Number 11 *November 1999*

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 on the following dates for the observance of holidays.

Dates Closed	Holiday Observance
Thursday, 11/11/99	Veterans Day
Thursday, 11/25/99	Thanksgiving
Friday, 11/26/99	Thanksgiving
Friday, 12/24/99	Christmas
Monday, 12/27/99	Christmas
Friday, 12/31/99	New Year's Day

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

Attention: HCFA-1500 Claim Form Billers

HCFA-1500 Claim Forms

EDS is no longer supplying HCFA-1500 claim forms. Over the last few years EDS has eliminated the distribution of all other Medicaid claim forms (i.e. UB-92, ADA and Pharmacy). The HCFA-1500 is a universal form and can be purchased at office supply stores. Orders received prior to this notification will be filled.

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.

THIS DOCUMENT IS A YEAR 2000 READINESS DISCLOSURE UNDER UNITED STATES FEDERAL LAW

Attention: All Providers

Update on Year 2000 Activities

EDS continues the effort to comply with year 2000 requirements. In July, EDS began testing with providers who have completed the changes to submit year 2000 compliant claim formats. In September EDS released the new North Carolina Electronic Claims Submission (NCECS) software. Providers should continue to monitor bulletin articles on the status of year 2000 testing and implementation. It is important that claims using the new software or formats not be submitted before the final dates published by the ECS unit. This information will be provided in the instructions released with the software.

DMA will accept claims in their current non-Y2K compliant format until the end of the transition period. Transition dates vary depending on the method of submission. This capability provides a high degree of comfort and flexibility as providers make the transition to Y2K compliant formats. However, all providers are reminded that they will be required to make the conversion to Y2K claims compliance. Details applicable to the various submission forms are provided below.

NECS Submitters

The current NECS software is being replaced by window-like software to be renamed the North Carolina Electronic Claims Submission (NCECS) software. As an added feature this software outputs a file or diskette of claims that is not only Y2K compliant, but is also in the ANSI 837 format. The NCECS software began distribution to providers in September 1999. NCECS providers will not require testing by EDS prior to accepting claims since EDS has internally tested the software. Providers will simply key claims data into the software. Contact the ECS department for information on how to obtain this software.

Tape Submitters

EDS sent providers specifications for the new format in February 1999. All tape submitters must to pass testing with EDS before Y2K compliant claims will be accepted. Providers are reminded to give as much notice as possible to their vendors or data processing support staff so that these changes can be made in a timely basis. Testing has started so providers should arrange for that testing with the ECS unit at EDS. Providers should insure that testing is completed before December 31, 1999.

ECS Submitters

EDS sent providers specifications for the new format in March 1999. All ECS submitters must pass testing with EDS before Y2K compliant claims will be accepted. Providers are reminded to give as much notice as possible to their vendors or data processing support staff so that these changes can be made in a timely basis. Testing has started so providers should arrange for that testing with the ECS unit at EDS. Providers should insure that testing is completed before December 31,1999.

Paper Submitters

There are no changes to the various paper claim forms. As space permits on the forms providers should input a four-digit year. Where the provider indicates only a two-digit year, EDS' data entry staff will enter a four-digit year that is appropriate. For example, a 00 will be keyed as 2000; a 99 will be keyed as 1999.

ANSI 837 Submitters

Providers not using the NCECS software will want to start submitting claims in the ANSI 837 format once EDS is capable of accepting them. The new NCECS software will provide claims in that format. EDS will use translator software to accept any ANSI 837 compliant claim. Each ANSI submitter not using NCECS software will be individually tested and upon completion allowed to submit the ANSI format. EDS is accepting ANSI formats from non-NCECS submitters beginning with the 4th calendar quarter of 1999.

	Current formats	NCECS	Tape	ECS / Vendors	Paper
Providers Install		beginning Sept 1999	beginning March 1999	beginning April 1999	
EDS Accepting Claims	until transition date established by DMA	beginning Sept 1999	beginning July 1999	beginning July 1999	continuous

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

Attention: All Providers

North Carolina Electronic Claims Submission Software (NCECS)

As mentioned in several recent bulletins, Medicaid is replacing the current NECS software with newer NCECS software. The new software creates files for transmission over modem as well as on a mail-in diskette. The NECS software is DOS based; the NCECS will run in Windows 95, Windows 98 or Windows NT 4.0, which are classified as 32 bit operating systems. NCECS will not operate in a Windows 3.1 environment since it is not a year 2000 compliant system.

Minimal PC requirements for the use of NCECS include:

- Pentium series recommended; 486 machines will function
- minimum of 32 megabytes of memory
- minimum 20 megabytes of hard drive storage
- a browser such as Microsoft Internet Explorer (version 3.0 or higher) or Netscape (version 3.0 or higher)
- a modem – minimal 2400 baud rate; at least 9600 baud rate recommended

Providers must supply the browser. These are on a release diskette as part of the Windows 95, 98 and NT Software, or may be downloaded and installed from one of the following addresses:

The Microsoft version is found at http://www.microsoft.com/catalog.
The Netscape version is available at http://home.netscape.com/computing/download/.

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

Attention: All Providers

Tax Identification Information

Alert - Tax Update Requested

North Carolina Medicaid must have the proper tax information for all providers. This ensures correct issuance of 1099 MISC forms each year and that the correct tax information is provided to the IRS. Inappropriate information on file can result in the IRS withholding 31% of a provider's Medicaid payments. Be sure the individual responsible for maintenance of tax information receives the following information.

How to verify tax information

The last page of the 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 Medicaid has the correct tax information on file. 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 the group. If a Medicaid RA is needed, call Provider Services 919-851-8888 or 1-800-688-6696 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 tax identification number exactly as the IRS has on file for the provider's business. Do not insert a Social Security Number unless the business is a sole proprietorship or individually owned and operated
- Part II Correction field - Indicate tax name exactly as the IRS has on file for the provider's business
- Part III - Indicate the appropriate type of organization for the provider's business. If a Social Security Number is indicated as the tax identification number, select individual/sole proprietor as the type of organization
- Part IV - An authorized person **MUST** sign and date this form,or it will be returned as incomplete and the tax data on file with Medicaid ***will not*** be updated

Send completed and signed forms by December 17, 1999 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 919-857-4017 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 DMA is not contacted and the incorrect provider number is used, that provider will be ***liable for taxes*** on income not necessarily received by the provider's 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:_____

Attention: All Providers

Medicaid Program Implements Penalties and Interest Assessments According to NC General Statute – 147-86.10

Effective October 1999

North Carolina (NC) General Statute Impact

- Definition of the NC Statute (147-86.10) – This State statute requires the effective cash management of all funds and as a result, all balances due to the Medicaid program and not returned or paid within 30 days will automatically be assessed a one time 10% penalty and interest on an accumulative basis. The variable interest rate assessed is set forth by the North Carolina Department of Revenue (NC DOR). The current interest rate is 8%. The interest rate will be updated to ensure compliance with any changes made by the NC DOR.

