Number 10 *October 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

Attention: Mecklenburg County Providers

Health Maintenance Organization Update

Effective October 1, 2001, The Wellness Plan of North Carolina, Inc. is no longer serving as a Health Maintenance Organization (HMO) to Medicaid recipients in Mecklenburg County.

Southcare/Coventry Health Care of the Carolinas, Inc. and United HealthCare of North Carolina, Inc. will remain as HMO providers in this county. Additionally, Metrolina (formerly C.W. Williams), a Federally Qualified Health Center (FQHC), will remain as another Medicaid option in Mecklenburg County.

Julia McCollum, Managed Care Section
DMA, 919-857-4022

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

Attention: All Providers

Changes to Copayment for Brand Name Medicines

Effective October 1, 2001, there is a change for Medicaid recipients required to pay copayments for prescriptions. The copayment for **brand name drugs** is now $3.00. Copayment for **generic drugs** remains at $1.00.

Denise Rogers, Recipient and Provider Services
DMA, 919-857-4019

Attention: Emergency Department Physicians

After-Hours, Weekend Visits, and On-Call Services

The N.C. Medicaid program does not allow separate reimbursement for CPT procedure codes 99050, 99052, 99054, and 99058 for services provided in an emergency department. Medicaid defines normal hours as those hours when the emergency department is routinely open. Emergency rooms are open and services are available to recipients 24 hours a day, 7 days a week. The following CPT procedure codes must not be billed:

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

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

Attention: Anesthesiologists, Certified Registered Nurse Anesthetists, Hospitals

Separate Billing for Supervision of Certified Registered Nurse Anesthesiologists

The N.C. Medicaid program does not reimburse supervision of Certified Registered Nurse Anesthetists (CRNA) as a separate service. This policy applies to all CRNAs whether they are enrolled as:

- independent providers, or
- employed by a hospital, or
- employed through a physician's office.

When a CRNA is employed by an anesthesiologist, the CRNA services are incident to the physician and should be billed under the physician provider number. No supervisory fee can be billed. When a CRNA is employed by the hospital, the CRNA services should be billed on the HCFA-1500 claim form using the hospital's professional number. No supervisory fee can be billed. There is also no supervisory fee should a physician supervise a CRNA by phone after normal business hours.

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

Attention: Physicians and Other Practitioners

Medicaid Fee Schedule

Effective with date of service September 1, 2001, the North Carolina Medicaid Fee Schedule shall be based on ninety-five percent (95%) of the Medicare Fee Schedule Resource Based Relative Value System (RBRVS) in effect on the date of service.

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

Attention: All Providers

Fee Schedules and Reimbursement Plans

Fee Schedule Request Form

There is no charge for fee schedules or reimbursement plans requested from the Division of Medical Assistance (DMA). However, all requests for publications **must be made** on the Fee Schedule Request form and mailed to:

Division of Medical Assistance
Financial Operations – Fee Schedules
2509 Mail Service Center
Raleigh, NC 27699-2509

Or, fax your request to DMA's Financial Operations section at 919-715-0896.

NOTE: PHONE REQUESTS ARE NOT ACCEPTED

☐ Advanced Practice Psychiatric Clinical Nurse Specialist
☐ Advanced Practice Psychiatric Nurse Practitioner
☐ After Care Surgery Period
☐ Ambulatory Surgery Center
☐ Anesthesia Base Units
☐ Community Alternatives Program
☐ Dental
☐ Durable Medical Equipment
☐ Health Department
☐ Home Health
☐ Home Infusion Therapy
☐ Hospital Reimbursement Plan
☐ ICF/MR Reimbursement Plan
☐ Laboratory
☐ Licensed Clinical Social Worker
☐ Licensed Psychologist
☐ Nurse Midwife
☐ Nursing Facility Reimbursement Plan
☐ Optical and Visual Aids
☐ Orthotics and Prosthetics
☐ Physician Fees (includes x-ray)
☐ Portable X-ray

Requestor: _____ Provider Type: _____

Address: _____

_____

_____

Technical Contact: _____ Phone: _____

Request for Diskettes

Some fee schedules, the after-care surgery schedule, and the anesthesia base units schedule are also available on **diskette** or by **e-mail. NOTE: To reduce costs, where available, schedules will be sent by e-mail.**

DMA stipulates that the information provided is to be used only for internal analysis. **Providers are expected to bill their usual and customary rate.**

Please complete the information below with each request:

