positive outcomes.

Physicians and pharmacists interested in participating on the DUR Board are encouraged to contact Sharman Leinwand, MPH, R.Ph. at 919-733-3590 ext. 229 or sharman.leinwand@ncmail.net

Ms. Leinwand is the Chief of the DUR Section. She has over 25 years experience in both clinical and retail settings. She is a member of the North Carolina Association of Pharmacists and the American Society of Hospital Pharmacists.

Sharman Leinwand, Drug Utilization Review Section
DMA, 919-733-3590, ext. 229

Attention: All Providers

Change in the Carolina Access Emergency Room Reimbursement Policy

Effective September 1, 2000, claims processed for facility or professional services provided in the hospital emergency departments will not require a Carolina ACCESS Primary Care Physician authorization number or a specified emergency diagnosis for payment. This revision in the Carolina ACCESS (CA) Emergency Room Reimbursement Policy is the result of recent clarification from HCFA on the Balanced Budget Act of 1997.

With this revision to the ER Policy, hospitals are also expected to provide a summary of the ER visit to the member's primary care provider and to work closely with the local Managed Care Representative in the county to provide educational materials to the CA members.

Also effective September 1, 2000, CPT code W9922 (medical screening exam) will no longer be covered under the Medicaid program. The appropriate E/M Code should be billed for the ER visit.

Darryl Frazier, Managed Care Section
DMA, 919-857-4233

Attention: Hearing Aid Providers

Coverage of Programmable Hearing Aids and FM Systems

Effective September 22, 1999 the Medicaid Hearing Aid Program has been expanded to include programmable hearing aids and FM systems. An expansion such as this requires much research and consultation to ensure the revisions meet the needs of recipients and providers. Although such revisions require time, the children's needs are immediate. Therefore, during the interim stages of development, please follow the instructions detailed below to submit prior approval requests (PA) for programmable aids or FM systems:

- Continue to submit PA, letter from physician or otologist stating medical necessity, hearing evaluation (to include audiogram), and the results of the hearing aid selection/evaluation tests to EDS;
- In "block 10" on the PA, record the manufacturer, model, and cost of requested aid;
- Also, in "block 10" document the type of aid being requested (i.e., ANALOG PROGRAMMABLE, DIGITAL PROGRAMMABLE, or FM SYSTEM);
- In "block 12" document the reason(s) recipient requires requested system.

PAs for digital programmable aids and FM systems will be reviewed by an audiologist on a case-by-case basis. The updated Medicaid Hearing Aid Manual should be available by the end of the year. If additional information is needed, please contact Ronda Owen at 919-857-4038.

Ronda Owen, Medical Policy
DMA, 919-857-4038

Attention: Durable Medical Equipment Providers

Addition of Tracheostomy Speaking Valve

Effective with date of service September 1, 2000, HCPCS code L8501, tracheostomy speaking valve, will be added to the Orthotic and Prosthetic Fee Schedule. (Items on the Orthotic and Prosthetic Fee Schedule are allowable only for recipients from birth through 20 years old.) The maximum new purchase reimbursement rate is $111.01. The maximum quantity limitation is seven per year. Prior approval is not required. As with all durable medical equipment, providers must maintain a physician's prescription and a completed Certificate of Medical Necessity and Prior Approval form in their records.

To qualify for a speaking valve, a recipient must have a tracheostomy and must be able to vocalize with the use of the valve.

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

Attention: All Providers

Modifier 79 and Multiple Session Procedure Codes

Effective October 1, 2000, Medicaid providers are to append postoperative Modifier 79 to "multiple session codes" to denote that a procedure performed during the postoperative period of an original procedure is unrelated to the original.

"Multiple session codes" are described as including one or more sessions and are listed in the table below.

65855	66761	66762	66821	66840	67031	67101	67105
67141	67145	67208	67210	67218	67220	67227	67228

The following examples indicate the appropriate use of Modifier 79 related to a multiple session code.

Example #1

- Multiple session code 67228, destruction of extensive or progressive retinopathy, one or more sessions; photocoagulation (laser or xenon arc) is performed on the right eye.
- During the 90-day postoperative period of the original procedure on the right eye, the same provider performs the same procedure (67228) on the left eye of the same recipient.
- The provider submits a claim for the procedure performed on the left eye with modifier 79 appended to 67228. This indicates that the procedure performed on the left eye is unrelated to the procedure performed on the right eye and is not part of the multiple sessions performed on the original procedure (the right eye).

Example #2

- Procedure code 49560, repair of initial incisional or ventral hernia; reducible is performed.
- During the 90-day postoperative period of procedure 49560, the same provider performs procedure 67228 on the left eye of the same recipient.
- The provider submits a claim for the procedure performed on the left eye with modifier 79 appended to 67228. This indicates that the second procedure is unrelated to the original procedure (49560).

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

Attention: Urgent Care Centers and Carolina ACCESS Providers

Change in Billing Procedures for Urgent Care Centers

Effective with date of processing September 1, 2000, Urgent Care Centers billing with a hospital provider number will no longer require a Carolina ACCESS primary care provider's authorization number for claims to pay. This change is being made to assure compliance with the Balanced Budget Act of 1997.

Terri Bruner, Quality Management, Managed Care Section
DMA, 919-857-4022

Attention: Local Health Department Dental Staff

Conversion from Clinic Visit Medicaid Billings to ADA Coded Billings Effective October 1, 2000

Effective with date of service October 1, 2000, Medicaid dental services provided by health department dental facilities will be billed using the 1999 ADA Claim Form, dental ADA codes from the American Dental Association Current Dental Terminology (CDT-3), and CPT codes from the Physicians' Current Procedural Terminology. The Division of Medical Assistance (DMA) determines which ADA and CPT codes will be covered under the Medicaid program. Only the procedures listed in the North Carolina Medicaid Dental Services Manual are covered under the North Carolina Medicaid Dental program.

Updated North Carolina Medicaid Dental Services Manuals were distributed to providers at the dental seminars in May. New manuals were mailed in June to all dental and health department providers that were unable to attend a dental seminar.

Each provider enrolled in the North Carolina Medicaid program is entitled to one copy of the Medicaid manual at no charge. Additional manuals may be purchased by contacting EDS Provider Enrollment or EDS Provider Services at 919-851-8888 or 1-800-688-6696.

Note: A sample of the 1999 ADA claim form is included on page 8 of this bulletin.

Watch for future mailings to health departments regarding updates on dental issues, including additional seminars that will be scheduled. The seminars are designed to provide Medicaid Dental program and billing information for this transition.

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

Dental Claim Form

©American Dental Association, 1999 version 2000

1. ☐Dentist's pre-treatment estimate ☐Dentist's statement of actual services Specialty (see backside)
2. ☐Medicaid Claim ☐EPSDT Prior Authorization #
3. Carrier Name
4. Carrier Address
5. City
6. State
7. Zip

PATIENT

8. Patient Name (Last, First, Middle)
9. Address
10. City
11. State
12. Date of Birth (MM/DD/YYYY)
13. Patient ID #
14. Sex ☐M ☐F
15. Phone Number ( )
16. Zip Code
17. Relationship to Subscriber/Employee: ☐Self ☐Spouse ☐Child ☐Other
18. Employer/School Name Address

SUBSCRIBER / EMPLOYEE

19. Subs./Emp. ID#/SSN#
20. Employer Name
21. Group #
22. Subscriber/Employee Name (Last, First, Middle)
23. Address
24. Phone Number ( )
25. City
26. State
27. Zip Code