- Effective Date of this Statute within Medicaid Processing – October 1, 1999

- Who It Will Affect – All providers, excluding state agencies, who do not return monies due to the Medicaid Program within a 30 day period.

- Highlights of Medicaid Processing Changes as a result of this implementing NC General Statute 147-86.10: *(The list below summarizes the primary changes initiated under the North Carolina General Statute project and* ***a special bulletin was issued in 10/99 providing*** *additional details and examples of all of the above.)*

    1. Penalty and Interest Assessment – Medicaid adjustments or other types of monies due to Medicaid, initiated by DMA, or initiated by audits and edits of the Medicaid program, and/or at the request of or known by the provider, which are not paid in full via claim payment or refunds within 30 days of processing will be assessed a one-time 10% penalty on the outstanding balance and 8% interest. Interest will be assessed every subsequent 30-day period on the total outstanding balance until the total balance is paid in full. In cases of extreme financial hardship only, the provider can contact the Financial Branch of the Division of Medical Assistance (DMA) and make a request for a payment plan. DMA will consider the request and if approval is granted, a payment plan will be established. DMA will establish the payment plan arrangements to include payment amount and timeline for repayment. Penalty and interest assessments will be made on the amount due during the payment plan timeline.

    2. Transfers of Adjustment Balances – Any adjustment balance aged will transfer from an inactive provider (no claims payment) to an active provider (claims payment) when determined to be operating under the same tax entity. As a result, balances will be transferred for immediate collection based on the following criteria:

        - If the adjustment balance has reached either of the milestones:
            - No payment has been received and the adjustment balance is more than 30 days old
            - Partial payment only has been received and the adjustment balance is more than 60 days old
        - If another provider with the same tax identification exists within the Medicaid program
        - Provider with same tax identification number is actively submitting claims and receiving payment from Medicaid
        - The current inactive providers' outstanding balance will be transferred to the active provider for immediate collection
        - Additionally, the appropriate assessment of penalty and interest will be assessed (as noted in the bullet above) and transferred as well

Please note, interest will continue to accumulate on the transferred balance until the total balance is paid in full.

3. Medicaid Remittance and Status Report Modifications and New Explanation of Benefit (EOB(s))
   For each change noted above, the Medicaid RA will be modified as required to detail all financial transactions to support reconciliation between payment and claims/financial transaction data. Additionally all dates will be expanded to comply with Year 2000 requirements and, as a result, the current format of MM/DD/YY (10/01/99) on the Medicaid RA will be reflected as MM/DD/CCYY (10/01/1999).

The above list summarizes the primary changes initiated under the North Carolina General Statute project. A special bulletin will be issued to provide additional details and examples of all of the above.

Thank you
EDS and DMA Financial Operations

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

Attention: HCFA-1500 Crossover Billers

Processing Enhancement on Professional Crossovers

Block 29 on the HCFA–1500 form is reserved for third party insurance only. For claims filing purposes Medicare is not considered a third party insurance payer, yet many claims are submitted with the Medicare payment erroneously entered in block 29. Providers **should not** submit the Medicare payment in block 29 of the HCFA-1500 form. This results in the Medicaid payment of coinsurance and deductible being reduced by the amount entered in this block, as though it were a separate third party insurance payment.

Therefore, effective with date of processing October 11, 1999 Medicaid processing of Medicare professional crossovers was enhanced to allow the eligibility file to be referenced for third party information, prior to payment. If a professional crossover claim is received with a money amount entered in block 29 of the HCFA–1500 and there is no third party insurance on file for the recipient, the claim will be denied with EOB 1404 "Private insurance payment indicated on claim. No record of TPL on file. Correct claim or update recipient TPL using DMA form 2057 and resubmit claim." The claim should then be corrected to remove this amount and resubmitted as a new claim. If the recipient does have other insurance, please complete the DMA form 2057 and forward to the appropriate address noted at the bottom of the form. This form can be found in any of the program handbooks. Once the information has been updated, the claim can then be resubmitted as a new claim. EOB 1404 will not require an adjustment to process the claim for payment.

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

Attention: All Providers

Policies and Billing Guidelines for Obstetrical Services

North Carolina Medicaid covers obstetric services performed by certified providers.

The services provided in uncomplicated maternity and delivery cases include antepartum care, delivery, postpartum care and associated lab tests. When a provider renders all services associated with the maternity care and delivery, the preferred billing method is with an OB Package Code. Providers should select the OB Package Code that describes the type of delivery performed:

59400	Routine obstetric are including antepartum care, vaginal delivery and postpartum care
59510	Routine obstetric care including antepartum care, cesarean delivery and postpartum care

An OB package code reimburses the provider rendering the care one fee for the following services related to the obstetrical care:

- Antepartum care
- Delivery
- Postpartum care
- Laboratory tests (OB panel, urinalysis, routine hemoglobin and venipuncture)
- Evaluation and management services

When a provider does not see the patient for three months before delivery, the provider may elect to bill a separate code and charge for each service with actual dates of service. It is the provider's responsibility to assure each claim is filed in accordance with normal claim filing procedures. The provider may also elect to bill a separate code and charge for each service when the provider knows from the onset of pregnancy that the case will be high risk and will require care above the normal amount of care for a routine obstetrical case.

Regardless of the billing method selected, delivery charges for multiple births should not exceed the normal billed amount for a single delivery. When there are extenuating circumstances and the claim has been denied, reconsideration for payment will be given through the Adjustments Unit at EDS. Request a medical review by submitting a completed Medicaid Adjustment form, a copy of the claim, a copy of the Remittance Advice, and medical records.

Antepartum Coverage

Antepartum care includes the initial and subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, laboratory tests and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery. Medicaid covered procedure codes that include antepartum care are 59400, 59425, 59426 and 59510.

The following guidelines apply to all antepartum procedure codes.