Requestor: _____ **E-mail Address:** _____

Address: _____

_____

Phone: _____

Type of File (circle one): **Format (circle one):**

Text File Excel Spreadsheet E-mail Diskette

Type of Schedule (check):

☐ Advanced Practice Psychiatric Clinical Nurse Specialist
☐ Advanced Practice Psychiatric Nurse Practitioner
☐ After Care Surgery Period
☐ Ambulatory Surgery Center
☐ Anesthesia Base Units
☐ Dental
☐ Health Department
☐ Laboratory
☐ Licensed Clinical Social Worker
☐ Licensed Psychologist
☐ Nurse Midwife
☐ Optical and Visual Aids
☐ Physician Fees (includes x-ray)
☐ Portable X-ray

Mail the request to**:**

Division of Medical Assistance
Financial Operations – Fee Schedules
2509 Mail Service Center
Raleigh, NC 27699-2509

Or, fax your request to DMA's Financial Operations section at 919-715-0896.

Attention: All Providers

Circumcision Policy for Newborns

Effective with date of service November 1, 2001, the N.C. Medicaid program will no longer cover routine newborn circumcisions. Medically necessary circumcisions will continue to be covered for all male recipients.

The American Academy of Pediatrics (AAP) policy on circumcision states that the benefits are not significant enough for the AAP to recommend circumcision as a routine procedure.

Physicians who perform routine circumcisions must follow the guidelines set forth in the North Carolina Administrative Code at 10 NCAC 26K.0106 concerning billing recipients for this noncovered service. Medicaid must not be billed for noncovered services.

Hospital claims must list all expenses related to routine newborn circumcisions as noncovered services and must not bill the family.

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

Attention: All Providers

Billing Nerve Conduction Studies

The N.C. Medicaid program reimburses for nerve conduction studies when they are medically necessary. Current procedural terminology codes 95900, 95903, and 95904 refer to testing performed using standard electro-diagnostic equipment. These devices must be capable of recording amplitude, duration, and response configuration as well as latency and sensory nerve action potential amplitude. Reimbursement for examinations using portable hand-held devices is included in the office visit and cannot be billed separately.

Procedure codes 95900 and 95903 cannot be billed for testing of the same nerve on the same day. Procedure code 95903 with F-wave study includes the services of a test without F-wave study. When one nerve is tested without F-wave study and a different nerve is tested with an F-wave study, bill both 95900 and 95903.

One unit of service represents all studies performed on a single nerve, including latency, velocity, amplitude, and response with antidromic or othodromic stimulation. The medical record must clearly document the medical necessity and identify each type of test performed.

The clinical efficacy and applicability of Current Perception Threshold testing in diagnosing or managing a disease has not been established. Therefore, Current Perception Threshold testing is not covered by Medicaid and will not be reimbursed.

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

Attention: All Providers

Response Time for Provider Inquiries

Due to budget constraints for the July 2001/2002 fiscal year, the Division of Medical Assistance (DMA) is experiencing a shortage in staff. As a result, providers may experience delays when contacting DMA with issues that require a response. DMA appreciates your patience and understanding during this temporary inconvenience.

To ensure that issues are handled effectively when calling Medicaid, refer to the following list for the contact source and telephone number related to your question.

Phone Numbers

Topic/Reason For Call	Call	Telephone Number
Accident Related Issues	DMA Third Party Recovery	1-919-733-6294
Advance Directives	DMA Medical Policy Section	1-919-857-4020
Automatic Deposits	EDS Finance Unit	1-800-688-6696 or 1-919-851-8888
Baby Love	DMA Baby Love Coordinator	1-919-857-4020
Billing Issues	EDS Provider Services	1-800-688-6696 or 1-919-851-8888
CAP Retroactive Requests	DMA Community Care	1-919-857-4021
Carolina ACCESS Enrollment Verification	AVR System	1-800-723-4337
Carolina ACCESS (Other than Denials)	DMA Managed Care Section	1-919-857-4022
ACCESS II Information	ACCESS II	1-919-715-7625
Carolina ACCESS Denials	EDS Provider Services	1-800-688-6696 or 1-919-851-8888
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 (Other than Eligibility Denials)	EDS Provider Services	1-800-688-6696 or 1-919-851-8888
Drug Utilization Review	DMA Program Integrity	1-919-733-3590
Electronic Data Interchange (EDI)	EDS	1-800-688-6696 or 1-919-851-8888
Eligibility Information, Current Day	AVR System	1-800-723-4337
Eligibility Information, Date of Service over 12 Months	DMA Claims Unit	1-919-857-4018
Electronic Claims Submission	EDS Electronic Commerce Services (ECS) Unit	1-800-688-6696 or 1-919-851-8888
Eligibility Denials	DMA Claims Analysis	1-919-857-4018
Fee Schedules	DMA Financial Operations	1-919-857-4015
Forms (Information and Orders)	EDS Provider Services	1-800-688-6696
Fraud and Program Abuse	DMA Program Integrity	1-919-733-6681

