North Carolina Medicaid Bulletin

An Information Service of the Division of Medical Assistance

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

Number 11 *November 1997*

Attention: All Providers

Holiday Observance

The Division of Medical Assistance (DMA) and EDS will be closed Tuesday, November 11, 1997, in observance of Veterans Day.

DMA and EDS will also be closed Thursday, November 27, 1997, and Friday, November 28, 1997, in observance of Thanksgiving.

Attention: Rural Health Clinics and Federally Qualified Health Centers

Third Party Liability Edits

Effective immediately, claims submitted by rural health clinics (RHC) and federally qualified health centers (FQHC) will be subject to the third party liability (TPL) edits in claims processing.

If a claim is denied for denial code 094, the provider must file that claim with the private insurance company indicated on the remittance statement in order to receive payment. If the private insurance company makes only partial payment or denies the claim, the provider may refile that claim with Medicaid indicating the partial payment or attaching the private insurance explanation of benefits denial. In order to meet the Medicaid timely filing requirements, a claim must be initially submitted to the private insurance company within the filing deadline requirements of that private plan, not to exceed one year from the date of service. Any resubmissions to Medicaid must be filed either within 18 months of the previous Medicaid filing or within 180 days of the private insurance company's partial payment or denial, whichever is later.

This change in editing does not affect particular service procedure codes which currently bypass TPL editing, such as Health Check screening claims. These particular service procedure codes will continue to bypass TPL editing.

Dawn Ely, Chief TPL
DMA, 919-733-6294

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

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Attention: All Electronic Billers

Discontinued EDS Electronic Formats

Effective January 1, 1998, in order to keep our system up to date with current formats, EDS will require the following electronic formats for direct data transmissions and diskette submissions:

- Pharmacy electronic formats beginning with a header record of 1RD (this format is replacing header record beginning with 1HD)
- Dental electronic formats beginning with a header record of 1RK (this format is replacing header record beginning with 1HK)

Claims received in these older formats will not be processed as of January 1, 1998.

If a provider uses software provided by a vendor, the provider must inform the vendor of the requirements to use the current formats by January 1, 1998. The vendor may contact the ECS unit at EDS to obtain these specifications.

If a provider is using the old EDS software, MicroECS, they will be affected. We encourage all providers currently using MicroECS to contact EDS to obtain a vendor list or a copy of the NECS software.

Contact the EDS ECS unit if you have questions.

EDS, ECS Unit
1-800-688-6696 or 919-851-8888, menu option #1

Attention: All Providers

New Carolina ACCESS Health Check Policy

Carolina ACCESS has required primary care providers (PCPs) who serve children birth through 20 years of age to directly provide Health Check services.

Effective September 2, 1997, the new policy allows PCPs to contract with or make referrals to local health departments for Health Check services when appropriate arrangements are made to coordinate services and exchange medical information. PCPs remain accountable for the screening rates of all their enrollees, regardless of whether the screening is conducted by the PCP or the health department. In addition, PCPs should retain the capability to perform the screenings in their office in situations when it would be in the enrollees' best interest.

The new policy enables PCPs with large patient loads to concentrate on sick care and related services and gives health departments the opportunity to continue providing well-care services in which they have developed significant expertise.

If PCPs are interested in this contractual arrangement with the health department, an Agreement Addendum (see next page) must be completed. Please contact your Carolina ACCESS Specialist for an Agreement Addendum or for further information.

Carolina ACCESS
1-800-228-8142 or 919-715-5417

AGREEMENT ADDENDUM

PRIMARY CARE PROVIDER AND HEALTH DEPARTMENT

We support the goals of Carolina ACCESS as outlined below:

- Improve access to primary care for Medicaid recipients
- Establish continuous and comprehensive relationships between primary care provider and patient
- Reduce inappropriate use of emergency room services
- Improve and increase primary care physician participation in Medicaid
- Promote the preventative aspects of health care

Providers who render medical services to children are required by the Carolina ACCESS program to provide Health Check services on a timely basis. The program recognizes that in some communities Health Departments have historically provided many of these services to children. The program also recognizes that it is in the best interest of the children of the community to continue with this arrangement because Health Departments have established tracking programs to ensure that children receive these services as scheduled. The following conditions must be agreed upon before the application to participate in Carolina ACCESS is approved:

1. Primary care physician's office will provide the County Health Department (CHD) monthly provider enrollment reports no later than the tenth day of each month.

2. CHD will enter this enrollment information into the CHD computer to identify and implement patient tracking for well child visits (Health Check Screenings) and immunizations.

3. Primary care physician/office staff will refer Carolina ACCESS patients to CHD for Health Check appointments. If the patient is in the office, the physician/office staff will assist patient in making CHD Health Check appointment.

4. CHD will generate appointment reminder and missed appointment letters for those patients who have Health Check appointments.

5. CHD will send primary care physician monthly report of those patients who received appointment reminders and missed appointment letters. Primary care physician will keep these records on site and readily available for review by Carolina ACCESS quality assurance staff.