SAMPLE

28. Date of Birth (MM/DD/YYYY)
29. Marital Status ☐Married ☐Single ☐Other
30. Sex ☐M ☐F

31. Is Patient covered by another plan ☐No (Skip 32–37) ☐Yes ☐Dental or ☐Medical
32. Policy #
33. Other Subscriber's Name
34. Date of Birth (MM/DD/YYYY)
35. Sex ☐M ☐F
36. Plan/Program Name
37. Employer/School Name Address

38. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

X
Signed (Patient/Guardian) Date (MM/DD/YYYY)

38. Subscriber/Employee Status ☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student
40. Employer/School Name Address
41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

X
Signed (Employee/subscriber) Date (MM/DD/YYYY)

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity
43. Phone Number ( )
44. Provider ID #
45. Dentist Soc. Sec. or T.I.N.
46. Address
47. Dentist License #
48. First visit date of current series:
49. Place of treatment: ☐Office ☐Hosp. ☐ECF ☐Other
50. City
51. State
52. Zip Code
53. Radiographs or models enclosed? ☐Yes, How many?_____ ☐No
54. Is treatment for orthodontics? ☐Yes ☐No If service already commenced: Date appliances placed: Total mos. of treatment remaining
55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No If no, reason for replacement: Date of prior placement:
56. Is treatment result of occupational illness or injury? ☐No ☐Yes Brief description and dates
57. Is treatment result of: ☐auto accident? ☐other accident? ☐neither Brief description and dates

58. Diagnosis Code Index (optional) 1. 2. 3. 4. 5. 6. 7. 8.

59. Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	City	Description	Fee

Admin. Use Only

60. Identify all missing teeth with "X"

Permanent: 1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16 | 32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17

Primary: A B C D E | F G H I J | T S R Q P | O N M L K

61. Remarks for unusual services

Total Fee	
Payment by other plan	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X
Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed
64. City
65. State
66. Zip Code

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J580 (Same as ADA Dental Claim Form) – J588, J590, J591

To Reorder, call 1-800-947-4746

Attention Nursing Facility Providers

Correction to the Medicaid Nursing Facility Provider Manual – June 1, 2000

Please note: The June 1, 2000, Nursing Facility Provider Manual, Page 8-3, Section Title: Medicaid Dual Eligibles, should read as below. Please make this change in the manual. An updated replacement page will be included in the next revision to the Nursing Facility manual.

Medicaid Dual Eligibles:
Medicaid pays Part B premiums and Part A premiums for all Medicaid recipients who are not entitled to "free" Part A.

Part A Medicare coverage. Medicare will help pay for care in a skilled nursing facility up to 100 days in a benefit period. Part A covers the full cost of services for the first 20 days. The nursing facility should bill the first 20 days to Medicare only.

Medicare pays all covered services for the next 80 days except the daily coinsurance. File charges to Medicare on the UB-92 claim form with the following additions:

1. In Form Locator 50, indicate NC Medicaid in the correct order that Medicaid would pay (e.g., after Medicare and any third party insurance), and
2. In Form Locator 51, enter the Medicaid recipient identification (MID) number (on the corresponding line) to signify Medicaid involvement.

After the 100th day and after all Medicare Part A lifetime reserve days have been exhausted, the provider should bill straight Medicaid.

Part B Medicare coverage only. If the Medicaid recipient has only Medicare Part B coverage, the provider should bill the charges associated with any ancillary services to Medicare on the UB-92 claim form. When completing this form, indicate NC Medicaid in Form Locator 50 and enter the Medicaid recipient identification (MID) number in Form Locator 51 (on the corresponding line).

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

Need a Form?

The most frequently requested Medicaid forms are now available online at:

www.dhhs.state.nc.us/dma

Attention: Hospitals, Physicians, Area Mental Health Programs, and County Departments of Social Services

Clarification of Prior Approval Guidelines for Inpatients (Adults and Children) Applying for Medicaid During a Psychiatric Hospital Stay

This is a policy statement to follow-up the DMA Memorandum of July 16, 2000 to all hospitals.

Hospitals admitting a patient who is neither Medicaid eligible on or before admission, nor pending eligibility, but applies for Medicaid during a psychiatric hospitalization, must send in the entire medical record to First Health (formerly First Mental Health) within 30 days of discharge. First Health (FH) will perform a post discharge review to determine prior approval (PA) for medically necessary days of acute care.

A phone call to FH will no longer be necessary for patients who apply for Medicaid during or after the stay. Hospitals must obtain a Medicaid identification (MID) number for the patient and send it to FH along with the medical record.

In addition to the MID number, if the patient is a child or adolescent admitted to a psychiatric hospital, a Certificate of Need (CON) must also be sent to FH. Due to difficulties in being able to meet HCFA requirements for performing a CON "on or before the Medicaid application date" and realizing hospitals may have problems receiving notification of a patient's application for Medicaid, the Division of Medical Assistance suggests a CON be performed and immediately submitted to FH on **every** child or adolescent admission to a psychiatric hospital, regardless of Medicaid status on admission. FH will place the CON in a holding file if the form indicates the patient has yet to apply for Medicaid. If a patient applies for Medicaid on or after the discharge date, the hospital must still send the entire medical record to FH for review with the CON (if applicable) and the Medicaid identification number.

Once eligibility has been verified, it will be determined by FH whether days were medically necessary. FH will send a notification letter to the hospital stating approval or denial of acute care days. Any approval will include a PA number.

If eligibility verification reflects the Medicaid application occurred on or before admission rather than during the stay as reported, the hospital stay would not be reviewed. For any patient already eligible or pending eligibility on admission, the hospital must still request **telephone prior approval** from FH within 48 working hours of admission and continue with the concurrent review process.

Diane Gupton, R.N.
First Health, 1-800-598-6462

Attention: All Providers

Medicaid Credit Balance Reporting

All providers participating in the Medicaid program are required to submit a **Quarterly Credit Balance Report** to the Division of Medical Assistance, Third Party Recovery Section. Providers are to report any OUTSTANDING credits owed to Medicaid that have not been reported previously on a Medicaid Credit Balance Report. (Hospital and Nursing Facility providers continue to be required to submit a report every calendar quarter even if a zero ($0.00) credit balance exists.) The report is to be submitted no later than 30 days following the end of the calendar quarter (March 31, June 30, September 30, and December 31).

The Medicaid Credit Balance Report is used to monitor and recover "credit balances" owed to the Medicaid program. A credit balance results from an improper or excess payment made to a provider. For example, refunds must be made to Medicaid if a provider is paid twice for the same service (e.g., by Medicaid and a medical insurance policy; by Medicare and Medicaid; by Medicaid and a liability insurance policy) if the patient liability was not reported in the billing process; or when computer or billing errors occur.

For the purpose of completing the report, a Medicaid Credit Balance is the amount determined to be refundable to the Medicaid program. 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, credit balances include money due Medicaid regardless of its classification in a provider's accounting records. 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 Medicaid program. The provider is responsible for identifying and repaying all monies owed the Medicaid program.

The Medicaid Credit Balance Report (a copy for reproduction immediately follows this article) requires specific information on each credit balance on a claim-by-claim basis. This form provides space for 15 claims but may be reproduced as many times as necessary to accommodate all the credit balances being reported. Specific instructions for completing the report are on the reverse side of the reporting form.

Submitting the Medicaid Credit Balance Report does not result in the credit balances automatically being reimbursed to the Medicaid program. If submitting a check is the preferred form of satisfying the credit balances, the check should be made payable to EDS and sent to EDS with the required documentation for a refund payment. If an adjustment is to be made to satisfy the credit balance, an adjustment form must be completed and submitted to EDS with all the supporting documentation for processing.