1. The date the provider first saw the patient for antepartum care must be entered in block 15 of the HCFA-1500 claim form.
2. An antepartum care code can only be used once during the pregnancy.
3. The delivery date is used as the date of service for the antepartum package codes or the total OB package codes.
4. OB package codes include antepartum care. The provider billing an OB package code must have rendered at least three months of antepartum care to the recipient.
5. A pregnancy related diagnosis must be entered as the primary diagnosis to bypass the 24-visit limit. Refer to the ICD-9 CM diagnosis book in section "Pregnancy, Childbirth, Puerperium" to select the appropriate diagnosis (diagnosis codes 640-676.9).

Postpartum Coverage

Medicaid covered procedure codes that include postpartum care are 59400, 59410, 59430, 59510 and 59515. The postpartum period includes 60 days of follow-up care after the date of delivery or termination of a pregnancy. Postpartum care is not reimbursed separately when an OB package code is billed. Reference the 1999 Current Procedural Terminology book for complete definitions of all maternity care and delivery codes. Medicaid reimburses providers for family planning procedures, including sterilization, when provided during this period.

Medicaid coverage for pregnant women with a pink Medicaid ID card extends through the end of the month in which the 60th postpartum day occurs. This is true for women who deliver a healthy baby, as well as women who experience a miscarriage, fetal death, molar pregnancy, neonatal death or therapeutic abortion.

Medicaid uses the terms antepartum, date of delivery and postpartum instead of the surgical terms pre-operative, intra-operative and post-operative. The spans of dates during and after the pregnancy are very different than the spans of dates typically associated with minor and major surgical pre and post operative periods. Postpartum codes have 60 days follow-up assigned. When a provider renders services on the date of delivery or during the postpartum period that is totally unrelated to the actual pregnancy or delivery, the provider can bill an Evaluation and Management procedure code appended with modifier 24 or 25 as applicable. Remember, these modifiers are only applicable to E&M codes. Please read the April 1999 Special Medicaid Bulletin to understand when to append the E&M code with a modifier.

The following modifiers should be reviewed prior to billing obstetrical procedure codes.

51	53	54	55
58	59	73	74
78	79	SG	Q6
62	80	82	YA
QS			

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

Attention: All Carolina ACCESS (CA) Primary Care Providers (PCPs)

Medicaid Provider Number Changes

The Carolina ACCESS PCP must contact the county Managed Care Representative whenever the Medicaid provider number used for Carolina ACCESS is scheduled to change. The Carolina ACCESS Participation Agreement is non-transferable and, therefore, changes such as a practice's change of ownership require a new CA application to be submitted and approved. The new Medicaid provider number issued by DMA Provider Enrollment will then be entered as a valid Carolina ACCESS provider number.

Failure to notify the Managed Care Representative of provider number changes may result in denied claims and nonpayment of management fees.

If there are questions or if the Managed Care Representative's name and/or phone number is needed, please contact Kirby Ferguson at (919) 857-4022.

Attention: All Providers

Synagis Coverage

The drug Synagis will be reimbursed through the pharmacy program and not the physician's program. Synagis has been approved for prevention of Respiratory Syncytial Viral (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 (a six month period), which has been identified as October 1999 through March 2000 in North Carolina .

Below are the guidelines for the use of Synagis, which are approved by the American Academy of Pediatrics. These guidelines must be strictly followed for Medicaid coverage of this drug.

- Synagis prophylaxis should be considered for infants and children younger than two years with BPD who 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 six months of age.
- Synagis has NOT been approved by the Food and Drug Administration (FDA) for patients with congenital heart disease only; therefore, Synagis will NOT be covered by the Medicaid Program for this condition alone, since Medicaid only covers FDA approved indications
- The physician is required to write in his or her own handwriting on the face of the prescription, the weight and date of birth of the child (Pharmacists are NOT allowed to fill the prescription without this written physician documentation)
- Every child under two years of age does NOT need 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

Reimbursement for Synagis is only for dates of services October 1, 1999 through March 31, 2000, unless it is determined that the season has changed for North Carolina. If it is determined, upon audit of physicians' and pharmacies'records, that the drug is being prescribed for conditions used outside these guidelines, the Medicaid Program will then consider the implementation of a strict prior approval process on all coverage of Synagis.

Benny Ridout, R.Ph., Pharmacy Director, Medical Policy
DMA, 919-857-4034

Attention: Dental Providers

New Dental Claim Form and Code Updates for the Year 2000

The American Dental Association (ADA) has updated the ADA claim form and the Current Dental Terminology Users Manual for the year 2000. The ADA recommends use of the 1999 ADA claim form beginning in January, 2000. While keeping in compliance with the ADA changes, DMA and EDS must allow time for system changes to be implemented before accepting the 1999 version of the ADA claim form. Providers should continue to use the 1994 ADA claim form for North Carolina Medicaid. DMA and EDS are working on the necessary system changes that must occur before acceptance of the 1999 form. Our anticipated implementation date for the 1999 ADA claim form is July 1, 2000. A transition period of three months will allow the 1994 and the 1999 claim forms to be accepted from July 1, 2000 through September 30, 2000.

A limited supply of the 1994 ADA claim forms are available from the ADA. Additional 1994 ADA claim forms can be ordered from the following paper product suppliers. Listed below are the addresses and toll free telephone numbers:

Colwell
P.O. Box 9024
Champaign, IL 61826-9024
1-800-637-1140

Medical Arts Press
8500 Wyoming Avenue North
Minneapolis, MN 55445
1-800-328-2179

Topform Data, Inc.
P.O. Box 15850
Rio Rancho, New Mexico
87174-0850
1-800-854-7470

Updates to the Current Dental Terminology Users Manual contain revised procedure code descriptions, procedure code deletions, and new ADA procedure code additions. DMA and EDS strive to use codes in accordance with the ADA; however, providers should continue to submit the procedure codes identified in the North Carolina Medicaid Dental Services Manual until further notification. DMA and EDS are working on the necessary system changes that must occur before the new procedure codes will be implemented. The anticipated implementation date for the new ADA procedure codes is also July 1, 2000.

Watch upcoming Medicaid Provider Bulletins for exact dates and additional information regarding implementation of the 1999 ADA claim form and 1999 ADA code updates.

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

Attention: Hospital Providers

Lower Level of Care and Swing Bed Rates

Effective with date of service October 1, 1999, the hospital lower level of care and swing bed rates per patient day are:

Level of Care	*Rate*
Skilled Nursing Care	$116.27
Intermediate Care	$88.35
Ventilator Dependent Care	$343.91

No adjustments will be made to previously filed claims.