6. All Health Check physicals and immunization records for patients enrolled with primary care physician will be sent monthly to the primary care physician. Primary care physician will maintain in the office a hard copy of physical and immunization records as a part of the patient's permanent chart.

7. Primary care physician agrees to monitor the information provided by the CHD to assure that children in the Carolina ACCESS program are receiving immunizations as scheduled and to counsel patients appropriately if noncompliant with well child visits or immunizations.

8. Transportation is often a problem for Medicaid recipients. Primary care provider agrees to inform patients about transportation services available through the Department of Social Services. In the event that the recipient does not have access to transportation, the primary care physician and the CHD will arrange for on site Health Check screenings and immunizations at the mutual convenience of both parties.

9. Primary care physician will arrange to have CHD complete Health Check physicals and/or immunizations on site in cases where it is the recipient's choice to have the screening on site. All required components of the Health Check screening will be provided at the time of screening.

10. Primary care physician agrees to review information provided by the CHD and to follow up with patients when additional services are needed.

11. Primary care physician agrees to work with the Carolina ACCESS local plan representative and the Health Check coordinator/Health Department Designee for CHD to assure the delivery of services.

12. Primary care physician agrees to allow the Carolina ACCESS quality assurance staff access to Carolina ACCESS patient records for the purpose of monitoring the success of this arrangement. Carolina ACCESS staff will provide adequate notice of audit visit to primary care physician.

13. Carolina ACCESS quality assurance staff will conduct an audit of records after this arrangement has been implemented for 90 days and again at six and 12 month intervals. Success of this arrangement will be determined by documentation that 80% of the Carolina ACCESS patients enrolled with the primary care physician will have been contacted and/or received Health Check screenings and immunizations in a timely manner by (date one year from when this goes into effect).

14. Any deficiencies discovered during any audit will be discussed between the primary care physician, CHD, and the Carolina ACCESS quality assurance staff. A plan of correction will be developed and implemented as necessary to maintain the integrity of the arrangement and assure compliance with the terms of the contract. See Section 6.2 "Contract Violation Provisions".

The program strongly encourages primary care providers to arrange for the provision of Health Check exams and immunizations to be provided at their practice. The personal delivery of these services provides for better continuity of care and accessibility to necessary preventative services.

The Carolina ACCESS program should be notified immediately if either the primary care physician and/or the CHD wishes to discontinue this arrangement.

_____ _____

Signature of Provider or Authorized Official Date

_____ _____

Signature Health Department Director/Designee Date

Practice Name: _____ Provider Number _____

Attention: Private Duty Nursing Providers

Faxing Requests and Supporting Documentation

Private Duty Nursing (PDN) provider agencies may fax or mail referrals, renewal requests, and supporting documentation to DMA's Community Care Section for approval. Send the material to the attention of "PDN Consultant." The fax number is 919-715-9025. It is not necessary to mail a hard copy of faxed materials unless requested by DMA staff.

Please refer to Section 9 of the Medicaid Community Care Manual if you have questions about submitting requests for PDN.

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

Attention: DME Providers

Criteria for Continuous Positive Airway Pressure and Bi-level Therapy Devices

Effective November 1, 1997, requests for prior approval for a continuous positive airway pressure (CPAP) device, HCPCS code E0601, will be subject to the following new criteria.

The physician must document one of the following diagnoses:

1. Obstructive sleep apnea
2. Upper airway resistance syndrome
3. Central sleep apnea.

In addition, the results of a sleep study must be submitted and must document a respiratory disturbance index (RDI) or apnea/hypopnea index (AHI) equal to or greater than 10 per hour of recorded sleep, AND must have a total of 30 apneas and/or hypopneas within the sleep study period. For children ages birth to 18, a RDI or AHI between 5 and 10 may be acceptable if the physician who is a sleep specialist provides appropriate documentation of medical necessity for the CPAP in each individual case on his letterhead stationery. The total of 30 apneas and/or hypopneas within the sleep study period will also be required for this age group. Only sleep studies which are recorded for 480 minutes or less are acceptable for the purposes of CPAP approval.

Effective November 1, 1997, requests for prior approval for bi-level therapy devices, HCPCS code E0452, "intermittent assist device with continuous positive airway pressure device", will be subject to the following new criteria.

The criteria for continuous positive airway pressure device (CPAP) must be met AND the prescribing physician must document that the patient meets one of the following conditions:

1. Has had an unsuccessful trial on CPAP, OR
2. Is unable to tolerate CPAP, OR
3. Is 5 years of age or younger, OR
4. Has special needs which are documented by the physician who is a sleep specialist on his letterhead stationary.

In order for patients with a diagnosis of nocturnal hypoventilation syndrome to qualify for bi-level therapy, the physician must document pCO_2 equal to or greater than 50 mm Hg during sleep.