Submit **Medicaid Credit Balance Report** to:	Submit **Refund checks** to:	Submit **adjustment forms** to:
Third Party Recovery Section Division of Medical Assistance 2508 Mail Service Center Raleigh, NC 27699-2508	EDS Refunds P.O. Box 300011 Raleigh, NC 27622-3011	EDS Adjustment Unit P.O. Box 300009 Raleigh, NC 27622-3009

Submit **ONLY** the completed Medicaid Credit Balance Report to the Division of Medical Assistance. **DO NOT** send refund checks or adjustment forms to the Division of Medical Assistance. **DO NOT** send the Credit Balance Reports to EDS.

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

Marilyn Vail, Third Party Recovery Section
DMA, 919-733-6294

MEDICAID CREDIT BALANCE REPORT

PROVIDER NAME: _____ CONTACT PERSON: _____

PROVIDER NUMBER: _____ TELEPHONE NUMBER: (_____) _____

QUARTER ENDING: (Circle one) 3/31 6/30 9/30 12/31 YEAR:_____

(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.							

Circle one: Refund Adjustment

Return form to: Third Party Recovery
DMA
2508 Mail Service Center
Raleigh, NC 27699-2508

Revised 8/00

(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**
- Circle the date of quarter end
- Enter year
- 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 name of the Medicaid recipient (e.g., Doe, Jane)

Column 2 - The individual Medicaid identification (MID) number

Column 3 - The month, day, and year of beginning service (e.g., 12/05/99)

Column 4 - The month, day, and year of ending service (e.g., 12/10/99)

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 (not the amount your facility billed or the amount Medicaid paid)

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 **Third Party Recovery, DMA, 2508 Mail Service Center, Raleigh, NC 27699-2508**.

Attention: Physicians and Home Health and Hospice Agencies

Care Plan Oversight (CPO) of Medicaid Home Health or Hospice Services

Effective with date of service September 1, 2000, North Carolina Medicaid covers medically necessary extensive Care Plan Oversight (CPO) provided by physicians for patients receiving Medicaid-covered Home Health or Hospice services rendered in a patient's residence or adult care home where they reside. CPO is not covered for physician supervision of a nursing facility patient. Medicare guidelines have been adopted for coverage criteria.

CPO is the physician supervision of a patient receiving home health services skilled nursing, physical therapy, speech pathology, occupational therapy, home health aide services or hospice services who requires complex or multidisciplinary care modalities involving:

1. regular physician development or revision of care plans,
2. review of subsequent reports of patient status,
3. review of related laboratory and other studies,
4. communication with other health professionals not employed in the same practice who are involved in the patient's care,
5. integration of new information into the medical treatment plan, or
6. adjustment of medical therapy.

It is expected that the type of home health or hospice patient who warrants CPO services is one who has a variety of physical and psychosocial conditions. The vast majority of home health and hospice patients will not meet the criteria outlined above. Generally, CPO services are included in payment for office or hospital evaluation and management services codes.

Direct involvement by a physician is required because of the level of medical judgement needed to manage a home health or hospice patient requiring complex or multidisciplinary care modalities. Complex refers to the care modalities rendered, not the patient's diagnoses. Multidisciplinary means services from other licensed providers such as skilled nurses, physical therapists, occupational therapists, or speech therapists. The role of the physician is to coordinate the activities of the various disciplines during the month for which CPO services are billed.

Conditions of Coverage

1. The recipient must require complex or multidisciplinary care modalities requiring ongoing physician involvement in the patient's plan of care.
2. The recipient must be receiving Medicaid-covered home health or hospice services during the period in which the CPO service is furnished.
3. The physician who bills CPO must be the same physician who signs the home health or hospice plan of care.
4. The physician must furnish at least 30 minutes of CPO within the calendar month for which payment is claimed and no other physician can be paid for care plan oversight within that calendar month.

5. The physician must have provided a covered physician service that required a face-to-face encounter with the recipient within the six months immediately preceding the provision of the first CPO service. (A face-to-face encounter does not include EKG, lab services, or surgery.)

   Note: A face-to-face encounter is defined as Evaluation and Management (E/M) codes in the ranges 99201 to 99263 or 99281 to 99357.
6. The care plan oversight billed must not be routine postoperative care provided in the global surgical period of a surgical procedure billed by the physician.
7. For recipients receiving Medicaid-covered home health services, the physician must not have a significant financial or contractual interest in the home health agency as defined in 42 CFR 424.22 (d).
8. For recipients receiving Medicaid-covered hospice services, the physician must not be the medical director or an employee of the hospice or providing services under arrangements with the hospice.
9. The CPO services must be personally furnished by the physician who bills them.
10. Services provided "incident to" a physician's service do not qualify as CPO and do not count toward the 30-minute requirement.
11. The physician my not bill CPO during the same calendar month in which a Medicaid monthly composite payment End Stage Renal Disease benefit is billed for the same recipient.

Countable Services

The following activities are countable services toward the 30-minute minimum requirement for CPO:

1. Review of charts, reports, treatment plans, or lab or study results, except for the initial interpretation or review of lab or study results that were ordered during or associated with a face-to-face encounter.
2. Telephone calls with other health care professionals (not employed in the same practice) involved in the care of the patient.
3. Team conferences (time spent per individual patient must be documented).
4. Telephone or face-to-face discussions with a pharmacist about pharmaceutical therapies.
5. Medical decision making.
6. Activities to coordinate services are countable if the coordination activities require the skills of a physician.

Noncountable Services

The following activities are not countable services toward the 30-minute minimum requirement for CPO:

1. Services furnished by nurse practitioners, physician assistants, and other non-physicians cannot be billed under the CPO service. This includes the time spent by staff getting or filing charts, calling home health agencies, patients, etc.
2. The physician's telephone call to patient or family, even to adjust medication or treatment. The physician's time spent telephoning prescriptions into the pharmacist unless the telephone conversation involves discussion of pharmaceutical therapies.
3. Travel time, time spent preparing claims, and time spent for claims processing.
4. Initial interpretation or review of lab or study results that were ordered during or associated with a face-to-face encounter.
5. Low-intensity services included as part of other E/M services.
6. Informal consultations with health professionals not involved in the patient's care.
7. The physician's time spent discussing a patient with the nurse, conversations the nurse has with the home health agency. However, the time spent by the physician working on the care plan after the nurse has conveyed the pertinent information to the physician is countable toward the 30 minutes.

8. Other physicians working with the physician who signed the plan of care are not permitted to bill for these services. Only one physician per month will be paid for CPO for a patient.
9. The work included in hospital discharge day management (99238 to 99239) and discharge from observation (99217) is not countable toward the 30 minute per month required for the billing of CPO. Physicians may bill for work on the same day as discharge but only for those services separately documented as occurring after the patient is physically discharged from the hospital.

Documentation

Documentation by the physician in the patient's records must establish the necessity for the care plan management at the physician level of expertise. Contributing to complexity would be the necessity for care modalities beyond routine nursing and would include, but not be limited to such entities as the use of ventilatory devices; pain management requiring IV infusion with frequently altered dosage schedules or medication; IV chemotherapy; or a requirement to manage unusual wound care.

Documentation of countable physician CPO activities must be date specific, action specific and activity specific. Documentation supplied by a home health agency may not be used in lieu of physician's documentation.

The physician must maintain documentation that demonstrates that all of the requirements for billing are met, including notations in medical records of duration of telephone calls.

Billing

The following CPT codes must be used to bill CPO:

- CPT code 99375, physician supervision of a patient under care of home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of the care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more
- CPT code 99378, physician supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of the care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) with other health care professionals involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more

Claims for service must not be submitted until the end of the month in which the service is performed.

Dates of service entered on the claim form must be the first and last date during which documented care planning services were actually provided during the calendar month, not just the first and last days of the calendar month for which the claim is submitted.

Maximum Reinbursement Rates

CPT CODE	NON-FACILITY RATE
99375	$94.00
99378	$97.38

Providers must bill their usual and customary charges.

