Number 12 *December 2002*

North Carolina Medicaid Bulletin

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

Visit DMA on the Web at: http://www.dhhs.state.nc.us/dma

In This Issue…… *Page #*

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

Bold, italicized material is excerpted from the American Medical Association Current Procedural Terminology (CPT) Codes. Descriptions and other data only are copyrighted 2001 American Medical Association. All rights reserved.

Attention: All Providers

Holiday Observance

The Division of Medical Assistance (DMA) and EDS will be closed on Tuesday, December 24, 2002 through Thursday, December 26, 2002 in observance of Christmas, and on Wednesday, January 1, 2003 in observance of New Year's Day.

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

Attention: All Providers

Medicaid Payment Accuracy Measurement Demonstration Project

DMA Program Integrity received a grant from the Centers for Medicare and Medicaid Services (CMS) to participate in a Medicaid Payment Accuracy Measurement (PAM) demonstration project. The goal of the project is to help CMS determine the feasibility of estimating Medicaid claim payment accuracy for the Medicaid program at the state and national level. This is an effort supported by the U.S. House of Representatives (HR 4878) and the Office of Inspector General (OIG).

An essential part of this project consists of a review of a stratified sample of Medicaid claims and a review of the corresponding medical records. Program Integrity staff and Medical Review of North Carolina will contact providers whose claims fall in the sample to obtain medical records for the services billed to Medicaid. Samples will be taken from inpatient hospital services, long-term care services, independent practitioners and clinics, prescription drugs, home- and community-based services, and other supplies and services.

Claim payment will be recouped due to lack of documentation for the service billed if medical records are not supplied by the deadline. The claim payment will be projected as an overpayment if the requests for records are not returned by the deadline. This will inflate the overall state payment error rate. That will also overestimate the error rate for the services involved.

If your office is contacted for records, we ask for your cooperation and timely response to our request. This will facilitate the review and minimize the need for direct contact with the providers in the sample. We will clearly indicate on our letters or faxes that the request is part of the PAM Grant sample. Thank you in advance for your cooperation.

Questions regarding this project or the sample can be directed to Chuck Brownfield at 919-733-6681. We look forward to working with you.

Bo Nowell, Program Integrity Section
DMA, 919-733-6681

Attention: All Providers

Proposed Medical Coverage Policies

In accordance with Session Law 2001-424, Senate Bill 1005, proposed new or amended Medicaid medical coverage policies are available for review and comment on DMA's website at http://www.dhhs.state.nc.us/dma/prov.htm. To submit a comment related to a policy, refer to the instructions on the website. Providers without internet access can submit written comments to the address listed below.

Darlene Creech
Medical Policy Section
Division of Medical Assistance
2511 Mail Service Center
Raleigh, NC 27699-2511

The initial comment period for each proposed policy is 45 days. An additional 15-day comment period will follow if a proposed policy is revised as a result of the initial comment period.

Darlene Creech, Medical Policy Section
DMA, 919-857-4020

Attention: All Providers

Claim Payments Suspend

Effective November 1, 2002, EDS began **suspending claim payments** for all providers who did not have a correct address on file. EDS currently receives returned Remittance and Status Reports (RAs) and checks that cannot be delivered due to an incorrect billing address on file for providers.

When EDS receives a returned RA or check, all claims for the provider number will be suspended and the subsequent RAs and/or checks will no longer be printed. EFT payments will also be discontinued. Once EDS has placed this suspension on the provider number, the provider will have 90 days to submit address changes. After 90 days, if the address has not been corrected, claims in suspension will deny and the provider number will be terminated.

Providers will be notified in writing and will have 21 days from the date of the letter to respond to the Division of Medical Assistance (DMA) Provider Services unit. If the letter is returned to DMA as undeliverable, the provider number will be terminated. Once terminated, providers will be subject to the full re-enrollment process and experience a period of ineligibility as a Medicaid provider.

Refer to the Notification of Change in Provider Status form on page 9 and the Carolina ACCESS Provider Information Change form on page 11 to report an address change.

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

Attention: All Providers

Provider Information Update

The N.C. Medicaid program is updating provider files to include a fax number and e-mail address. These two methods of communication will complement the already existing methods of communication and provide a quick avenue for providers to receive information. Because only one e-mail address and one fax number can be entered for a provider number, please submit the most appropriate information for the provider number given. Please complete and return the following form to EDS Provider Enrollment at the address listed below.