Rodney Jenkins, DMA Financial Operations, 919-857-4015

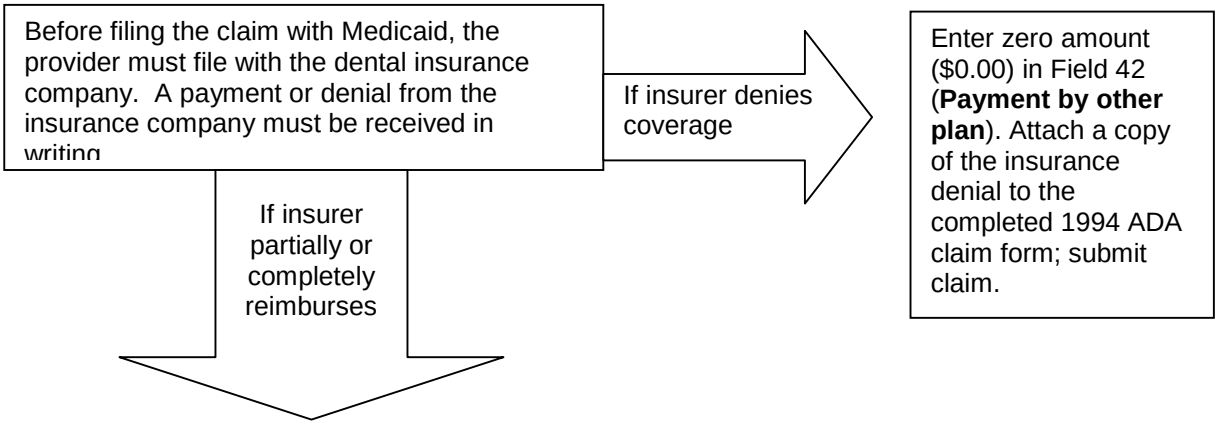
Attention: Dental Providers

Recipients Covered by Both Dental Insurance and Medicaid

When a recipient is covered by both dental insurance and Medicaid:

- The dental insurance is the primary payer
- Medicaid is the payer of last resort
- Medicaid does not allow coordination of benefits
- Medicaid will not pay more than the Medicaid maximum allowable

During post payment review it was discovered that overpayments have occurred due to incorrect filing of Medicaid claims for recipients with dental insurance. Although dental insurance EOBs (explanation of benefits) were submitted with the Medicaid claims, the amount paid by the dental insurance was not indicated on the 1994 ADA (American Dental Association) claim form in Field 42 (Payment by other plan). Listed below are instructions for filing Medicaid claims involving dental insurance coverage.



Provider must file the 1994 ADA claim form as instructed by NC Medicaid, including the following items to be completed as fully as possible:

- **Name and address of carrier(s)** - Provide the name and address of the insurance carrier (Field 15-a)
- **Group no.(s)** - Policy number (Field 15-b)
- **Total fee charged** - Enter total charges, both covered and noncovered. Do not deduct any payments received (Field 41)
- **Payment by other plan** - Indicate the amount of the insurance payment. Do not deduct co-payment (Field 42). *It is imperative that this information is entered*
- **Max. allowable** - Enter the difference between the total fee charged and payment received from the dental insurance (Field 42)

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

Attention: All Providers

Clarification to the September 1999 Bulletin Article "Modifiers Questions and Answers"

Due to inquiries concerning the response to question #4 in the September 1999 Medicaid Bulletin article, Modifier "Question & Answers", please note the following clarification.

Question: Is there a limit to how many multiple procedures can be done? Are all additional procedures paid at 50%? How would the same procedure be billed if performed multiple times?

Answer: There is not a limit on the number of procedures that can be performed in one day by the same provider. Medicaid will allow up to five procedures per day without documentation. "Add-on" codes and "Endoscopy" codes are not considered part of the five procedures that require review of medical records. Subsequent procedures to the primary must be appended with modifier 51. The procedure code billed without modifier 51 is considered the primary procedure code.

Not all additional procedure codes are paid at 50%. Add-on codes are not subject to multiple procedure pricing. "Add-on" codes will pay 100% of the allowable when billed with its corresponding primary procedure. Medicaid does not determine the primary procedure for "Add-on" codes. "Add-on codes should not be billed with modifier 51. If, however, the "Add-on" code is appended with modifier 51 it will be reimbursed at 50% of the allowable.

When the same procedure code is billed multiple times, that procedure should be billed as multiple procedure codes are billed. The procedure code entered on the first detail is billed without modifier 51 and the remaining same procedure code is billed on subsequent details and appended with modifier 51.

Reminders:

Endoscopy procedure codes are not billed with modifier 51. However, they are subject to multiple procedure pricing following endoscopy pricing.

When a vaginal delivery and a sterilization are performed on the same date of service by the same attending provider do not append either procedure code with modifier 51. Reimbursement for both procedure codes will be paid at 100% of the allowable charges. However, if a third procedure is performed, it must be billed with modifier 51 and will be reimbursed at 50% of the allowable charges. However when a cesarean section and a sterilization are performed on the same DOS, by the same attending provider, modifier 51 must be appended to the subsequent procedure.

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

Attention: All Providers

Resubmission vs. Filing Adjustment

If one of the following EOBs is received and the validity is questionable, do not appeal by submitting an adjustment request. Please contact EDS provider services at 1-800-688-6696 or 919-851-8888. Adjustments submitted for these EOB denials will be denied with EOB 998 "Claim does not require adjustment processing, resubmit claim with corrections as a new day claim" or EOB 9600 "Adjustment denied – claim has been resubmitted. The EOB this claim previously denied for does not require adjusting. In the future, correct/resubmit claim in lieu of sending **an adjustment request."**
(Last Revision 09/20/99)