Claims for patients who are Medicare/Medicaid eligible must be submitted to Medicare. Medicaid will pay applicable deductibles and coinsurance. If CPO service is not covered by Medicare, the service must meet Medicaid coverage criteria for reimbursement by Medicaid with the exception of MQB.

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

Attention: All Providers

Reimbursement of Inpatient Services Provided to Carolina ACCESS Enrollees

Carolina ACCESS (CA) policy outlines the criteria for reimbursement of inpatient hospital services provided to CA enrollees. Inpatient hospital services filed for CA enrollees admitted from the emergency room (ER) will no longer require an authorization number from the enrollee's primary care provider (PCP) in block 11 of the UB-92 claim form. However, revenue code 450 (RC 450) must be listed on the UB-92 to identify an admission from the ER. To maintain continuity of care, inpatient physician services will continue to require an authorization number from the enrollee's PCP, and this number must be entered in block 19 of the HCFA-1500 claim form.

If you are not able to identify a CA enrollee's PCP from information contained in the hospital record, you may obtain this information by:

- calling the EDS Automated Voice Response (AVR) system number, 1-800-723-4337 (refer to the June 1999 Special Bulletin for additional AVR information)
- using Electronic Data Interchange (EDI), where available

Questions about reimbursement of services provided to CA enrollees admitted to a hospital from the ER should be directed to a CA nurse or consultant with the Division of Medical Assistance at 919-857-4022.

Vickie Dean, R.N., Managed Care Section
DMA, 919-857-4022

Attention: Health Check Providers (Physicians, Nurse Practitioners, Nurse Midwives, Federally Qualified Health Centers, Rural Health Centers)

Coverage of Health Check Screenings Performed by Child Health Nurse Screeners

Effective with date of service September 1, 2000, North Carolina Medicaid reimburses Health Check screenings of children by a Registered Nurse (RN) as an "incident to service" when these assessments are performed for the purpose of health screening. (Refer to the July 1997 Medicaid Bulletin for additional information on "incident to services.") The RN must meet specific education and practice requirements and be "rostered" (or listed) through the Division of Public Health, Women's and Children's Health Section (DPH/WCH) and the Office of Public Health Nursing and Professional Development (OPHNPD). Policies concerning coverage of Health Check screening visits performed by RNs employed by local health departments have not changed.

ROSTERING REQUIREMENTS

Initial Requirements

To become a Rostered Child Health Nurse Screener a nurse must:

- Have current licensure as an RN in the State of North Carolina.
- Have a non-Bachelor of Science in Nursing (BSN). RNs employed in a public health setting must complete the "Introduction to Principles and Practices of Public Health and Public Health Nursing" course.
- Complete one of the following:

    1. The North Carolina Child Health Training Program (CHTP) with documented 60 hours minimum of clinical preceptorship.

        OR

    2. Comparable pediatric history and physical examination courses (essential components of course are described below) with documented 60 hours of clinical preceptorship, **and** successful completion of the CHTP Challenge Procedure which includes written and clinical examinations.

A letter acknowledging the RNs rostered status will be mailed from the OPHNPD upon successful completion and documentation of the initial requirements. A roster of RNs who qualify as Health Check screeners for purposes of Medicaid reimbursement will be maintained by the OPHNPD. The local employing agencies or providers must maintain documentation of the RNs rostered status and must be made available to the Division of Medical Assistance or its agents upon request.

Continuing Requirements

Nurses who wish to maintain rostered Child Health Nurse Screener status must:

- Make biennial submission of statement of continuing performance of child health screenings to the OPHNPD (including history and physical assessment) with a minimum of 200 hours for a 2-year period, and
- Attend 20 contact hours of continuing education over a 2-year period and submit documentation of the course titles and hours with the statement of continuing performance of child health screenings.

The OPHNPD will mail a letter to the RN acknowledging receipt of the required documentation and their continued rostered status.

Alternate Renewal Requirements

The following options are available when an RN has not met requirements for continued rostering:

Option A

Pass the CHTP Challenge Procedure (clinical examination only).

Option B

Retake the CHTP course or audit the CHTP course and pass the CHTP Challenge Procedure

Components of the North Carolina CHTP

(or required components of a comparable pediatric history and physical examination course)

COURSE DESCRIPTION

Essential Course Content:

- Parent and children interviews
- History taking
- Physical appraisal of infants and children
- Screening tests, including hearing, vision, language, development, anthropometric, and laboratory
- Nutritional appraisal
- Care planning for child and family
- Counseling and anticipatory guidance
- Referrals and follow-up procedures
- Legal issues related to the North Carolina Nursing Practice Act

Didactic Component and Clinical Requirements

- Two weeks of didactic instruction with clinical experiences.
- Minimum of 60 hours clinical preceptorship providing child health screens, including both history and physical assessment, with satisfactory evaluation by a "local clinical advisor" who will evaluate the performance of the participant during the clinical phase. A local clinical advisor may be a nurse practitioner, physician assistant, physician, or an RN who has completed the CHTP and has six months or more experience.
- Completion of four homework assignments. The CHTP educators must evaluate the fourth assignment as "Satisfactory."
- Successful completion of final course examination (written) and demonstration of complete history and physical appraisal, assessment of problems, and plan.

The CHTP is sponsored by DPH/WCH to provide training for RNs to become rostered Child Health Nurse Screeners. DPH/WCH regional child health nurse consultants will provide technical assistance and consultation regarding child health nurse screening practice and rostering procedures. Contact the child health nurse consultant in the appropriate region for more information and to initiate the rostering process.

WCH Region	Regional Office Site	Telephone Number
1	Asheville	828-251-6788
2	Asheville	828-251-6788
3	Winston-Salem	336-771-4608
4	Mooresville	704-663-1699
5	Raleigh	919-571-4700
6	Fayetteville	910-486-1191
7	Washington	252-946-6481

Components of a Health Screening

A Health Check screening visit, also called a child health screen visit, meets the requirements for reimbursement by Medicaid if it includes the following required components:

- Comprehensive unclothed physical examination
- Comprehensive health history
- Developmental screening (including mental, emotional, and behavioral)
- Vision and hearing screenings
- Measurements, blood pressure (age four and over), and vital signs
- Nutritional assessment
- Laboratory procedures including lead screening
- Immunizations
- Anticipatory guidance and health education

Providers must follow the established Medicaid guidelines for billing Health Check screening.

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

Attention: Health Departments

Supervision of Services Performed in Health Departments

Medical or other remedial care or services provided by licensed health care practitioners employed by Medicaid providers enrolled as health departments and school-based health clinics (sponsored by health departments) must be provided by or rendered under the overall direction and supervision of:

1. a physician licensed under State law to practice medicine or osteopathy, or
2. other individuals approved to perform medical acts, tasks, or functions (nurse practitioners, certified nurse midwives, physician assistants).

The supervising practitioner may be employed by or under contract with the health department or school-based health clinic. Supervision does not mean that the practitioner is required to be present when the service is rendered, but must be "immediately available" via phone or pager. Supervision may include directions provided through established standing physician's orders for services provided by a registered nurse or an enhanced-role registered nurse consistent with NCGS 90-171.20 7 (f), 21 NCAC 36.0224 (a) (1)(A)(B) (6), and the North Carolina Board of Nursing.

Physician supervision of nurse practitioners, certified nurse midwives, and physician assistants must meet all other applicable State requirements concerning supervision.

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

Attention: All Providers

Renovation of the MMIS System – Identification Tracking Measurement Enhancement (ITME) Project

The Division of Medical Assistance (DMA) is upgrading and enhancing the Medicaid Management Information System (MMIS). The goals of the renovation, as noted in the April, 2000 Bulletin, are:

- more efficient claims processing
- improved flexibility to administer special programs and experiment with new methods for program oversight
- begin use of web-based technologies

The enhancements will include minimal changes to the Remittance and Status Advice (RA), submission of adjustment requests, prior approval, and voice response and eligibility verification systems.