Phone Numbers, continued

Topic/Reason For Call	Call	Telephone Number
Health Care Connection (Mecklenburg County Managed Care)	DMA Managed Care Section	1-919-857-4022
Health Care Connection, Local	Health Benefits Advisors	1-704-373-2273
Health Check	DMA Managed Care Section	1-919-857-4022
Health Insurance Payment Program (HIPP)	DMA Third Party Recovery	1-919-733-6294
HMO Risk Contracting, including Health Care Connection	DMA Managed Care Section	1-919-857-4022
HMO Enrollment Verification	AVR System	1-800-723-4337
Medical Policy Questions	EDS Provider Services	1-800-688-6696 or 1-919-851-8888
Medicare Crossovers	EDS Provider Enrollment	1-800-688-6696 or 1-919-851-8888
Preadmission Screening and Annual Resident Review (PASARR)	First Health of Tennessee (FH)	1-800-639-6514
Preadmission Review for Inpatient Psychiatric Admissions/Continued Stay	First Health of Tennessee (FH)	1-800-770-3084
Prior Approval	EDS Prior Approval Unit	1-800-688-6696 or 1-919-851-8888
Private Insurance (Denials)	DMA Third Party Recovery	1-919-733-6294
Procedure Code Pricing	AVR System	1-800-723-4337
Provider Enrollment – Managed Care Provider Enrollment – MQB Provider Enrollment – All Other Providers	DMA Managed Care EDS Provider Enrollment DMA Provider Services	1-919-857-4022 1-800-688-6696 or 919-851-8888 1-919-857-4017
Rate Setting and Reimbursement	DMA Financial Operations	1-919-857-4015
Recipient Questions (Number for recipients to call)	DHHS Care Line	1-800-662-7030
Third Party Insurance Code Book	DMA Third Party Recovery Section	1-919-733-6294 Fax: 1-919-715-4725

The Automated Voice Response (AVR) system (1-800-723-4337) can be used to inquire about:

Recipient Eligibility	Hospice Participation	Hysterectomy Statement Status
Managed Care Enrollment	Drug Coverage Information	Sterilization Consent Status
Prior Approval Information	Dental Benefit Limitations	Claim Status
Procedure Code Pricing	Refraction Benefit Limitations	Checkwrite Information
Modifier Information		

The Automated Attendant telephone line (1-800-688-6696 or 919-851-8888) can be used to access the EDS Provider Services unit, Prior Approval unit or the Electronic Commerce Services (ECS) unit.

For Electronic Commerce Services "Press 1"	**For Prior Approval "Press 2"**	**For Provider Services Press 3"**
If you select ECS from the main menu, you will be prompted to: **"Press 1 to reach an ECS Analyst"**	If you select Prior Approval from the main menu, you will be prompted to: **"Press 2 for Optical or Hearing Aid"** **"Press 3 for Long-Term Care, Surgery or Out-of-State"** (Includes Psychiatric and Ambulance services) **"Press 4 for Dental"** **"Press 5 for DME"** **"Press 9 for Enhanced Care, Therapeutic Leave or Hospice"** (Includes High Risk Intervention providers)	If you select Provider Services from the main menu, you will be prompted to: **"Press 6 if you are calling from a Physician's Office or a County Health Department"** (Includes Health Check, Eye Care, Chiropractor, Ambulatory Surgery, IP, Nurse Midwife, Nurse Practitioner, Radiologist, Podiatrist, Health-Related Services in Public Schools Providers, CRNA, Independent Diagnostic Testing Facilities, Independent Mental Health, and Anesthesiology providers) **"Press 7 if you are calling from a Hospital or a Long-Term Care Facility"** (Includes Mental Health, Psychiatric Residential Treatment Facilities Level II – IV, Hearing Aid, and Dialysis providers) **"Press 8 if you are a Pharmacy, Dental, Health Care, Personal Care, DME or Domiciliary Care Facility"** (Includes Ambulance, CAP, DSS/DHS, Hospice, Home Infusion Therapy, Private Duty Nursing, Rural Health, FQHC, Adult Care Homes, At-Risk Case Management, and HIV Case Management providers)
"For operator-assisted calls - stay on the line" Once you select the appropriate unit, you will be connected to an individual to handle your call or placed in a queue for the first available agent. All calls placed in a queue are handled in the order in which they are received.		