0002	0080	0154	0211	0316	0580	0688	0919	1023
0003	0082	0155	0213	0319	0581	0689	0920	1035
0004	0084	0156	0215	0325	0584	0690	0922	1036
0005	0085	0157	0217	0326	0585	0691	0925	1037
0007	0089	0158	0219	0327	0586	0698	0926	1038
0009	0090	0159	0220	0356	0587	0732	0927	1043
0011	0093	0160	0221	0363	0588	0734	0929	1045
0013	0094	0162	0222	0364	0589	0735	0931	1046
0014	0095	0163	0223	0394	0590	0749	0932	1047
0017	0100	0164	0226	0398	0593	0755	0933	1048
0019	0101	0165	0227	0424	0604	0760	0934	1049
0023	0102	0166	0235	0425	0607	0777	0936	1050
0024	0103	0167	0236	0426	0609	0797	0940	1057
0025	0104	0170	0237	0427	0610	0804	0941	1058
0026	0105	0171	0240	0428	0611	0805	0942	1059
0027	0106	0172	0241	0430	0612	0814	0943	1060
0029	0108	0174	0242	0435	0616	0817	0944	1061
0033	0110	0175	0244	0438	0620	0819	0945	1062
0034	0111	0176	0245	0439	0621	0820	0946	1063
0035	0112	0177	0246	0452	0622	0822	0947	1064
0036	0113	0179	0247	0462	0626	0823	0948	1078
0038	0114	0181	0249	0465	0635	0824	0949	1079
0039	0115	0182	0250	0505	0636	0825	0950	1084
0040	0118	0183	0251	0511	0641	0860	0952	1086
0042	0120	0185	0253	0513	0642	0863	0953	1087
0041	0121	0186	0255	0516	0661	0864	0960	1091
0046	0122	0187	0256	0523	0662	0865	0967	1092
0047	0123	0188	0257	0525	0663	0866	0968	1152
0049	0126	0189	0258	0529	0665	0867	0969	1154
0050	0127	0191	0270	0536	0666	0868	0970	1170
0051	0128	0194	0279	0537	0668	0869	0972	1175
0058	0129	0195	0282	0548	0669	0875	0974	1177
0062	0131	0196	0283	0553	0670	0888	0986	1178
0063	0132	0197	0284	0556	0671	0889	0987	1181
0065	0133	0198	0286	0557	0672	0898	0988	1183
0067	0134	0199	0289	0558	0673	0900	0989	1184
0068	0135	0200	0290	0559	0674	0905	0990	1186
0069	0138	0201	0291	0560	0675	0908	0991	1197
0074	0139	0202	0292	0569	0676	0909	0992	1198
0075	0141	0203	0293	0572	0677	0910	0995	1204
0076	0143	0204	0294	0574	0679	0911	0997	1232
0077	0144	0205	0295	0575	0680	0912	0998	1233
0078	0145	0206	0296	0576	0681	0913	1001	1275
0079	0149	0207	0297	0577	0682	0916	1003	1278
	0151	0208	0298	0578	0683	0917	1008	1307
	0153	0210	0299	0579	0685	0918	1022	1324

1350	2920	5405	7905	7941	7977	8909	9224	9261
1351	2921	5406	7906	7942	7978	9036	9225	9263
1355	2922	5407	7907	7943	7979	9054	9226	9264
1380	2923	5408	7908	7944	7980	9101	9227	9265
1381	2924	5409	7909	7945	7981	9102	9228	9266
1382	2925	5410	7910	7946	7982	9103	9229	9267
1400	2926	6703	7911	7947	7983	9104	9230	9268
1404	2927	6704	7912	7948	7984	9105	9231	9269
1442	2928	6705	7913	7949	7985	9106	9232	9272
1443	2929	6707	7914	7950	7986	9174	9233	9273
1502	2930	6708	7915	7951	7987	9175	9234	9274
1506	2931	7700	7916	7952	7988	9180	9235	9275
1513	2944	7701	7917	7953	7989	9200	9236	9291
1866	3001	7702	7918	7954	7990	9201	9237	9295
1868	3002	7703	7919	7955	7991	9202	9238	9600
1873	3003	7704	7920	7956	7992	9203	9239	9611
1944	5001	7705	7921	7957	7993	9204	9240	9614
1949	5002	7706	7922	7958	7994	9205	9241	9615
1956	5201	7707	7923	7959	7996	9206	9242	9625
1999	5206	7708	7924	7960	7997	9207	9243	9630
2024	5216	7709	7925	7961	7998	9208	9244	9631
2027	5221	7712	7926	7962	7999	9209	9245	9633
2235	5222	7717	7927	7963	8174	9210	9246	9642
2236	5223	7733	7928	7964	8175	9211	9247	9684
2237	5224	7734	7929	7965	8326	9212	9248	9801
2238	5225	7735	7930	7966	8327	9213	9249	9804
2335	5226	7736	7931	7967	8400	9214	9250	9806
2911	5227	7737	7932	7968	8401	9215	9251	9807
2912	5228	7738	7933	7969	8901	9216	9252	9919
2913	5229	7740	7934	7970	8902	9217	9253	9947
2914	5230	7741	7935	7971	8903	9218	9254	9993
2915	5400	7788	7936	7972	8904	9219	9256	
2916	5401	7794	7937	7973	8905	9220	9257	
2917	5402	7900	7938	7974	8906	9221	9258	
2918	5403	7901	7939	7975	8907	9222	9259	
2919	5404	7904	7940	7976	8908	9223	9260	

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

Attention: All Providers

Anesthesia services for Labor, Delivery and Sterilization Procedures

Effective with date of service 10/01/1999, procedure code 00857 is a covered service. Providers should select the procedure code that explains the method of delivery performed when billing epidural analgesic management:

- 00955 continuous epidural for analgesic management during labor and subsequent vaginal delivery
- 00857 continuous epidural for analgesic management during labor and subsequent cesarean delivery

This table contains various combinations of medical services that can be provided for labor and delivery on the same date of service. Please reference this table to determine how to bill for such situations.

Service	Code	Modifier(s) required	Units
Delivery only under general	59409 or 59514	YA	1 minute = 1 unit
Labor and Delivery under epidural	00857 or 00955	No modifier	1
Labor under epidural and Delivery under general	00857 or 00955 and Delivery code	No modifier YA	1 1 minute = 1 unit

Providers must use medical judgement when making the decision to perform sterilization on the same date of service as labor and delivery. Careful attention should be given in billing when a combination of services are rendered to a recipient on the same date of service. Providers have two procedure codes to select from when billing for a sterilization procedure.

- W8208 sterilization only under epidural anesthesia
- W5075 sterilization under general anesthesia

This table contains various combinations of medical services for labor, delivery and/or sterilization.

Procedure(s)	Code	Modifier	Units
Sterilization under epidural	W8208	No modifier	1
Sterilization under general	W5075	YA	1 minute = 1 unit
Labor/Delivery under epidural and Sterilization under general	00857 or 00955 Plus W5075	No modifier YA	1 1minute = 1 unit
Delivery/Sterilization under general	Delivery code *Plus* W5075	YA YA	1 minute = 1 unit 1 minute = 1 unit
Labor/Delivery under epidural with Sterilization under general	00857 or 00955 **and** W5075	No modifier YA	1 1 minute = 1 unit
Labor/Delivery under general and Sterilization under epidural	Delivery code and W8208	YA No modifier	1 minute = 1unit 1

North Carolina Medicaid will reimburse code W8208 to reflect monitoring only when billed with either 00955 or 00857 on the same date of service.