Changes to the following parts are detailed in the Provider Impact section of this article.

Part I – Remittance and Status Advice
Part II - Adjustment Requests – NEW FORM
Part III – Prior Approval (PA)
Part IV - Automated Voice Response (AVR) System and Eligibility Verification System (EVS)

Implementation Schedule
The system changes will be implemented with an effective date of December 1, 2000. The RA will reflect the changes noted in Part I beginning December 1, 2000. Part II reflects the new NC Medicaid adjustment form. Use of this form is required as of December 1, 2000. Part III provides new instructions for submitting services that have been prior approved. Part IV addresses changes to the AVR System and EVS resulting from this enhancement.

Provider Impact
Part I: Remittance and Status Advice (RA) - See Example 1

RA modifications/format changes will be kept to only those that are necessary in conjunction with the ITME project. Overall, the RA will look very similar to the current format. Please note the format changes on the RA sample following this article (Example 1).

Addition of Financial Payer Code
A financial payer code follows the claim internal control number (ICN) in the first line of the claim data reflected on the RA. This financial payer code denotes the entity responsible for payment of the claims listed on the RA. Upon implementation, NC Medicaid will be the only financially responsible payer; therefore, the North Carolina Medicaid payer code of NCXIX (five characters) will be reflected.

Addition of Population Group Payer Code

The RA reflects the population payer code for each claim detail. The population payer code is printed at the beginning of each claim detail line on the RA. The population payer code denotes the special program/population group from which a recipient is receiving Medicaid benefits. Examples of population payer codes are as follows:

Code	**Name**	**Description**
CA-I	Carolina ACCESS	All recipients enrolled in Medicaid's Carolina ACCESS program
CA-II	ACCESS II	All recipients enrolled in Medicaid's ACCESS II program
CAB	ACCESS III – Cabarrus County	All recipients enrolled in Medicaid's ACCESS III program for Cabarrus County
PITT	ACCESS III – Pitt County	All recipients enrolled in Medicaid's ACCESS III program for Pitt County
HMOM	Health Management Organization (HMO)	All recipients enrolled in Medicaid's HMO program
NCXIX	Medicaid	All recipients not enrolled in any of the above noted population payer programs. Any recipient not identified with Carolina ACCESS, ACCESS II, ACCESS III, or HMO will be assigned the NCXIX population payer code to identify them with the Medicaid fee-for-service program.

Other population payers may be designated by DMA in the future.

Addition of new totals following the current claim total line

An additional line is added following each claim total line of the paid and denied claim sections of the RA for the following claim types: Medical (J), Dental (K), Home Health, Hospice and Personal Care (Q), Medical Vendor (P), Outpatient (M), and Professional Crossover (O). This additional line reflects original claim billed amount, original claim detail count, and total number of financial payers. Upon implementation in December 2000, NC Medicaid will be the only financial payer; these new totals will reflect the submitted claim totals.

These additional totals do not appear for claim types Drug (D), Inpatient (S), Nursing Home (T), and Medicare crossover (W) since they are not processed at the claim detail level and will not have multiple financial payers assigned, based on current NC Medicaid billing policy.

Addition of a new summary page at end of RA

For each Medicaid population payer identified on the paper RA, a new summary page showing total payments by population payer is provided at the end of the RA. This provides population payer detail information for tracking and informational purposes.

New specifications for Tape RA

Updated specifications have been mailed to all Tape RA Providers. If you are currently receiving a Tape RA and have not received the updated specifications, or have questions regarding the changes, please contact Glenda Raynor, Manager of EDS Electronic Commerce Services, at 919-851-8888 extension 5-3099.

Part II: Adjustment Requests – NEW FORM (Example 2)

The North Carolina Medicaid program will begin using a new RA format in December, 2000. This new format affects the way adjustment request forms are completed by the provider and processed by EDS. The appropriate "financial payer" information found on the new RA will be required on all adjustment request forms after December 1, 2000. DMA and EDS have implemented a new adjustment request form to help with these changes. One of the predominant changes is in the "claim number" field. This area is now identified with twenty boxes, each box for one number of the referenced claim number. Until December 1, 2000, there will be five empty boxes at the end of the claim number. After the December 1, 2000 implementation of the MMIS enhancements, these spaces will be used for the financial payer code information. Providers may begin using this new adjustment request form now if it facilitates implementing these changes. (Refer to example of claim field below.) Please contact EDS Provider Services with questions about the new format and processing of an adjustment request.

Claim # field on Adjustment form from RA prior to December 1, 2000:

Claim #:	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#					

Claim # field on Adjustment form from RA after December 1, 2000:

Claim #:	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#	N	C	X	I	X

Part III: Prior Approval (PA)

Effective December 1, 2000, entering the prior approval number on the claim form by the provider to receive payment for services rendered will no longer be required. This holds true for all prior approved Medicaid services, regardless of the entity giving the prior approval.

Prior approval requirements and the criteria for approval of services have not changed. Those services that previously required prior approval before the implementation of the enhanced MMIS will continue to require prior approval. If a service was approved prior to December 1, 2000 but was not provided or billed until after December 1, 2000, the original prior approval is still valid. The MMIS will verify that prior approval was obtained before claims payment can occur. If the services being submitted on the claim form require prior approval, and approval has not been obtained, that claim will be denied. The only change is that the input of the prior approval number is no longer required on the claim form by the provider as of December 1, 2000.

Part IV: Automated Voice Response (AVR) System and Eligibility Verification System (EVS)

These systems will be enhanced with new messages that will explain under which special Medicaid program or programs a recipient is enrolled as a participant. Additional information regarding these system enhancements will be provided in subsequent bulletin articles.