To ensure that correspondence and documents are processed in a timely manner, refer to the following list of mailing addresses for the Medicaid program.

EDS Addresses

HCFA-1500 Claims EDS PO Box 30968 Raleigh, NC 27622	**Prior Approval Requests** EDS PO Box 31188 Raleigh, NC 27622
Pharmacy Claims EDS PO Box 300001 Raleigh, NC 27622	**Drug Rebates** EDS PO Box 300002 Raleigh, NC 27622
Adjustments EDS PO Box 300009 Raleigh, NC 27622	**Medicare Crossovers** EDS PO Box 300011 Raleigh, NC 27622
UB-92 Claims EDS PO Box 300010 Raleigh, NC 27622	**All Other Claims** EDS PO Box 300011 Raleigh, NC 27622
Returned Checks EDS PO Box 300001 Raleigh, NC 27622	**Sterilization Consent Forms** EDS PO Box 300012 Raleigh, NC 27622
Hysterectomy Statements EDS PO Box 300012 Raleigh, NC 27622	**General Correspondence** EDS PO Box 300009 Raleigh, NC 27622
When sending Certified mail, UPS or Federal Express, send to:	EDS 4905 Waters Edge Drive Raleigh, NC 27606

DMA Addresses

Carolina ACCESS Division of Medical Assistance 2516 Mail Service Center Raleigh, NC 27699-2516	**Claims Analysis and Medicare Buy-in** Division of Medical Assistance 2519 Mail Service Center Raleigh, NC 27699-2519
Community Care Program Division of Medical Assistance 2502 Mail Service Center Raleigh, NC 27699-2502	**Eligibility Unit** Division of Medical Assistance 2512 Mail Service Center Raleigh, NC 27699-2512
Financial Operations Division of Medical Assistance 2509 Mail Service Center Raleigh, NC 27699-2509	**Managed Care** Division of Medical Assistance 2516 Mail Service Center Raleigh, NC 27699-2516
Medical Policy/Utilization Control Division of Medical Assistance 2511 Mail Service Center Raleigh, NC 27699-2511	**Program Integrity** Division of Medical Assistance 2515 Mail Service Center Raleigh, NC 27699-2515
Provider Services Division of Medical Assistance 2506 Mail Service Center Raleigh, NC 27699-2506	**Third Party Recovery/Health Insurance Premium Payment Program** Division of Medical Assistance 2508 Mail Service Center Raleigh, NC 27699-2508
If you do not know which DMA section or unit's address to use, send correspondence to the following general address: **(Name of DMA employee)** Division of Medical Assistance 2501 Mail Service Center Raleigh, NC 27699-2501	
When sending Certified mail, UPS or Federal Express, send to: Division of Medical Assistance 1985 Umstead Drive Raleigh, NC 27626	

Jane S. Johnson, Claims Analysis Unit
DMA, 919-857-4018

Attention: All Prescribers

Synagis Coverage

Synagis is reimbursable through the pharmacy program and not the physician's program. It has been approved for prevention of RSV disease in children less than 24 months of age with bronchopulmonary dysplasia (BPD) or with a history of premature birth. The drug is administered once per month during the RSV season, which has been identified as being from October 2001 – March 2002 in our state.

Below is a list of guidelines that are approved by the American Academy of Pediatrics, which must be adhered to for drug coverage to be obtained.

- Synagis prophylaxis should be considered for infants and children younger than two years with BPD that are currently receiving or have received oxygen therapy within the six months prior to the anticipated RSV season.
- Infants with a gestational age of 28 weeks or less **may** benefit from prophylaxis until 12 months of age.
- Infants with a gestational age of 29 to 32 weeks **may** benefit from prophylaxis until 6 months of age.
- Infants with a gestational age of 32 to 35 weeks **may** benefit from prophylaxis until 6 months of age if they are also predisposed to at least two to of the following risk factors: A number of young siblings, exposure to tobacco smoke in the home, child care center attendance, multiple births.
- Synagis has not been approved by the Food and Drug Administration (FDA) for patients with congenital heart disease and therefore, will not be covered by the Medicaid program for this condition alone, since Medicaid can only cover FDA approved indications.
- The physician is required to write in his own handwriting on the face of the prescription the weight and date of birth of the child. (Pharmacist will not be allowed to fill the prescription without this documentation.)
- Not every child under two years of age needs to be placed on Synagis. Only those at high risk or those who already have complicated respiratory problems should be considered. Decisions regarding each patient should be individualized.