Melody B. Yeargan, P.T., Medical Policy
DMA, 919-733-9434

Attention: DME Providers

Lifetime Expectancies for Wheelchair Components

Effective with claims processing date November 1, 1997, the following lifetime expectancies will be effective for wheelchair components:

CODE	DESCRIPTION	LIFETIME
K0015	detachable, non-adjustable height armrest	3 years
K0016	detachable, adjustable height armrest, complete assembly	3 years
K0017	detachable, adjustable height armrest, base	3 years
K0018	detachable, adjustable height armrest, upper portion	3 years
K0019	arm pad	2 years
K0020	fixed adjustable height armrest, complete assembly	3 years
K0021	anti-tipping device	2 years
K0022	reinforced back upholstery	2 years
K0023	solid back insert, attached with straps	2 years
K0024	solid back insert, adjustable hook hardware	3 years
K0025	hook-on headrest extension	2 years
K0026	back upholstery for ultralightweight or high strength lightweight wheelchairs	2 years
K0027	back upholstery for wheelchair types other than ultralightweight and high strength lightweight	2 years
K0028	fully reclining back	3 years
K0029	reinforced seat upholstery	2 years
K0030	solid seat insert	3 years
K0031	safety belt/pelvic strap	3 years
K0032	seat upholstery for ultralightweight or high strength lightweight wheelchair	2 years
K0033	seat upholstery for wheelchair types other than ultralightweight and high strength lightweight	2 years
K0034	heel loop	2 years
K0035	heel loop with ankle strap	2 years
K0036	toe loop	2 years
K0037	high mount flip-up footrest	3 years
K0038	leg strap	2 years
K0039	leg strap, H style	2 years
K0040	adjustable angle footplate	3 years
K0041	large size footplate	3 years
K0042	standard size footplate	3 years
K0043	footrest, lower extension tube	3 years
K0044	footrest, upper hanger bracket	3 years

K0045	footrest, complete assembly	3 years
K0046	elevating legrest, lower extension tube	3 years
K0047	elevating legrest, upper hanger bracket	3 years
K0048	elevating legrest, complete assembly	3 years
K0049	calf pad	2 years
K0050	ratchet assembly	3 years
K0051	cam release assembly, footrest or legrest	3 years
K0052	swingaway, detachable footrests	3 years
K0053	elevating footrests, articulating	3 years
K0059	plastic coated handrim	2 years
K0060	steel handrim	3 years
K0061	aluminum handrim	3 years
K0062	handrim with 8-10 vertical or oblique projections	3 years
K0063	handrim with 12-16 vertical or oblique projections	3 years
K0064	zero pressure tube (flat free insert), any size	2 years
K0065	spoke protectors	2 years
K0066	solid tire, any size	1 year
K0067	pneumatic tire, any size	1 year
K0068	pneumatic tire tube, any size	1 year
K0069	rear wheel assembly, complete, with solid tire, spokes or molded	3 years
K0070	rear wheel assembly, complete, with pneumatic tire, spokes or molded	3 years
K0071	front caster assembly, complete, with pneumatic tire	3 years
K0072	front caster assembly, complete, with semi-pneumatic tire	3 years
K0073	caster pin lock	3 years
K0074	pneumatic caster tire, any size	1 year
K0075	semi-pneumatic caster tire, any size	2 years
K0076	solid caster tire, any size	1 year
K0077	front caster assembly, complete, with solid tire	3 years
K0078	pneumatic caster tire tube	1 year
K0079	wheel lock extension	3 years
K0080	anti-rollback device	3 years
K0081	wheel lock assembly, complete	3 years
K0082	22 NF deep cycle lead acid battery	1 year
K0083	22 NF gel cell battery	1 year
K0084	Group 24 deep cycle lead acid battery	1 year
K0085	Group 24 gel cell battery	1 year
K0086	U-1 lead acid battery	1 year

K0087	U-1 gel cell battery	1 year
K0088	battery charger, lead acid or gel cell	2 years
K0089	battery charger, dual mode	2 years
K0090	rear wheel tire for power wheelchair, any size	1 year
K0091	rear wheel tire tube for other than zero pressure for power wheelchair, any size	1 year
K0092	rear wheel assembly for power wheelchair, complete	4 years
K0093	rear wheel, zero pressure tire tube (flat free insert) for power wheelchair, any size	2 years
K0094	wheel tire for power wheelchair, any size	1 year
K0095	wheel tire tube other than zero pressure for power wheelchair, any size	1 year
K0096	wheel assembly for power wheelchair, complete	4 years
K0097	wheel zero pressure tire tube (flat free insert) for power wheelchair, any size	2 years
K0098	drive belt for power wheelchair	1 year
K0099	front caster for power wheelchair	4 years
K0100	amputee adapter	3 years
K0101	one-arm drive attachment	3 years
K0102	crutch and cane holder	3 years
K0103	transfer board, less than 25 inches	3 years
K0104	cylinder tank carrier	3 years
K0105	IV hanger	3 years
K0106	arm trough	3 years
K0107	wheelchair tray	3 years

Providers are reminded to review Section 6.8 "Replacing DME" in the Durable Medical Equipment Manual before replacing medical equipment, especially with regard to warranty coverage of equipment.