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

EXAMPLE 1

NORTH CAROLINA MEDICAID
REMITTANCE AND STATUS REPORT

XYZ CORPORATION
ACCOUNTS RECEIVABLE DEPT
P O BOX 1111
ANYWHERE NC 22222

280767

PROVIDER NUMBER **8900000** REPORT SEQ. NUMBER **21** DATE **10/27/1999** PAGE **1**

NAME / RECIPIENT ID / POPULATION GROUP	SERVICE DATES FROM MM DD CCYY	SERVICE DATES TO MM DD CCYY	DAYS OR UNITS	PROCEDURE/ACCOMMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMOUNT	EXPLANATION CODES
PAID CLAIMS MEDICAL												
JONES MARY D **CO=81 RCC=**				**CLAIM NUMBER=101999165181580***NCXIX*								
988888888A				**MED REC=9999999**					**ATTN PROV=89XXXX**		**1.0000**	
NCXIX	**06011999**	**06011999**	**1 3**	**99244 25 OUTPT. CONSULT, SEVERE- PHY**	**23000**	**11029**	**11971**	**00**	**11971**	**00**	**11971**	**534**
NCXIX	**06011999**	**06011999**	**1 3**	**93526 26 COMB RT HEART CATHETERIZATI**	**130000**	**00**	**130000**	**00**	**130000**	**00**	**130000**	**99**
NCXIX	**06011999**	**06011999**	**1 3**	**93543 INJECTION FOR HEART X-RAY**	**25100**	**22328**	**2772**	**00**	**2772**	**00**	**2772**	**98**
NCXIX	**06011999**	**06011999**	**1 3**	**93545 INJECTION FOR HEART X-RAY**	**42500**	**39585**	**2915**	**00**	**2915**	**00**	**2915**	**98**
NCXIX	**06011999**	**06011999**	**1 5**	**93555 26 IMAGING SUPERVISION, INTERP**	**26000**	**22581**	**3419**	**00**	**3419**	**00**	**3419**	**98**
NCXIX	**06011999**	**06011999**	**1 5**	**93556 26 IMAGING SUPERVISION, INTERP**	**36500**	**32438**	**4062**	**00**	**4062**	**00**	**4062**	**98**
DEDUCTIBLE= .00 PAT LIAB= .00 CO PAY= .00 TPL= .00					*283100*	*127961*	*155139*	*00*	*155139*	*00*	*155139*	
ORIGINAL BILLED AMOUNT= 2831.00 ORIGINAL DETAIL COUNT= 6 TOTAL FINANCIAL PAYERS= 1												
MOORE JOE D **CO=77 RCC=**				**CLAIM NUMBER=101999170192650***NCXIX*								
999777777A				**MED REC=00008888888**					**ATTN PROV=8900000**		**1.0000**	
NCXIX	**05311999**	**05311999**	**4 3**	**84520 UREA NITROGEN; QUANTITATIVE**	**2000**	**1061**	**939**	**00**	**939**	**00**	**939**	**2955**
NCXIX	**05311999**	**05311999**	**1 3**	**82565 CREATININE; BLOOD**	**2300**	**2300**	**00**	**00**	**00**	**00**	**00**	**2954**
NCXIX	**05311999**	**05311999**	**1 3**	**84132 POTASSIUM SERUM**	**2000**	**2000**	**00**	**00**	**00**	**00**	**00**	**2954**
NCXIX	**05311999**	**05311999**	**1 3**	**85014 BLOOD COUNT; OTHER THAN SPU**	**1400**	**1073**	**327**	**00**	**327**	**00**	**327**	**98**
NCXIX	**05311999**	**05311999**	**1 3**	**85018 HEMOGLOBIN**	**1800**	**1473**	**327**	**00**	**327**	**00**	**327**	**98**
NCXIX	**06011999**	**06011999**	**1 3**	**93010 ELECTROCARDIOGRAM REPORT**	**3500**	**2491**	**1009**	**00**	**1009**	**00**	**1009**	**534**
DEDUCTIBLE= .00 PAT LIAB= .00 CO PAY= .00 TPL= .00					*13000*	*10398*	*2602*	*00*	*2602*	*00*	*2602*	
ORIGINAL BILLED AMOUNT= 130.00 ORIGINAL DETAIL COUNT= 6 TOTAL FINANCIAL PAYERS= 1												
2 CLAIMS 15 MEDICAL *******					**296100**	**138359**	**157741**	**00**	**157741**	**00**	**157741**	
******--> TOTAL PAID CLAIMS 2 CLAIMS**					**296100**	**138359**	**157741**	**00**	**157741**	**00**	**157741**	

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XYZ CORPORATION
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PROVIDER NUMBER **8900000** REPORT SEQ. NUMBER **21** DATE **10/27/1999** **280767** PAGE **2**

NAME / RECIPIENT ID / POPULATION GROUP	SERVICE DATES FROM (MM DD CCYY)	SERVICE DATES TO (MM DD CCYY)	DAYS OR UNITS	PROCEDURE/ACCOMMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMOUNT	EXPLANATION CODES
ADJUSTED CLAIMS												
PROFESSIONAL ADJUSTMENT												
BARNES LARRY D **CO=43 RCC=**				**CLAIM NUMBER=901999183001888***NCXIX* ****ADJ**DEBIT TO 101998100300888***NCXIX*								
977788888A								**PAID 12231998**	**ATTN PROV=**			**8926**
NCXIX	**08131998**	**08141998**	**2 3**	**99232 HOSP VISIT, MODERATE. PHYS**	**18200**	**8096**	**10104**	**8083**	**2021**	**00**	**2021**	**8926**
86 ADJUSTMENT OF CLAIM *NCXIX* **101998100300888 MED REC=00009033333**												
21 DUPLICATE OF CLAIM *NCXIX* **101999046666666 PAID 03011999**												
NCXIX	**08171998**	**08171998**	**1 3**	**99231 HOSP VISIT, STABLE. PHYS T**	**5900**	**2474**	**3426**	**2741**	**685**	**00**	**685**	**8926**
86 ADJUSTMENT OF CLAIM *NCXIX* **101998100300888**												
NCXIX	**18181998**	**08181998**	**1 3**	**99232 HOSP VISIT, MODERATE. PHYS**	**9100**	**4048**	**5052**	**4042**	**1010**	**00**	**1010**	**8926**
86 ADJUSTMENT OF CLAIM *NCXIX* **101998100300888**												
NCXIX	**08191998**	**08191998**	**1 3**	**99238 HOSPITAL DISCHARGE DAY MANA**	**10200**	**4227**	**5973**	**4778**	**1195**	**00**	**1195**	**8926**
86 ADJUSTMENT OF CLAIM *NCXIX* **101998100300888**												
DEDUCTIBLE= .00 PAT LIAB= .00 CO PAY= .00 TPL= .00					*43400*	*18845*	*24555*	*19644*	*4911*	*00*	*4911*	
1 CLAIMS			**5**	**PROFESSIONAL ADJUSTMENT**		**18845**		**19644**		**00**		
					43400		**24555**		**4911**		**4911**	
******--> TOTAL ADJUSTED CLAIMS**			**1 CLAIMS**			**18845**		**19644**		**00**		
					43400		**24555**		**4911**		**4911**	

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PROVIDER NUMBER **8900000** REPORT SEQ. NUMBER **21** DATE **10/27/1999** **280767** PAGE **3**

NAME / RECIPIENT ID / POPULATION GROUP	SERVICE DATES FROM (MM DD CCYY)	SERVICE DATES TO (MM DD CCYY)	DAYS OR UNITS	PROCEDURE/ACCOMMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMOUNT	EXPLANATION CODES
DENIED CLAIMS MEDICAL												
JONES JERRY D **CO=77**				**CLAIM NUMBER=901999197050025***NCXIX*								
977777777A				**MED REC= 00006100000**					**ATTN PROV= 8910000**			
NCXIX	**11091998**	**11091998**	**1 3**	**86316 TUMOR ANTIGEN IMMUNOASSAY**	**8200**	**5324**	**2876**	**00**	**00**	**00**	**00**	**21**
21 DUPLICATE OF CLAIM*NCXIX* **101999047777777 PAID 0531999**												
DEDUCTIBLE= .00 PAT LIAB= .00 CO PAY= .00 TPL= .00					*8200*	*5324*	*2876*	*00*	*0*	*00*	*0*	
ORIGINAL BILLED AMOUNT= 82.00 ORIGINAL DETAIL COUNT= 1 TOTAL FINANCIAL PAYERS= 1												
PERRY JOHHNY A **CO=48**				**CLAIM NUMBER=901999172168421***NCXIX*								
944444444B				**MED REC= 10455555**					**ATTN PROV= 7924000**			
NCXIX	**06081999**	**06081999**	**1 3**	**99213 OV ESTAB. PT, MODERATE. PHYS**	**6200**	**6200**	**00**	**00**	**00**	**00**	**00**	**270**
NCXIX	**06081999**	**06081999**	**1 3**	**82962 BLOOD GLUCOSE BY MONITORING D Q4**	**1300**	**1300**	**00**	**00**	**00**	**00**	**00**	**270**
DEDUCTIBLE= .00 PAT LIAB= .00 CO PAY= .00 TPL= .00					*7500*	*7500*	*00*	*00*	*00*	*00*	*00*	
ORIGINAL BILLED AMOUNT= 75.00 ORIGINAL DETAIL COUNT= 2 TOTAL FINANCIAL PAYERS= 1												
2 CLAIMS			**3**	**MEDICAL *******		**12824**		**00**		**00**		
					15700		**2876**		**00**		**00**	
******--> TOTAL DENIED CLAIMS**			**2 CLAIMS**			**12824**		**00**		**00**		
					15700		**2876**		**00**		**00**	