Synagis will be reimbursable from October 1, 2001 to March 31, 2002 unless it is determined that the season has changed for our state. If it is determined, upon audit of physicians and pharmacist records, that the drug is being used outside the guidelines, the Medicaid program will consider a strict prior approval on all coverage of this drug.

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

Attention: Nursing Facility Providers

Change in Assigning Retroactive Prior Approval Level of Care on the FL2 Form

Effective with date of service October 1, 2001, the Division of Medical Assistance will implement a new prior approval procedure to allow the EDS Prior Approval Unit to assign more than one level of care on an individual FL2 form.

When EDS receives an FL2 retroactive level of care request with medical records, the record documentation may indicate more than one level of care for the retroactive request period. If more than one level of care is approved, EDS staff will document both the **time-limited** level of care and the most **current** level of care on the FL2 form. Once completed, EDS will forward the approved FL2 to the appropriate county department of social services (DSS). The county DSS will then forward a copy of the approved FL2 form to the appropriate nursing facility.

Example (see page 14):

On March 10, 2001, EDS receives medical records with an FL2 requesting approval for skilled level of care for Jimmy Doe beginning January 1, 2001. EDS determines that the medical record supports the criteria for skilled level of care beginning January 1, 2001 to February 12, 2001. The medical record documentation supports the intermediate level of care beginning February 13, 2001. EDS documents the following on the FL2:

Upper Right-Hand Corner:

- Service Review Number (SRN) – 2001001112345
- January 1 to February 12, 2001 – the time-limited skilled level of care
- MI – mail in request
- **LH – initials of the nurse reviewer**

Block 12:

- SRN – 2001044102055

Block 13:

- **Approved – circled**
- 2/13/01 – beginning approval date
- **IC – intermediate level of care**
- MI – mail in as the type of review
- LH – initials of the EDS nurse reviewer

Reminder: For the retroactive prior approval policy, refer to the January 2001 general Medicaid bulletin.

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

FL-2 (86)
INSTRUCTIONS ON REVERSE SIDE

NORTH CAROLINA MEDICAID PROGRAM
LONG TERM CARE SERVICES

20010011 12345 1/1/01 to 2/12/01
SN/MI/LH

☐ PRIOR APPROVAL ☐ UTILIZATION REVIEW ☐ ON-SITE REVIEW

IDENTIFICATION

1. PATIENT'S LAST NAME	FIRST	MIDDLE	2. BIRTHDATE (M/D/Y)	3. SEX	4. ADMISSION DATE (CURRENT LOCATION)
Doe	Jimmy	R.	00/00/00	M	January 1, 2001

5. COUNTY AND MEDICAID NUMBER	6. FACILITY	ADDRESS	7. PROVIDER NUMBER
01 0030020047 A	Feel Good	456 Peaceful Lane	

8. ATTENDING PHYSICIAN NAME AND ADDRESS

9. RELATIVE NAME AND ADDRESS

10. CURRENT LEVEL OF CARE	11. RECOMMENDED LEVEL OF CARE	12. PRIOR APPROVAL NUMBER	14. DISCHARGE PLAN
___ HOME ___ DOMICILIARY ___ SNF ___ (REST HOME) X ICF ___ OTHER ___ HOSPITAL 1234567A	___ HOME ___ DOMICILIARY X SNF ___ (REST HOME) ___ ICF ___ OTHER Reno 11/01	200104102055 13. DATE (APPROVED) DENIED 2/13/01 IC/MI/LH	___ SNF X HOME ___ ICF ___ DOMICILIARY (REST HOME) ___ OTHER