If a claim for a wheelchair component with prior approval before November 1, 1997 is denied, re-submit as an adjustment.

Melody B. Yeargan, P.T., Medical Policy
DMA, 919-733-9434

Attention: Hospital Providers

Lower Level of Care and Swing Bed Rates

Effective with date of service October 1, 1997, the hospital lower level of care and swing bed rates per patient day are:

Level of Care	**Rate**
Skilled Nursing Care	$108.11
Intermediate Care	$82.13
Ventilator Dependent Care	$348.85

Cecile Alston, Financial Operations
DMA, 919-733-6784

Attention: DME Providers

Items No Longer Requiring Prior Approval

Effective with claims processing date November 1, 1997, the following DME items will no longer require prior approval:

CODE	DESCRIPTION
K0019	arm pad
K0026	back upholstery for ultralightweight or high strength lightweight wheelchairs
K0027	back upholstery for wheelchair types other than ultralightweight and high strength lightweight
K0032	seat upholstery for ultralightweight or high strength lightweight wheelchair
K0033	seat upholstery for wheelchair types other than ultralightweight and high strength lightweight
K0034	heel loop
K0035	heel loop with ankle strap
K0036	toe loop
K0038	leg strap
K0039	leg strap, H style
K0040	adjustable angle footplate
K0041	large size footplate
K0042	standard size footplate
K0043	footrest, lower extension tube
K0044	footrest, upper hanger bracket
K0045	footrest, complete assembly
K0049	calf pad
K0050	ratchet assembly
K0051	cam release assembly, footrest or legrest
K0059	plastic coated handrim
K0060	steel handrim
K0061	aluminum handrim
K0064	zero pressure tube (flat free insert), any size
K0065	spoke protectors
K0066	solid tire, any size
K0067	pneumatic tire, any size
K0068	pneumatic tire tube, any size
K0069	rear wheel assembly, complete, with solid tire, spokes or molded
K0070	rear wheel assembly, complete, with pneumatic tire, spokes or molded
K0071	front caster assembly, complete, with pneumatic tire
K0072	front caster assembly, complete, with semi-pneumatic tire
K0073	caster pin lock
K0074	pneumatic caster tire, any size
K0075	semi-pneumatic caster tire, any size
K0076	solid caster tire, any size
K0077	front caster assembly, complete, with solid tire
K0078	pneumatic caster tire tube
K0079	wheel lock extension
K0080	anti-rollback device
K0081	wheel lock assembly, complete
K0082	22 NF deep cycle lead acid battery
K0083	22 NF gel cell battery
K0084	Group 24 deep cycle lead acid battery
K0085	Group 24 gel cell battery
K0086	U-1 lead acid battery
K0087	U-1 gel cell battery
K0090	rear wheel tire for power wheelchair, any size
K0091	rear wheel tire tube for other than zero pressure for power wheelchair, any size

CODE	DESCRIPTION
K0092	rear wheel assembly for power wheelchair, complete
K0093	rear wheel, zero pressure tire tube (flat free insert) for power wheelchair, any size
K0094	wheel tire for power wheelchair, any size
K0095	wheel tire tube other than zero pressure for power wheelchair, any size
K0096	wheel assembly for power wheelchair, complete
K0097	wheel zero pressure tire tube (flat free insert) for power wheelchair, any size
K0098	drive belt for power wheelchair
K0099	front caster for power wheelchair

Providers are reminded that medical necessity must be documented on a Certificate of Medical Necessity and Prior Approval form for each item of durable medical equipment supplied. See Sections 5.7 "Record Keeping" and 6.4 "Getting Coverage" in the Durable Medical Equipment Manual.

Melody B. Yeargan, P.T., Medical Policy
DMA, 919-733-9434

Attention: All Providers

Medicaid Treatment of Private Insurance Plan Payments and Denials

Non-Compliance Denials

Effective with date of service December 1, 1997, State and Federal third party liability (TPL) laws mandate that Medicaid not pay for services denied by private health plans due to noncompliance with those private plan requirements. Common noncompliance denials include:

- Non-participating provider
- Failure to obtain pre-approval
- Exceeds time filing deadline
- Service not provided in proper location
- Service not payable separately but is lumped with payment for other services, etc.

If the service would have been a covered service and payable by the private plan, but some requirement of the plan was not met, then Medicaid will not pay for this service.

The recipient and the provider both have responsibility for complying with private plan requirements. If the recipient did not inform the provider of the existence of the recipient's private plan, and the plan's requirements were not met because the provider was unaware of them, the provider may bill the recipient for those services if both the private plan and Medicaid deny payment due to noncompliance. Similarly, if a recipient fails to cooperate in any way in meeting any private plan requirement, the provider may bill the recipient for the service(s). Recipients are being informed of their responsibility and that they may be billed for services which do not comply with their private plans. However, if the recipient presents the private payer information, and the provider is aware that the provider is not a participating provider in that plan or cannot meet any other private plan requirement, the provider must inform the recipient of that fact and that the recipient will be responsible for payment.