W5075 is reflected on the RA whenever any of the following procedure codes are billed:

56301	56302	58600	58605
58611	58615	58982	58983

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

Attention: All Providers

Additions to Medicare/Medicaid Crossover Information

Medicare claims cross over automatically to Medicaid IF the provider's Medicare number is cross-referenced to their North Carolina Medicaid provider number in Medicaid's cross-reference files. If providers have Medicare claims that are not automatically crossing over to Medicaid, they should complete the form below and return to EDS PROVIDER ENROLLMENT. DO NOT SEND THIS FORM TO MEDICARE. Provider Enrollment will verify the provider's Medicare and Medicaid information. If the numbers are not cross-referenced, EDS will add the provider information to the crossover file. If Provider Enrollment has any questions, they will contact the provider. If you have multiple Medicare carriers and Medicare provider numbers, each number must be referenced to a Medicaid provider number. Please use a separate form for each cross-reference.

Note: Multiple Medicare numbers can be cross-referenced to a single Medicaid number, but multiple Medicaid numbers cannot be cross-referenced from a single Medicare number.

Prompt return of this information will ensure crossover claims are processed correctly and in a timely manner. Fax forms to 919-851-4014, ATTN: Provider Enrollment or mail to the address listed below.

(✂ cut here and return Medicare Crossover Reference Request form only)
MEDICARE CROSSOVER REFERENCE REQUEST

Provider Name: _____
Contact Person:(required) _____ Telephone Number: (required) _____

Indicate your *Medicare Carrier*, the *Action to be taken*, and your *Medicare* and *Medicaid* provider numbers**. If this section is not completed, the form will not be processed.**

These are the only carriers for which EDS can currently cross-reference provider numbers.

- ☐ NC BC/BS
- ☐ TN BC/BS
- ☐ FL BC/BS *****
- ☐ TX BC/BS
- ☐ MS BC/BS
- ☐ Palmetto
- ☐ Riverbend Government Benefits Administration
- ☐ Mutual of Omaha *****
- ☐ United Healthcare *****
- ☐ CIGNA
- ☐ United Government Services of WI
- ☐ Adminq Star*****
- ☐ GA BC/BS
- ☐ Other_____

Action to be taken:

- ☐ *Addition* **-** *This is used to add a new provider number (Medicare or Medicaid) to the crossover file.*
  Medicare Provider number: _____ Medicaid Provider number: _____
- ☐ *Change - This is used to change an existing provider number (Medicare or Medicaid) on the crossover file.*
  Medicare Provider number: _____ Medicaid Provider number: _____

Mail to: Provider Enrollment
EDS
PO Box 300009
Raleigh, NC 27622

* These are additional Medicare carriers with whom EDS is in the process of coordinating the automatic claim crossover function with North Carolina Medicaid.

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

Attention: Home Health Services Providers

Answers to Frequently Asked Home Health Services Questions

The Division of Medical Assistance has received numerous inquiries concerning Home Health Services policy and reimbursement. Some of the most frequently asked questions are listed below:

1. Q: Our agency provides physical therapy to a patient receiving home health aide services. Must a registered nurse supervise the aide?

   A: A registered nurse must provide supervision if the patient receives skilled nursing care. If the patient does not receive skilled nursing care but receives another skilled service (physical therapy, occupational therapy, or speech-language pathology services), supervision may be provided by the appropriate therapist.

2. Q: A recipient contacted our agency for ostomy supplies. She is not homebound and receives no other home health service. Will Medicaid reimburse for supplies only?

   A: Supplies are covered when specifically ordered by the physician in the plan of care and when Medicaid requirements are met. The patient does not have to be homebound or receiving another service.

3. Q: Does our agency have to make a skilled nursing visit every 60 days to a patient receiving supplies only?

   A: Yes, an RN must make a reassessment visit to the patient's home every 60 days to ensure that the patient is receiving appropriate medical supplies. The visits may be billed to Medicaid.

4. Q: Does Medicaid reimburse for psychiatric nursing?

   A: Skilled nursing visits for psychiatric nursing are covered under Home Health when ordered by the physician in the plan of care.

5. Q: Does Medicaid reimburse for medical social services?

   A: Visits for medical social services are not covered under home health services.

6. Q: We have been asked to provide physical therapy visits to a CAP/DA participant three days a week at an adult day health center. May we bill these visits to Medicaid?

   A: No. Home health skilled services may only be provided in a private residence or the adult care home where the patient resides. Home health aide services may be provided only in a patient's private home.

7. Q: We have been asked to provide skilled nursing visits to a patient receiving home infusion therapy (HIT). May we bill Medicaid for the visits?

   A: You may provide the required skilled nursing care for enteral or parenteral nutrition therapy. However, home infusion drug therapy is covered as a package and you may not provide services related to the drug therapy. Visits for other medical needs must be coordinated with the HIT provider to avoid more than one person working with the patient at the same time.

8. Q: Our agency has been asked to provide skilled nursing visits to a dialysis patient on non-dialysis days to check the access site of a new shunt. May we bill the visits to Medicaid?

   A: You may not bill home health skilled nursing visits for dialysis-related treatment. This is the responsibility of the dialysis center.

9. Q: May non-sterile gloves provided to family members for routine personal care of the patient be billed to Medicaid?

   A: Non-sterile gloves are covered for family members and similar caregivers only if the caregiver is in contact with the patient's blood or other potentially infectious body fluids. The primary focus is on hepatitis B and HIV. The gloves must be specifically ordered by the physician in the plan of care with those conditions cited.

DMA, 919-857-4021

Attention: Podiatrists, Physicians, Nurse Practitioners

Trimming of Dystrophic Nails, any number, G0127

Section 1862(a) (13) (c) of the Social Security Act prohibits payment for routine foot care. Services including cutting or removing corns and calluses; trimming, cutting, clipping, and debriding of nails; and other hygienic care, are normally considered routine and are not covered by Medicaid. The only circumstances in which routine foot care service is reimbursed by Medicaid are those which are medically necessary and are an integral part of otherwise covered services (such as plantar warts); and/or there exists the presence of metabolic, neurological, and/or peripheral vascular diseases; and/or there is evidence of mycotic nails that, in the absence of a systemic condition, result in pain or secondary infection.