15. ADMITTING DIAGNOSES - PRIMARY, SECONDARY, DATES OF ONSET

1. Fx. (R) Hip
2. HTN
3. GERD
4. CVA
5. Constipation
6.
7.
8.

16. PATIENT INFORMATION

DISORIENTED	AMBULATORY STATUS	BLADDER	BOWEL
N/A CONSTANTLY	✓ AMBULATORY	✓ CONTINENT	✓ CONTINENT
INTERMITTENTLY	✓ SEMI-AMBULATORY 1+ ASSIST	INCONTINENT	INCONTINENT
INAPPROPRIATE BEHAVIOR	NON-AMBULATORY	INDWELLING CATHETER	COLOSTOMY
WANDERER	**FUNCTIONAL LIMITATIONS**	EXTERNAL CATHETER	**RESPIRATION**
N/A VERBALLY ABUSIVE	✓ SIGHT glasses	**COMMUNICATION OF NEEDS**	✓ NORMAL
N/A INJURIOUS TO SELF	HEARING	✓ VERBALLY	TRACHEOSTOMY
N/A INJURIOUS TO OTHERS	SPEECH	NON-VERBALLY	OTHER:
INJURIOUS TO PROPERTY	CONTRACTURES	DOES NOT COMMUNICATE	O2 PRN CONT.
OTHER:	**ACTIVITIES/SOCIAL**	**SKIN**	**NUTRITION STATUS**
PERSONAL CARE ASSISTANCE	PASSIVE	✓ NORMAL	✓ DIET Regular
BATHING	✓ ACTIVE	OTHER:	SUPPLEMENTAL
FEEDING	GROUP PARTICIPATION	DECUBITI-DESCRIBE:	SPOON
DRESSING	RE-SOCIALIZATION		PARENTERAL
TOTAL CARE	FAMILY SUPPORTIVE		NASOGASTRIC
PHYSICIAN VISITS	**NEUROLOGICAL**		GASTROSTOMY
✓ 30 DAYS	N/A CONVULSIONS/SEIZURES		INTAKE AND OUTPUT
60 DAYS	N/A GRAND MAL	**DRESSINGS:**	FORCE FLUIDS
OVER 180 DAYS	PETIT MAL		WEIGHT 180 lbs.
	FREQUENCY		HEIGHT 71"

17. SPECIAL CARE FACTORS	FREQUENCY	SPECIAL CARE FACTORS	FREQUENCY
BLOOD PRESSURE		BOWEL AND BLADDER PROGRAM	
DIABETIC URINE TESTING		RESTORATIVE FEEDING PROGRAM	
X PT (BY LICENSED PT)	5 x's q wk x's 3 wks.	SPEECH THERAPY	
RANGE OF MOTION EXERCISES		RESTRAINTS	

18. MEDICATIONS / NAME & STRENGTHS, DOSAGE & ROUTE

1. HCTZ 25 mg. 1 q.d.
2. Celebrex 200 mg. 1 q.d
3. Prilosec 20 mg. 1 q.d.
4. Dulcolax 1 suppository 10 mg q. 3 day prn constipation
5. ASA 81 mg. 1 po q.d.
6. Tylenol 325 mg. 2 po q. 4° prn for pain
7.
8.
9.
11.
12.

19. X-RAY AND LABORATORY FINDINGS / DATE:

20. ADDITIONAL INFORMATION:

21. PHYSICIAN'S SIGNATURE

22. DATE 3/4/01

372-124 (12-92)

EDS - DMA COPY

Attention: All Providers

Cytogenetic Studies

Recently, the Division of Medical Assistance implemented diagnosis editing on CPT codes 88230 through 88239 and 88245 through 88291. For the diagnosis and treatment of the following conditions, one of the diagnoses listed must be on the claim in order for the claim to process:

Antepartum Condition or Complication
- 659.43
- 659.53
- 659.63

Genetic Disorders in a Fetus
- 758.0 through 758.9
- 655.11 through 655.13
- 655.21 through 655.24

Failure of Sexual Development
- 259.0

Chronic Myelogenous Leukemia
- 205.10 through 205.11
- 205.80 through 205.81

Acute Leukemia Lymphoid, Myeloid, and Unclassified
- 204.00 through 204.01
- 204.90 through 204.91
- 205.00 through 205.01
- 208.00 through 208.01

Myelodysplasia
- 238.7

Although medical records will not be required, documentation supporting the diagnosis billed must be maintained for a period of not less than five years.

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

Attention: All Providers

Reporting Changes in Provider Status to Medicaid

Providers, including Managed Care providers (Carolina ACCESS, ACCESS II, ACCESS III, and HMO Risk Contracting), are required to report all changes in status to the N.C. Medicaid program. This includes changes of address, ownership, name, tax identification number, and addition or deletion of group members. Because failure to provide timely notice may prevent or delay payments to the provider, all changes should be sent to the Medicaid program within 30 calendar days.