When submitting claims to Medicaid with private insurance denials, the insurance company explanation of benefits (EOB) MUST be included with the claim, along with the explanation of any denial codes. If a claim is submitted with an insurance denial, and either the EOB or the denial code explanation is missing, the claim will be either returned to the provider as incomplete or denied for insufficient information.

Discounted Fee-For-Service Payments

This section updates portions of the May 1996 Bulletin article on reimbursement for private insurance co-payments. The Medicaid program makes payment to providers on behalf of the recipients for medical services rendered, but is not an "insurer." As such, Medicaid is not responsible for any amount for which the recipient is not responsible. Therefore, a provider cannot bill Medicaid for any amount greater than what the provider agreed to accept from the recipient's private plan. If the recipient is not responsible for payment, then Medicaid is not responsible for payment. The provider should bill only the amount which the provider has agreed to accept as payment in full from the private plan. All other portions of that May 1996 article regarding billing co-payments are still valid and in effect.

TPL Overrides and EOBs Generally

With respect to paper claims, if the provider received a payment from a private plan, the provider may continue to indicate such payment on the claim, and submit the claim without attaching the EOB. However, the provider must bill Medicaid only the amount for which the recipient is responsible, in accordance with the requirements outlined above. Additionally, the provider must keep the EOB records on file for a period of three years pursuant to the Medicaid provider agreements and manuals. The Third Party Recovery (TPR) Section of DMA will conduct audits of provider records and billings, and providers will be required to provide copies of such EOBs. If no EOB is retained, Medicaid may recoup its payment made for the service(s). However, if the provider files a paper claim and receives a denial from a private plan, the EOB, with the denial code explanation, must be attached to the claim, as stated above. In extreme cases where the provider has tried repeatedly to obtain a private insurance EOB without success, the DMA form 2057, "Health Insurance Information Referral Form" may be used in lieu of an EOB.

When submitting claims electronically, if the provider received a payment from a private plan, the provider may continue to indicate the payment amount as traditionally done, complying with the limitations set out above regarding the billed amount. If the provider received a private plan denial, providers may use the following occurrence codes to override the TPL edits electronically in UB92 form locators 32-35a-b: (1) code 24 - Insurance Denied and Date; (2) code 25 - Benefits Terminated and Date; and (3) codes A3-C3 - Benefits Exhausted and Date. Occurrence code 24, "Insurance Denied" is defined to mean the following **only**: the private plan denied payment because this service is not a covered service by this private plan. This means that the service never would have been covered under any circumstance. This does **not** mean that the plan denied payment for the service due to the provider's or recipient's noncompliance with that plan's requirements. As stated above with paper claims, the providers are required to retain the private plan EOBs for a period of three years, and the providers will be required to submit copies of such EOBs upon request by DMA.

All claims should be submitted to EDS for processing except the following:

(1) Claims with a private plan denial for any denial ***other than***

(a) applied to the deductible

(b) benefits exhausted

(c) not a covered service, as defined above

(d) pre-existing condition

(e) Medicare eligible with no private insurance (any denial meeting (1)(a)-(e) should be sent to EDS, any other denial to TPR)

(2) Claims with a DMA-2057 form

Claims for copayments due from the recipients having capitated plans, as discussed in the May 1996 Bulletin article referenced above should now be sent to EDS. Claims meeting the requirements in either (1) or (2) above only, should be submitted directly to the TPR Section at P.O. Box 29551, Raleigh, NC 27626-9551.

Deborah Bowen or Dawn Ely, TPR Section
DMA, 919-733-6294

Attention: Physician Providers

Rate Adjustments

Effective with date of service October 1, 1997, Medicaid will adjust the following fees to conform with Medicare allowables. Due to providers instruction to bill their usual and customary charge, no adjustments will be made.

Procedure Code	TOS	New Allowable
11000	3	37.64
11001	3	21.07
11971	3	156.17
11976	3	97.83
12001	3	68.17
12002	3	80.12
12004	3	102.89
12005	3	132.42
12006	3	167.20
12011	3	75.41
12013	3	91.64
12014	3	111.07
12015	3	147.02
12016	3	189.94
12041	3	97.19
12042	3	119.19
12044	3	145.96
15201	3	120.22
15610	3	200.89
15620	3	242.78
15625	3	170.53
15792	3	82.89
15851	3	35.68
16000	3	38.14
16010	3	36.60
16020	3	35.11
16040	3	105.30
19030	3	61.92

Procedure Code	TOS	New Allowable
20225	3	134.73
20500	3	47.33
20501	3	32.52
20550	3	38.52
20610	3	38.53
20615	3	83.36
20816	3	1,772.82
20822	3	1,465.52
20824	3	1,772.82
20827	3	1,506.83
20962	3	2,454.64
21181	3	624.97
21282	3	302.93
21300	3	62.81
21310	3	42.11
21348	3	827.80
21356	3	343.87
21400	3	93.87
21454	3	553.54
21930	3	286.80
22310	3	174.89
23350	3	47.03
23472	3	1,448.54
23620	3	144.40
24200	3	69.82
24220	3	56.06
25246	3	59.97
25915	3	992.07