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PROVIDER NUMBER **8900000** REPORT SEQ. NUMBER **21** DATE **10/27/1999** **280767** PAGE **4**

NAME / RECIPIENT ID / POPULATION GROUP	SERVICE DATES FROM / TO (MM DD CCYY)	DAYS OR UNITS	PROCEDURE/ACCOMMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMOUNT	EXPLANATION CODES
CLAIMS IN PROCESS - THESE CLAIMS ARE BEING PROCESSED AS LISTED											
PROFESSIONAL											
945751888A GARRETT JOE	**R09081998 09111998**		**CLAIM= 101999167167167***NCXIX*	**23600**		**MED REC= 00006655555**					**102**
901200000A MCCONNELL JERRY	**04281999 04281999**		**CLAIM= 101999155166144***NCXIX*	**26500**		**MED REC= 00009160000**					**102**
900534500A SHEPHERD DAVID	**J11011998 11011998**		**CLAIM= 101999167111111***NCXIX*	**3500**		**MED REC= 00006644444**					**102**
945999200A BEAN ALICE	**J02011999 02011999**		**CLAIM= 101999134988888***NCXIX*	**223**		**MED REC= 00004333333**					**101**
249666666A BROWN WADE	**01141999 01141999**		**CLAIM= 901999155555555***NCXIX*	**1047**		**MED REC= 00009588888**					**101**
252645999A DIXON EDNA	**07121998 07121998**		**CLAIM= 901999160999999***NCXIX*	**1370**		**MED REC= 00004444444**					**101**
6 CLAIMS			**PROFESSIONAL** ********	**56240**							
******--> TOTAL PENDING CLAIMS**			**6 CLAIMS**	**56240**							

FINANCIAL ITEMS: ADJUSTMENTS (PRINCIPAL, PENALTY, INTEREST), REFUND, PAYOUT ACTIVITY

RECIPIENT NAME/ RECIPIENT ID	FROM DOS/ TXN DATES	ADJUSTMENT ICN/ ORIGINAL CCN	TRANSFER CCN	PROVIDER % W/H / ADJUSTMENT % W/H <100%	TXF IND	ORIGINAL/ TRANSFER AMOUNT (A)	FROM PRIOR CYCLE (B)	AMOUNT COLLECTED (C)	WRITE-OFF AMOUNT (D)	ENDING BALANCE (B-C-D=E) (E)	EOB
ADJUSTMENTS											
NEGATIVE											
PRINCIPAL											
JONES MIRA	**09/01/1999**	**931999307990020***NCXIX*	**1999254751630***NCXIX*	**99%/**	**N**	**50000**	**50000**	**00**	**00**	**50000**	**0112**
900846721Q	**11/15/1999**	**1999309750040***NCXIX*									
				SUB TOTAL:		**50000**	**50000**	**00**	**00**	**50000**	
INTEREST											
MOORE JOHN	**08/01/1999**	**931999400500040***NCXIX*	**1999254751631***NCXIX*		**N**	**1627**	**1627**	**00**	**00**	**1627**	**2256**
976542318P	**10/20/1999**	**1999293502360***NCXIX*									
YOUTH GLADYS	**08/01/1999**	**931999504221001***NCXIX*			**N**	**2075**	**2075**	**00**	**00**	**2075**	**2256**
976542318P	**11/25/1999**	**1999329502360***NCXIX*									
				SUB TOTAL:		**3702**	**3702**	**00**	**00**	**3702**	
				TOTAL PPI:		**53702**	**53702**	**00**	**00**	**53702**	

(TOTAL OF COLUMN C FOR PRINCIPAL, PENALTY, AND INTEREST = WITHHELD AMOUNT ON CLAIMS PAYMENT SUMMARY PAGE)

EXAMPLE 1

NORTH CAROLINA MEDICAID
REMITTANCE AND STATUS REPORT

XYZ CORPORATION
ACCOUNTS RECEIVABLE DEPT
P O BOX 1111
ANYWHERE NC 22222

280767

PROVIDER NUMBER **8900000** REPORT SEQ. NUMBER **21** DATE **10/27/1999** PAGE **5**

NAME / RECIPIENT ID / POPULATION GROUP	SERVICE DATES FROM (MM DD CCYY)	SERVICE DATES TO (MM DD CCYY)	DAYS OR UNITS	PROCEDURE/ACCOMMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMOUNT	EXPLANATION CODES

FINANCIAL ITEMS: ADJUSTMENTS (PRINCIPAL, PENALTY, INTEREST), REFUND, PAYOUT ACTIVITY

RECIPIENT NAME/ RECIPIENT ID	FROM DOS/ TXN DATES	REFUND CCN/ ORIGINAL CCN/ICN	AR CCN	REFUND AMOUNT (A)	BAL FROM PRIOR CYCLE (B)	$ APPLIED THIS CYCLE (C)	ENDING BALANCE (B-C=E) (E)	EOB
REFUNDS								
INMAN WILLI	**04/22/1998**	**1999153000002***NCXIX*		**4359**	**4359**	**517**	**3842**	**2242**
246705500A	**05/03/1999**	**101999109666666***NCXIX*						
ROPER JOE	**03/28/1998**	**1999177400050***NCXIX*		**2755**	**2755**	**2755**	**00**	**2242**
246705500A	**02/01/1999**	**101999204772555***NCXIX*						
			TOTAL:	**7114**	**7114**	**3272**	**3842**	

(TOTAL OF COLUMN C=TO CREDIT AMOUNT ON CLAIMS PAYMENT SUMMARY PAGE)

TOTAL FINANCIAL ITEMS	**5**	********	**60816**	**60816**	**56974**	

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NORTH CAROLINA MEDICAID
REMITTANCE AND STATUS REPORT

XYZ CORPORATION
ACCOUNTS RECEIVABLE DEPT
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ANYWHERE NC 22222

PROVIDER NUMBER **8900000** REPORT SEQ. NUMBER **21** DATE **10/27/1999** **280767** PAGE **6**

NAME / RECIPIENT ID / POPULATION GROUP	SERVICE DATES FROM MMDDCCYY	SERVICE DATES TO MMDDCCYY	DAYS OR UNITS	PROCEDURE/ACCOMMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMOUNT	EXPLANATION CODES

CLAIMS PAYMENT SUMMARY **EFT NUMBER 123456**

	CLAIMS PAID	A PAID CLAIMS AMOUNT	B WITHHELD AMOUNT(*)	C NET PAY AMOUNT (A-B)	D CREDIT AMOUNT	E NET 1099 AMOUNT (C-D)	F IRS WITHHELD AMOUNT	G POS & EDI	H OTHER W/H	I ADJUSTED (NET PAY (C-F-G-H)
CURRENT PROCESSED	5	1626.52	.00	1626.52	32.72	1593.80	.00	.00	.00	1626.52
YEAR-TO-DATE TOTAL	12	5000.00	.00	5000.00	32.72	4967.28	.00	.00	.00	5000.00

1099 INFORMATION 1099 - THIS INFORMATION IF BEING FURNISHED TO THE INTERNAL REVENUE SERVICE
PROVIDER TAX ID: 62-2222222 PROVIDER TAX NAME: XYZ CORPORATION
PAYER ID: ELECTRONIC DATA SYSTEMS CORPORATION, PO BOX 30968 RALEIGH, NC 27622 #75-2548211