The procedure for reporting changes to the Medicaid program is determined by the provider type. Physicians report changes to Medicaid through Blue Cross and Blue Shield of North Carolina. Other providers report changes to the Division of Medical Assistance (DMA) using the Notification of Change in Provider Status form. Managed Care providers must also report changes within their practice to DMA's Managed Care Section. (Refer to the September 2001 general Medicaid bulletin for a copy of and information about the Carolina ACCESS Provider Information Change form.)

Revisions have been made to the Notification of Change in Provider Status form (see page 17). Providers are now required to submit a copy of their W9 for changes of ownership, name, and tax identification number.

The Notification of Change in Provider Status form, the Carolina ACCESS Provider Information Change form, and the W9 form are available from the DMA website at http://www.dhhs.state.nc.us/dma.

Darlene Cagle, Provider Services Unit
DMA, 919-857-4017

NOTIFICATION OF CHANGE IN PROVIDER STATUS

This form **is** intended for use by ALL PROVIDERS except as noted on the back of this form.
This form **is not** intended for use by PHYSICIANS. Physicians must make changes through Blue Cross and Blue Shield of North Carolina.

If you are requesting changes to a group, you **must** include the group name and number.
Indicate the type of change you are submitting by placing an "X" in the appropriate box(es).

☐ **Address Change** ☐ **Name Change (Attach W-9)** ☐ **Change of Ownership (Attach W-9)** ☐ **Tax ID Change (Attach W-9)** ☐ **Delete Group Member**

Indicate whether the change is for: ☐ **Individual Provider** ☐ **Group Provider**

Effective Date of Change _____

	NEW	**OLD (Existing information)**
Provider Name		
Medicaid Provider Number **REQUIRED**		
Provider Site Address		
Provider Billing Address		
Phone Number	( )	( )
Tax ID Number		
Tax ID Name		

Name of Individual Provider to be Deleted from Group _____

Provider Number for Individual Provider to be Deleted from Group _____

Contact Name _____ Contact Telephone Number ( ) _____

Signature of Owner or Authorized Agent _____

Print Name and Title of Owner or Authorized Agent _____

Return form to: **Provider Services, DMA, 2506 Mail Service Center, Raleigh, NC 27699-2506**

Revised 7/01

Report all changes to the Division of Medical Assistance using this form.
If you are enrolled as a Carolina ACCESS provider, you must also report changes to the Managed Care Section using the *Carolina ACCESS Provider Information Change Form*.**
Ambulance Services
Certified Registered Nurse Anesthetists
Developmental Evaluation Centers
DSS Case Management
Federal Qualified Health Centers
Head Start Programs
Health Departments
Hearing Aid Dealers
HIV Case Management
Independent Diagnostic Treatment Facilities
Independent Practitioners

- Audiologists
- Occupational Therapists
- Physical Therapists
- Respiratory Therapists
- Speech Therapists

Licensed Clinical Social Workers
Licensed Psychologists
Mental Health Centers
Nurse Midwives
Nurse Practitioners
Optical Services
Out-of-State Hospitals
Planned Parenthood Programs
Psychiatric Clinical Nurse Specialist
Psychiatric Nurse Practitioners
Public School Health Programs
Residential Evaluation Centers
School Based Health Centers

Report all changes to the Division of Medical Assistance using this form. Include a copy of your new CLIA certificate.
Independent Free-Standing Laboratories

Report all changes to the Division of Medical Assistance using this form. Include a copy of your new accreditation from the Commission of Free-Standing Birthing Center.
Free-Standing Birthing Centers

Revised 7/01

Report all changes to the Division of Medical Assistance using this form. Include a copy of your new license.
Durable Medical Equipment Services
Home Infusion Therapy Services
Personal Care Services
Pharmacies
Private Duty Nurses

Report all changes to the Managed Care Section using the *Carolina ACCESS Provider Information Change Form*.**
Providers (except chiropractors, dentists, optometrists, osteopaths, medical doctors, podiatrists) must also report changes to the Division of Medical Assistance using this form.
Carolina ACCESS Providers

Report all changes to the Managed Care Section using the *Carolina ACCESS Provider Information Change Form* and to the N.C. Office of Research, Demonstrations, and Rural Health Development (919-733-2040).**
ACCESS II and ACCESS III Providers