Procedure Code	TOS	New Allowable
26010	3	60.55
26125	3	274.67
26555	3	979.09
26580	3	1,058.08
26585	3	811.35
26590	3	1,041.91
27040	3	105.66
27227	3	1,274.57
27228	3	1,390.53
27333	3	632.06
27370	3	48.31
27443	3	920.74
27648	3	45.82
29200	3	28.42
29705	3	41.77
29804	3	702.08
29883	3	811.30
30430	3	387.40
31090	3	778.90
31235	3	190.78
31500	3	107.70
31588	3	854.10
31590	3	459.90
31611	3	444.51
31628	3	272.04
31629	3	240.48
31708	3	67.74
31715	3	48.95

Procedure Code	TOS	New Allowable
31717	3	87.45
32000	3	75.55
33208	3	537.23
33247	3	716.94
33414	3	2,095.82
33415	3	1,703.87
33416	3	1,728.58
33470	3	1,500.84
33472	3	1,892.20
33475	3	1,909.97
33476	3	2,037.28
33478	3	2,198.02
33504	3	1,619.09
33505	3	1,832.01
33506	3	1,832.01
33647	3	2,425.72
33665	3	2,269.50
33670	3	2,725.04
33762	3	1,655.09
33764	3	1,655.09
33786	3	2,796.53
33788	3	2,129.42
33803	3	1,583.61
33814	3	2,131.33
33845	3	2,040.18
33851	3	2,004.44
34501	3	645.83
34510	3	781.35
34520	3	819.94

34530	3	1,085.61
35162	3	1,439.08
35450	3	724.28
35471	3	724.28
35474	3	539.36
35492	3	487.34
35495	3	442.04
35548	3	1,534.31
35549	3	1,679.29
35870	3	955.08
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36005	3	43.82
36145	3	147.64
36218	3	50.44
36248	3	50.44
36420	3	47.02
36460	3	360.99
36493	3	58.39
36500	3	108.71
36510	3	43.71
36522	3	160.75
36625	3	92.96
36660	3	58.00
36832	3	536.66
36835	3	306.91
37200	3	188.74
37201	3	330.99
38790	3	92.63
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40842	3	552.22
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41822	3	200.81
41823	3	278.87

41830	3	292.59
42145	3	621.38
42550	3	51.93
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43204	3	268.98
43215	3	188.59
43216	3	189.01
43217	3	204.07
43219	3	200.62
43220	3	150.53
43226	3	167.56
43227	3	256.73
43234	3	144.84
43239	3	192.81
43241	3	186.49
43246	3	310.44
43247	3	242.60
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43456	3	157.73
43460	3	168.61
43600	3	73.83
43750	3	272.08
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44365	3	269.97
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44389	3	225.23
44955	3	140.19

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46945	3	95.12
46946	3	139.04
47490	3	298.54
47505	3	55.41
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47525	3	214.79
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47555	3	313.96
47556	3	344.10
47630	3	372.83
48102	3	212.06
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49501	3	473.54
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50392	3	178.13
50393	3	222.72
50394	3	40.73
50395	3	209.59
50396	3	79.26
51605	3	35.16
51610	3	48.80
51736	3	38.38
51741	3	63.70

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62281	3	109.81
62287	3	579.91
62290	3	151.73
62298	3	100.53
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63086	3	288.82
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64405	3	50.75
64408	3	76.42
64410	3	67.36
64412	3	56.00
64413	3	66.36
64415	3	53.71
64417	3	65.18
64418	3	67.66
64420	3	56.48
64421	3	78.92
64425	3	71.92