PLEASE VERIFY THE FOLLOWING IDENTIFICATION NUMBERS THAT HAVE BEEN ASSIGNED TO YOU. IF ANY OF THE NUMBERS ARE INCORRECT, PLEASE SEND CORRECTIONS TO:
EDS
PO BOX 300009
RALEIGH, NORTH CAROLINA 27622

CLIA - NONE ASSIGNED
UPIN - NONE ASSIGNED

THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION CODES UTILIZED THROUGHOUT THE REPORT

98 FEE ADJUSTED TO MAXIMUM PAYABLE
99 PAID AS BILLED
101 PENDING NORMAL IN-HOUSE PROCESSING
102 PENDING IN-HOUSE REVIEW
112 CHECK AMOUNT REDUCED BY RECOUPMENT AMOUNT
270 BILLING PROVIDER IS NOT THE RECIPIENT'S CAROLINA ACCESS PCP. CONTACT THE PCP FOR AUTHORIZATION; PUT AUTHORIZATION NUMBER IN BLOCK 19 ON THE HCFA-1500 OR FORM LOCATOR 11 OF THE UB-92
534 COPAY PREVIOUSLY DEDUCTED FOR THIS DATE OF SERVICE
2242 REFUND APPLIED TO OUTSTANDING PRINCIPAL, PENALTY, AND INTEREST BALANCES (REFER TO WRITE-OFF EOB). 1099 CREDITED FOR RETURN OF MEDICAID PAYMENTS
2954 REIMBURSEMENT WAS MADE ON PREVIOUSLY PAID DETAIL. PAYMENT IS DETERMINED BY # OF AUTOMATED TESTS BILLED. PAYMENT OF # OF UNITS ARE REFLECTED ON 1ST DETAIL. SEE 5/98 BULLETIN.
2955 PAYMENT REDUCED TO EQUAL THE NUMBER OF AUTOMATED LAB TESTS BILLED FOR THIS RECIPIENT. ADDITIONAL PAYMENT WAS MADE ON A PREVIOUSLY PAID DETAIL. SEE 5/98 BULLETIN
8926 ALLOWABLE REDUCED FOR OTHER INSURANCE PAYMENT

EXAMPLE 1

NORTH CAROLINA MEDICAID
REMITTANCE AND STATUS REPORT

XYZ CORPORATION
ACCOUNTS RECEIVABLE DEPT
P O BOX 1111
ANYWHERE NC 22222

PROVIDER NUMBER **8900000** REPORT SEQ. NUMBER **21** DATE **10/27/1999** **280767** PAGE **7**

NAME / RECIPIENT ID / POPULATION GROUP	SERVICE DATES FROM (MM DD CCYY)	SERVICE DATES TO (MM DD CCYY)	DAYS OR UNITS	PROCEDURE/ACCOMMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMOUNT	EXPLANATION CODES

****
* **SPECIAL NOTE: IF YOUR REMITTANCE ADVICE IS TEN PAGES OR MORE AND YOU ARE DUE A PAPER CHECK FOR CLAIMS REIMBURSEMENT, YOUR** *
* **CHECK WILL BE MAILED IN A SEPARATE ENVELOPE.** *
****

EXAMPLE 1

NORTH CAROLINA MEDICAID
REMITTANCE AND STATUS REPORT

XYZ CORPORATION
ACCOUNTS RECEIVABLE DEPT
P O BOX 1111
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PROVIDER NUMBER **8900000** REPORT SEQ. NUMBER **21** DATE **10/27/1999** PAGE **8**

NAME / RECIPIENT ID / POPULATION GROUP	SERVICE DATES FROM (MM DD CCYY)	SERVICE DATES TO (MM DD CCYY)	DAYS OR UNITS	PROCEDURE/ACCOMMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMOUNT	EXPLANATION CODES

TOTALS BY POPULATION GROUPING:

POPULATION GROUPING NUMBER	POPULATION GROUPING DESCRIPTION	CURRENT PAID AMOUNT	YTD PAID AMOUNT
NCXIX	MEDICAID	1626.52	3000.00
CA-I	CCN1	0	1100.00
CA-II	CCN2	0	900.00
TOTAL PAID		1626.52	5000.00

MEDICAID CLAIM ADJUSTMENT REQUEST

(This form is not to be used for claim inquiries or time limit overrides.)
PLEASE COMPLETE THIS FORM IN BLUE OR BLACK INK ONLY

MAIL TO:
EDS ADJUSTMENT UNIT
PO BOX _____(PAYER SPECIFIC)
RALEIGH, NC 27622

A CORRECTED CLAIM AND THE APPROPRIATE RA MUST BE ATTACHED

EDS USE ONLY

One Step: _____

EDS USE ONLY. DO NOT WRITE IN THIS BOX.

Provider #:_____ Provider Name:_____

Recipient Name:_____ MID#:_____

SUBMIT A COPY OF THE RA WITH REQUEST

Claim #: | | | | | | | | | | | | | | | | | | | |

Date Of Service: From:_____/_____/_____ To: _____/_____/_____

Billed Amount: $_____

Paid Amount: $_____

RA Date: _____/_____/_____

Please check (✓) reason for submitting the adjustment request:

☐ Over Payment ☐ Under Payment ☐ Full Recoupment ☐ Other

Please check (✓) changes or corrections to be made:

☐ Units ☐ Procedure/Diagnosis Code ☐ Billed Amount

☐ Dates of Service ☐ Patient Liability ☐ Further Medical Review

☐ Third Party Liability ☐ Medicare Adjustments ☐ Other

Please Specify Reason for Adjustment Request:

Signature Of Sender: Date: / / Phone #: ( ) -

EDS INTERNAL USE ONLY

Clerk ID#:_____Sent to:_____ Date sent:_____/_____/_____

Reason for review:_____

Reviewed by:_____ Date reviewed:_____/_____/_____

Outcome of review:_____

Date received back in the Adjustment Department: _____/_____/_____

Revised: 08/21/00

Attention: Independent Practitioners (IP's)

Postponement of the IP Seminars and Individual Visits

The seminars that were scheduled for October, 2000, have been postponed until further notice. Please watch future bulletins for more information.

EDS is now offering individual provider visits for IP providers. These visits are offered for new as well as existing providers with billing issues. Please complete and return the form below. An EDS Provider Representative will contact you to schedule a visit and discuss the type of issues to be addressed.

(cut and return visit request form only)

.....

Independent Practitioners Provider Visit Request Form

(No Fee)

Provider Name _____ Provider Number_____

Address _____ Contact Person _____

City, Zip Code_____ County _____

Telephone Number _____ Date _____

List any specific issues you would like addressed in the space provided below.

_____

_____

_____

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

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

Attention: Optical Providers

Optical Seminars

Optical seminars are scheduled for November, 2000. The October 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: Private Duty Nursing Providers

Individual Visits

EDS is offering individual provider visits for Private Duty Nursing providers. Please complete and return the form below. An EDS Provider Representative will contact you to schedule a visit and discuss the type of issues to be addressed.

(cut and return visit request form only)

.....

Private Duty Nursing Provider Visit Request Form

(No Fee)

Provider Name_____ Provider Number _____

Address _____ Contact Person _____

City, Zip Code_____ County _____

Telephone Number_____ Date _____

List any specific issues you would like addressed in the space provided below.

_____

_____

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

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

Checkwrite Schedule

September 6, 2000	October 10, 2000	November 7, 2000
September 12, 2000	October 17, 2000	November 14, 2000
September 19, 2000	October 26, 2000	November 21, 2000
September 28, 2000		November 30, 2000

Electronic Cut-Off Schedule

September 1, 2000	October 6, 2000	November 3, 2000
September 8, 2000	October 13, 2000	November 10, 2000
September 15, 2000	October 20, 2000	November 17, 2000
September 22, 2000		November 22, 2000

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

John W. Tsikerdanos
Executive Director
EDS

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