Report all changes to the N.C. Office of Research, Demonstrations, and Rural Health Development (919-733-2040).
Providers (except chiropractors, dentists, optometrists, osteopaths, medical doctors, podiatrists) must also report changes to the Division of Medical Assistance using this form.
ACCESS II and ACCESS III Administrative Entities

Report all changes to your HMO.
HMO Providers

Report all changes to the DMA Managed Care section (1-888-245-0179 or 919-857-4022) and to the Division of Medical Assistance using this form.
HMO Risk Contracting Managed Care Plans

Report all changes to EDS by calling 1-800-688-6696 or 919-851-8888 or submit changes in writing on company letterhead.
MQB Providers

Report all changes to the Division of Medical Assistance using this form. The DMA Provider Services unit will contact you to obtain additional information as needed to complete your change request.
Community Alternative Program Services

Report all changes to the Division of Medical Assistance using this form.
Providers must also report changes to the Division of Facility Services by calling 919-733-1610.
If you are enrolled as a Carolina ACCESS provider, you must also report changes to the Managed Care Section using the *Carolina ACCESS Provider Information Change Form*.**
Adult Care Homes
Ambulatory Surgical Centers
Critical Access Hospitals
Dialysis Centers
Home Health Agencies
Hospice
Intermediate Care/Mental Retardation Facilities
In-State Hospitals
Nursing Facilities
Portable X-Ray Suppliers
Psychiatric Residential Treatment Facilities
Residential Child Care Facility (Level II – IV)
Rural Health Clinics

Physicians must report all changes to their regional Blue Cross Blue Shield of North Carolina Representative.
If you are enrolled as a Carolina ACCESS provider, you must also report changes to the Managed Care Section using the *Carolina ACCESS Provider Information Change Form*.**
Physicians

- Chiropractors
- Dentists
- Optometrists
- Osteopaths
- Medical Doctors
- Podiatrists

**A copy of the *Carolina ACCESS Provider Information Change Form* is available on the Internet at www.dhhs.state.nc.us/dma or by calling the DMA Managed Care Section at 919-857-4022.

Attention: Physician and Physician Extenders Providing the Oral Screening Preventive Package under Codes W8002 and W8003

Oral Screening Preventive Package Update

A reminder to offices providing the oral screening preventive package: Medicaid will reimburse for a total of six oral screening preventive package visits per patient, from the time of tooth eruption **UNTIL** the third birthday. Services provided on or after the third birthday will **NOT** be reimbursed. These services can be provided at well child checkups, during a sick visit or at a separately scheduled visit.

Example of Oral Screening Preventive Package Visits:

Well Child Visit (months)	Procedure Performed?
Six	Yes (if teeth are erupted)
Nine	Yes (if teeth are erupted)
Twelve	Yes
Eighteen	Yes
Twenty-four	Yes
Before thirty-six	Yes

Begin providing the services as soon as the first teeth erupt. If services are provided at the six- or nine-month well child checkup, you must wait at least three months before providing the services again. Ideally, the procedure should be performed every 4 to 6 months, but flexibility is allowed to get patients on schedule.

Complete information regarding the Oral Screening Preventive Package was printed in the February 2001 general Medicaid bulletin. For training information call Kelly Haupt, Project Coordinator at 919-833-2466.

Kelly Haupt, Project Coordinator
919-833-2466

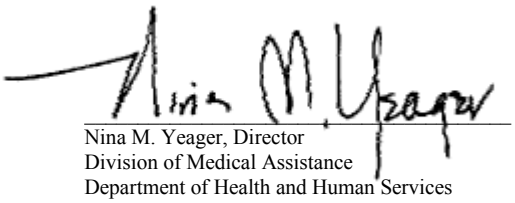
Checkwrite Schedule

October 9, 2001	November 6, 2001	December 11, 2001
October 16, 2001	November 14, 2001	December 18, 2001
October 25, 2001	November 20, 2001	December 28, 2001
	November 29, 2001	

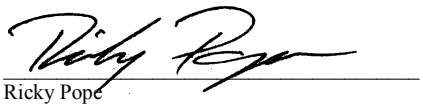
Electronic Cut-Off Schedule

October 5, 2001	November 2, 2001	December 7, 2001
October 12, 2001	November 9, 2001	December 14, 2001
October 19, 2001	November 16, 2001	December 21, 2001
	November 21, 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.



Nina M. Yeager, Director
Division of Medical Assistance
Department of Health and Human Services



Ricky Pope
Executive Director
EDS

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