64440	3	66.25
64441	3	87.09
64442	3	81.82
64443	3	50.87
64445	3	60.71
64505	3	61.13
64508	3	67.24
64510	3	61.48
64520	3	65.56
64530	3	88.09
64600	3	157.47
64605	3	220.88
64630	3	148.59
64640	3	104.95
64680	3	131.64
65220	3	38.14
65710	3	916.44
65730	3	1,148.80
65750	3	1,135.89
65755	3	1,149.87
65855	3	386.61
65860	3	291.56
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66762	3	390.32
66821	3	228.27
66983	3	739.75
67010	3	637.06
67030	3	387.05
67031	3	369.34
67036	3	1,028.99
67039	3	1,211.04
67040	3	1,406.69
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67110	3	712.74
67141	3	423.02
67145	3	438.05
67255	3	724.96
67335	3	244.75
67830	3	142.92
67903	3	539.17
67904	3	517.30
67908	3	428.55
67911	3	447.13
67914	3	311.59
69200	3	36.84
69210	3	25.82
69450	3	480.60
69604	3	1,198.76
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69801	3	725.55
69806	3	1,045.26
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70015	5	53.20
70032	5	24.63
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70460	5	50.77
70470	5	57.00
70480	5	57.61
70481	5	61.87
70482	5	65.05
70486	5	51.07
70487	5	58.21
70488	5	63.84
70490	5	57.61
70491	5	61.87
70492	5	65.05
70540	5	66.58
70551	5	66.58
70552	5	80.27
70553	5	106.72
71034	5	20.83
71036	5	24.63
71038	5	24.63
71040	5	26.46
71090	5	24.63
71250	5	51.98
71260	5	55.64
71270	5	61.87
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72127	5	57.00
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72130	5	57.00
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72141	5	72.21
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72146	5	72.21
72147	5	86.50
72148	5	66.58
72149	5	80.27
72156	5	115.68
72157	5	115.68
72158	5	106.72
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72193	5	51.98
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72196	5	72.21
72240	5	41.05
72255	5	41.05
72270	5	59.74
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73085	5	24.63
73115	5	24.63
73200	5	48.79
73201	5	51.98
73202	5	54.41
73220	5	66.58
73525	5	24.63
73580	5	24.63
73615	5	24.63
73700	5	48.79
73701	5	51.98
73702	5	54.41
73720	5	66.58
74150	5	53.20
74160	5	57.00
74170	5	62.93
74181	5	72.21
74220	5	20.83
74230	5	24.33
74235	5	53.20
74245	5	41.05
74249	5	41.05
74250	5	21.13
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74283	5	90.90
74320	5	24.63
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74360	5	24.63
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74775	5	28.28
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75600	5	22.04
75605	5	51.07
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75662	5	74.64
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75671	5	74.64
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75685	5	58.82
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75710	5	51.07
75716	5	58.82
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75994	5	58.82
76003	5	24.63
76062	5	24.63
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76092	5	20.27
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76100	5	26.46
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76355	5	54.11
76360	5	51.67
76365	5	51.67
76370	5	38.31
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76400	5	72.21
76506	5	28.59
76511	5	36.68
76516	5	24.63
76519	5	24.63
76529	5	25.84
76536	5	25.54
76604	5	25.24
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76705	5	26.76
76775	5	26.46
76800	5	50.77
76810	5	88.62
76815	5	29.50

76816	5	25.84
76828	T	31.59
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77328	5	93.94
77331	5	39.22
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77605	5	93.94
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77615	5	93.94
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78018	5	42.87
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78135	5	28.89
78140	5	27.67
78172	5	24.33
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78585	5	48.79
78587	5	22.04
78593	5	22.04
78594	5	24.33
78596	5	57.00
78601	5	23.42
78605	5	24.33
78606	5	28.89
78607	5	55.02
78635	5	27.67
78645	5	25.84
78650	5	27.67
78707	5	42.26
78726	5	39.22
78740	5	25.84
78760	5	29.80
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79001	5	46.97
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79035	5	113.56

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79200	5	89.68
79300	5	71.90
79400	5	88.01
79420	5	67.79
79440	5	89.68
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88304	5	15.62
88342	T	9.93
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91000	5	41.07
91010	3	111.01
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91011	3	130.50
91011	5	99.02
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91012	5	108.97
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91032	3	99.72
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91033	3	135.14
91033	5	93.75

91052	3	50.32
91052	5	39.93
91055	3	54.07
91055	5	44.76
91060	5	29.69
91065	3	32.55
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91105	3	26.03
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92012	3	34.16
92018	3	60.55
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92284	3	21.51
92506	3	42.81
92512	3	31.91
92520	3	40.11
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92953	3	29.65
92982	3	785.39
92984	3	214.05
92986	3	1,000.30
92990	3	797.22
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93024	5	83.61
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93230	3	150.86
93233	3	37.67
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93237	3	32.15
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93272	3	28.83
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93321	3	44.98
93321	5	10.72
93325	5	3.50
93350	3	139.82
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93505	3	291.63
93505	5	230.26
93510	5	228.95
93511	5	235.93
93526	5	355.59
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93539	3	42.34
93540	3	42.34
93541	3	33.78
93542	3	33.47
93543	3	28.07
93544	3	26.86
93545	3	47.59
93561	3	56.26
93561	5	39.70
93562	3	29.91
93562	5	20.00
93600	3	211.47
93600	5	151.62

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93642	3	570.12
93642	5	350.53
93720	3	34.25
93722	3	12.40
93724	3	345.79
93875	3	51.54
93875	5	17.15
93880	5	30.79
93886	5	42.11
93888	3	115.66
93888	5	27.83
93923	5	30.73
93924	5	34.25
93925	5	30.19
93930	5	26.72
93965	5	25.41
93970	5	33.66
93971	3	108.36
93971	T	85.97
93975	5	68.03
93976	3	143.58
93976	T	97.91
93978	5	32.44
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94260	3	26.24
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94662	3	32.52