Effective with date of service November 1, 1999, CPT code G0127 must be used to bill trimming of dystrophic nails, any number, when a medically necessary condition exists. Documentation to substantiate the condition must be present in the medical record and kept on file for a period of not less than five years.

Billing

When billing G0127, dystrophic nails:

- An ICD-9 CM diagnosis describing the patient's systemic condition must be included on the claim
- The patient must be under the active care of a physician for the systemic condition
- Modifiers must be used on the claim to report class findings
- Multiple surgery rules apply. If G0127 is performed in addition to a primary procedure, modifier 51 must be appended to the secondary procedure
- Global surgery guidelines apply. An evaluation and management service will be reimbursed with G0127 only when the service is a significant, separately identifiable service identified by modifier 25 appended to the evaluation and management code. Records must document this separately identifiable service
- Unit = 1 regardless of the number of nails trimmed
- Maximum reimbursement rate for G0127 is $12.71

(See the June 1999 Bulletin, page 12-13 for a complete description of the class finding modifiers and instructions for billing nondystrophic nails).

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

Attention: Physicians, Nurse Practitioners and Nurse Midwives

Diabetes Outpatient Self-Management Training Services

Effective with date of service November 1, 1999, North Carolina Medicaid will cover Diabetes Outpatient Self-Management Training. The training program provides patient education in the successful management of diabetes. It includes education about self-monitoring of blood glucose, diet and exercise, specifically developed insulin treatment plan for insulin-dependent patients, and motivation for patients to use the skills for self-management.

Title XVIII of the Social Security Act, Section 1862 (a)(1)(A), allows coverage and payment only for those services that are considered to be medically reasonable and necessary.

Coverage Requirements
Diabetes Outpatient Self-Management Training is covered when the following criteria are met:

1. Physician certification that the services are needed under a comprehensive plan of care related to the patient's diabetic condition to ensure therapy compliance, or to provide the individual with necessary skills and knowledge in management of the condition.
2. Training given by a "recognized provider", and
3. Program specific quality standards are met.

Recognized Providers
Recognized providers are designated as physicians, nurse practitioners, certified nurse midwives, and entities that meet the National Standards for Diabetes Self-Management Education Programs and whose education program is recognized by the American Diabetes Association.

Non-physician practitioners (nurse practitioners, certified nurse midwives, physician assistants, nurses, Certified Diabetic Educators (CDE) and dieticians) who are employed by physicians or entities that meet the National standards may provide diabetes outpatient self-management training services "incident to" a physician's professional services. This means the services must be an integral, although incidental part of the physician's personal professional services, and must be performed under the physician's personal supervision.

Note: If the supervising physician is not on the premises at the time the service is rendered by a non-physician practitioner, the supervising physician must be designated "on call". The designated physician must always be available for direct communication by radio, telephone or telecommunications with a predetermined plan for emergency services. Physician supervision must meet all other applicable state requirements concerning supervision.

Independent Nurse Practitioners and Nurse Midwives who are enrolled Medicaid providers, have education programs that meet the National standards, and are recognized by the American Diabetes Association may receive direct reimbursement for diabetes outpatient self-management training.

Standards
A complete listing of the National Standards for Diabetes Self-Management Education Programs and information on the provider recognition application process may be obtained by calling the American Diabetes Association at 1-888-232-0822. Documentation to support compliance with standards that address curriculum, participant access, process, and outcome must be maintained and made available for review by DMA or its agent upon request. These standards include the following:

Standard 12: Based on the needs of the target population, the program must be capable of offering instruction in the following content areas:

a. Diabetes overview
b. Stress and psychosocial adjustment
c. Family involvement and social support
d. Nutrition
e. Exercise and activity

f. Medications
g. Monitoring and use of results
h. Relationships among nutrition, exercise, medication, and glucose levels
i. Prevention, detection, and treatment of acute complications
j. Prevention, detection, and treatment of chronic complication
k. Foot, skin, and dental care
l. Behavior change strategies, goal setting, risk factor reduction, and problem solving
m. Benefits, risks, and management options for improving glucose control
n. Preconception care, pregnancy, and gestational diabetes
o. Use of health care systems and community resources

Standard 13: The program shall use instructional methods and materials that are appropriate for the target population and the participants being served.

Standard 17: An individualized assessment shall be developed and updated in collaboration with each participant. The assessment shall include relevant medical history, present health status, health service or resource utilization, risk factors, diabetes knowledge and skills, cultural influences, health beliefs and attitudes, health behaviors and goals, support systems, barriers to learning, and socioeconomic factors.

Standard 18: An individualized education plan, based on the assessment, shall be developed in collaboration with each participant.

Standard 19: The participant's educational experience, including assessment, intervention, evaluation, and follow-up shall be documented in a permanent medical or education record. There shall be documentation of collaboration and coordination among program staff and other providers.

Standard 20: The program shall offer appropriate and timely educational interventions based on periodic reassessments of health status, knowledge, skills, attitudes, goals, and self-care behaviors.

Billing

- Diabetes self-management training services must be billed using the following HCPCS codes:

Code	Description	Fee
99404	Preventive medicine, individual counseling, approximately 60 minutes	$49.09
99412	Preventive medicine, group counseling, approximately 60 minutes	$28.79

- There must be an acceptable ICD-9 CM diabetes diagnosis code on the claim
- The name of the physician certifying the need for the service must be included in form locator 19 of the HCFA-1500. The date of the initial evaluation visit must be placed in form locator 15.

The "Certificate of Recognition" from the American Diabetes Association that affirms recognized provider status for the education program, must be maintained by the provider and made available to DMA or its agent upon request. Documentation certifying the need for diabetic training and documentation of the training provided must be maintained in the patient's record for a period of not less than five years.

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

Attention: All Providers

Fee Schedules, Reimbursement Plans and Medicaid Bulletin Subscriptions

Request for Paper Schedules/Plans

There is no charge for fee schedules or reimbursement plans requested from the Division of Medical Assistance. However, all requests for publications should be made on the form below at the following address, or you can fax your request as indicated below:

Division of Medical Assistance
Financial Operations - Fee Schedules
2509 Mail Service Center
Raleigh, N. C. 27699-2509

PLEASE NOTE: PHONE REQUESTS ARE NOT ACCEPTED

You may fax your request to (919) 715-0896/ DMA Financial Operations.

Do not mail your requests for paper schedules to EDS.