94681	3	57.62
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95962	5	142.93
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97018	3	9.71
97020	3	8.32
97022	3	11.32
97024	3	8.63
97026	3	8.01
97028	3	8.46
97036	3	15.26
97039	3	13.93
97139	3	11.59
99271	3	32.61
99272	3	48.70
99303	3	100.43
99355	3	76.36
99357	3	77.26
99431	3	74.03
99432	3	79.85
99433	3	39.16

Pam Sanders, Financial Operations
DMA, 919 733-6784

Attention: All Providers

Tax Identification Information

Alert - Tax update requested

North Carolina Medicaid must have proper tax information for all providers. This will ensure correct issuance of 1099 MISC forms each year and also ensure the correct tax information is provided to the IRS. If inappropriate information is given or is on file, this can result in IRS mandatory 31% withholding of payments made by Medicaid. Be sure the individual responsible for maintenance of tax information in your organization receives the following information.

How to verify tax information

The last page of your Medicaid Remittance and Status (RA) report indicates the provider tax name and number (FEIN) Medicaid has on file. Refer to the Medicaid RA throughout the year for each provider number to ensure we have the proper information. The tax information needed for a group practice is as follows: (1) Group tax name and group tax number; (2) Attending Medicaid provider numbers in group. If you do not have a Medicaid RA, call Provider Services 1-800-688-6696 or 919-851-8888 to verify the tax information on file for each provider number.

Providers should complete a special W-9 (see next page) for all provider numbers with **incorrect** information on file. Instructions for completing the special W-9 are listed below.

- Fill in the North Carolina Medicaid Provider Name Block (**this must be completed)**
- Fill in the North Carolina Medicaid Provider Number (**this must be completed)**
- Part I Correction field - Indicate your tax identification number exactly as the IRS has on file for you and/or your business. Do not put your Social Security Number unless you are an individual or sole proprietor
- Part II Correction field - Indicate your tax name exactly as the IRS has on file for you and/or business
- Part III - Indicate the appropriate type of organization for your tax identification number. Please note, if you are using your Social Security Number as your tax identification number, you must select individual/sole proprietor as type of organization
- Part IV - An authorized person **MUST** sign and date this form, otherwise it will be returned as incomplete and your tax data ***will not*** be updated

Send completed and signed forms to:

EDS 4905 Waters Edge Drive Raleigh NC 27606 Attention: Provider Enrollment	**OR**	FAX to (919) 851-4014 Attention: Provider Enrollment

Change of ownership

Contact DMA Provider Enrollment at 919-733-2130 to report all changes in business ownership. If necessary, a new Medicaid provider number will be assigned and Provider Enrollment will ensure the correct tax information is on file for Medicaid payments. If you ***do not contact*** DMA and ***continue to use a provider number*** with incorrect tax data, you could ***become liable for taxes*** on income not received by your business. DMA will assume no responsibility for penalties assessed by the IRS or for misrouted payments prior to written receipt of notification of ownership changes.

Group practice changes

When a physician leaves or a physician is added to a group practice, contact DMA Provider Enrollment to update Medicaid enrollment and tax information. Remember, without notifying DMA Provider Enrollment, the wrong tax information could remain on file and your business could become liable for taxes on Medicaid payments you did not receive.

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

Special W-9

Complete all four parts below and return to EDS. Incomplete forms will be returned to you for proper completion.

Provider Name: Provider Number:

Part I. Provider Taxpayer Identification Number:

Your tax identification number should be reflected below exactly as the IRS has on file for you and/or your business. Please verify the number on file (per the last page of your most recent RA) and update as necessary in the correction fields listed below:

Correction Field (please write clearly in black ink):

Employer Identification Number/Taxpayer Identification Number

Social Security Number **If you do not have an employer ID then indicate social security number if you are an individual or sole proprietor only

Part II. Provider Tax Name:

Your tax name should be reflected below exactly as the IRS has on file for you and/or your business. Individuals and sole proprietors must use their proper personal names as their tax name. Please verify the name on file (per the last page of your most recent RA) and update as necessary in the correction fields listed below:

Correction Field:

Part III. Type of Organization - Indicate below:

____Corporation/Professional Association _____ Individual/Sole Proprietor _ Partnership

____Other: _____ _____ Government: _____

Part IV. Certification

Certification - Under the penalties of perjury, I certify that the information provided on this form is true, correct, and complete.

_____

Signature Title Date

EDS Office Use Only

Date Received: _____Name Control: _____Date Entered: _____

Checkwrite Schedule

November 4, 1997
November 12, 1997
November 18, 1997
November 26, 1997
December 9, 1997
December 16, 1997
December 30, 1997

Electronic Cut-Off Schedule *

October 31, 1997
November 7, 1997
November 14, 1997
November 21, 1997
December 5, 1997
December 12, 1997
December 19, 1997

****** ***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

James R. Clayton
Executive Director
EDS

Bulk Rate
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Raleigh, N.C.
Permit No. 1087

EDS

PO Box 30968
Raleigh, North Carolina 27622