- ☐ After Care Surgery Period
- ☐ Ambulatory Surgery Center
- ☐ Anesthesia Base Units
- ☐ CAP
- ☐ Dental
- ☐ DME
- ☐ Home Health
- ☐ Home Infusion Therapy
- ☐ Hospital Reimbursement Plan
- ☐ ICF/MR Reimbursement Plan
- ☐ Laboratory
- ☐ Nurse Midwife
- ☐ Nursing Facility Reimbursement Plan
- ☐ Optical and Visual Aids
- ☐ Physician Fees (includes X-Ray)
- ☐ Prosthetics and Orthotics
- ☐ Portable X-Ray

Requestor:_____ Provider Type:
_____

Address:_____

Contact:_____Phone: _____

Request for Diskette of Physician Fee Schedule and Anesthesia Base Units Schedule

The PHYSICIAN FEE SCHEDULE and the ANESTHESIA BASE UNIT SCHEDULE are available on diskette or via email at no charge from DMA. The North Carolina Division of Medical Assistance stipulates that the information provided may be used only for your internal analysis. The actual billed amount on your claims must always contain your regular billed amount and not the price on the fee schedule unless the listed price represents what you normally bill another payor or patient. DMA considers the billed amount in their rate setting efforts.

Please complete the information below with each request:

Requestor:_____
_____

Address:
_____
__

Email
Address:_____Phone:_____
____

Type of File:
3 1/2" PC Diskette (circle one):

TEXT FILE Excel Spreadsheet

Type of Schedule (check one): Diskette

☐ Physician Fee Schedule

☐ Anesthesia Base Units

Please submit this request to**:**

Division of Medical Assistance
Financial Operations
2509 Mail Service Center
Raleigh, North Carolina 27699-2509

Medicaid Bulletin Subscriptions

N. C. Medicaid bulletins are mailed to all enrolled providers. Non providers (i.e. billing agencies) may subscribe to the bulletin for an annual subscription fee of $12.00. To subscribe, send a letter requesting the subscription, including the subscriber's mailing address and a check for $12.00 payable to EDS.

Mail the request to:

EDS
Attention: Provider Enrollment
P. O. Box 300009
Raleigh, N. C. 27622

Contact: DMA – Financial Operations for schedules
EDS – Provider Enrollment for Bulletin Subscriptions

Attention: All Carolina ACCESS Providers

Blanket Authorization/Protocol Policy

The establishment of a continuous and comprehensive patient/provider relationship is an essential component of the Carolina ACCESS program. Carolina ACCESS primary care providers (PCPs) act as gatekeepers for their enrollees' health care needs; therefore, they must provide or arrange for primary care coverage for services, consultation, or referrals twenty-four hours per day, seven days per week. Automatic referral to the emergency department is a violation of the Carolina ACCESS Participation Agreement.

Carolina ACCESS requires PCPs to use their discretion and medical judgement when individually assessing each emergency room encounter for payment authorization.[1] Therefore, Carolina ACCESS policy does not allow blanket authorizations for payment of services rendered.

It is preferable for the PCP and the Emergency Department to develop a relationship of mutual trust and understanding. Therefore, Carolina ACCESS does allow the following:

Protocols are written agreements between the PCPs and the Emergency Department.[2] Protocols define when the PCP wishes to be notified of his or her enrollee's visit to the ER. Acceptable protocols also may define which clinical conditions the PCP will approve automatically for payment in the Emergency Department.

Please note: Protocols are not mandatory and their implementation is left completely to the discretion of the Carolina ACCESS PCP.

* Carolina ACCESS does not encourage contact with the PCP before completion of the medical screening exam.
* Both the hospital and the PCP should sign and date the written protocol. Each party should keep a copy of the established protocols. These protocols must be provided to the Carolina ACCESS Quality Management Unit upon request.

[1] See Carolina ACCESS Emergency Room Reimbursement Policy
[2] Protocols must be written agreements to avoid misinterpretations, abuse or fraudulent activity

Attention: All Providers

Additional Medicaid Fair Handbooks Still Available

Providers unable to attend the Medicaid Fair in September 1999 still have an opportunity to purchase the handbook that was distributed. EDS published one large spiral-bound book that incorporated all the handouts and notes covered by the workshops. It is an excellent resource with 396 pages of policies, procedures, and helpful billing information.

To obtain copies of the Medicaid Fair Handbook (while supplies last), send a check in the amount of $20 per copy payable to EDS. Please complete the form below and mail to the following address:

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

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

(Cut and return form below)

Name _____

Address_____

City/State _____ Zip Code _____

Please send _____ 1999 Medicaid Fair Handbooks.

Cost per book is $20.00

Total amount of check included: _____

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Attention: Adult Care Home Providers

Increase in Capitated Fee for Transportation

Effective with date of service October 1, 1999, the capitated fee for medically necessary non-emergency non-ambulance transportation for residents in Adult Care facilities has increased to $.55 cents per Medicaid resident per day. No adjustments will be made to previously filed claims.

DMA, 919-857-4015

Attention: Adult Care Home Providers

Increase in Reimbursement Rates:

Effective with date of service October 1,1999, the per diem rates paid by Medicaid for Adult Care Home Personal Care Services are:

W8251	Basic ACH/PC	$ 9.39
W8252	Enhanced ACH/PC (Basic/Eating)	$ 18.60
W8253	Enhanced ACH/PC (Basic/Toileting)	$ 12.67
W8254	Enhanced ACH/PC (Basic/Eating & Toileting)	$ 21.88

No adjustments will be made to previously filed claims.

DMA, 919-857-4015

Attention: Obstetric Providers

Revised List of Codes Included in the Total OB Package

The August 1999 Medicaid Bulletin published a list of all codes included in the global OB package. Since that publication, several codes have been removed as being included in the global OB package.

Following is the list of codes included in the global OB package.

G0001	80055	81000	81001	81002	81003	83020	83021	83026
83030	83033	83036	83045	83050	83051	83055	83060	83065
83068	83069	99201	99202	99203	99204	99205	99211	99212
99213	99214	99215	99241	99242	99243	99244	99245	99251
99252	99253	99254	99255	99261	99262	99263		

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

Checkwrite Schedule

November 9, 1999	December 7, 1999	January 12, 2000
November 16, 1999	December 14, 1999	January 19, 2000
November 24, 1999	December 21, 1999	January 27, 2000
	December 28, 1999	

Electronic Cut-Off Schedule

November 5, 1999	December 3, 1999	January 7, 2000
November 12, 1999	December 10, 1999	January 14, 2000
November 19, 1999	December 17, 1999	January 21, 2000
	December 23, 1999	

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

EDS

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