To report a change of ownership, name, address, tax identification number changes, group member, or licensure status, please use the Notification of Change in Provider Status form. Managed Care providers (Carolina ACCESS, ACCESS II, and ACCESS III) must also report changes using the Carolina ACCESS Provider Information Change form, including changes in daytime or after-hours phone numbers.

Date _____
Provider Number: _____
Provider Name: _____
Site Address: Street _____
City _____
State _____ Zip Code _____
Contact Person: _____
Phone Number: (____) _____
Fax Number: (____) _____
E-Mail Address: _____

Return completed form to:

EDS Provider Enrollment
PO Box 300009
Raleigh, NC 27622

Fax: 919-851-4014

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

Attention: All Providers

Tax Identification Information

Alert – Tax Update Requested

The N.C. Medicaid program must have the correct tax information on file for all providers. This ensures that 1099 MISC forms are issued correctly each year and that correct tax information is provided to the IRS. Incorrect information on file with Medicaid can result in the IRS withholding 30 percent of a provider's Medicaid payments. **The individual responsible for maintenance of tax information must receive the information contained in this article.**

How to Verify Tax Information

The last page of the Medicaid Remittance and Status Report (RA) indicates the tax name and number on file with Medicaid for the provider number listed. Review the Medicaid RA throughout the year to ensure that the correct tax information is on file for each provider number. If you do not have access to a Medicaid RA, call EDS Provider Services at 919-851-8888 or 1-800-688-6696 to verify the tax information on file for each provider.

The tax information listed for a group practice is as follows:

1. group tax name and group tax number
2. attending Medicaid provider number in the group

How to Correct Tax Information

All providers are required to complete a W-9 form for each provider number with **incorrect** information on file. Correct information must be received by December 15, 2002. The procedure for submitting corrected tax information to the Medicaid program is determined by the provider type.

- Physicians must submit completed and signed W-9 form to their Blue Cross Blue Shield of North Carolina (BCBSNC) representative
- Other providers, including Managed Care providers, must submit completed and signed W-9 forms along with a completed and signed Notification of Change in Provider Status form to the Division of Medical Assistance (DMA) Provider Services Unit at the address listed below

Division of Medical Services
Provider Services
2506 Mail Service Center
Raleigh, NC 27699-2506

Refer to the following instructions for completing the W-9. Additional instructions can be found on the IRS website at www.irs.gov under the link "Forms and Pubs."

- List the N.C. Medicaid provider number in the block titled "List account number(s) here."
- List the N.C. Medicaid provider name in the block titled "Business Name." It should appear **EXACTLY** as the IRS has on file.
- Indicate the appropriate type of business.
- Fill in either a social security number **OR** a tax identification number. Indicate the number **EXACTLY** as the IRS has on file for the provider's business. **Do not enter a social security number unless the business is a sole proprietorship or individually owned and operated.**
- An authorized person **MUST** sign and date this form or it will be returned as incomplete and the tax information on file with Medicaid **will not** be updated.

Change of Ownership

- Physicians must contact BCBSNC to report all changes in business ownership.
- All other providers, including Managed Care providers, must report changes to DMA Provider Services using the Notification of Change in Provider Status form.
- Carolina ACCESS (CA) providers must report changes to DMA Provider Services using the Carolina Access Provider Information Change form.

DMA Provider Services will assign a new Medicaid provider number if necessary and will ensure the correct tax information is on file for Medicaid payments.

If DMA is not contacted and the incorrect tax identification 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.

Physician Group Practice Changes

When a physician leaves or a physician is added to a group practice, contact BCBSNC to update Medicaid enrollment and tax information. Carolina ACCESS (CA) providers must also report changes to DMA Provider Services using the Carolina ACCESS Provider Information Change Form.

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

Form **W-9**
(Rev. December 2000)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Please print or type

Name (See **Specific Instructions** on page 2.)

Business name, if different from above. (See **Specific Instructions** on page 2.)

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ▶ .....

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

Part I **Taxpayer Identification Number (TIN)**

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). **However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 2.** For other entities, it is your employer identification number (EIN). If you do not have a number, see **How to get a TIN** on page 2.

Note: *If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.*

Social security number

or

Employer identification number

List account number(s) here (optional)

Part II **For U.S. Payees Exempt From Backup Withholding** (See the instructions on page 2.)

▶

Part III **Certification**

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item **2** above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item **2** does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 2.)

Sign Here **Signature of U.S. person ▶** **Date ▶**

Purpose of Form

A person who is required to file an information return with the IRS must get your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to give your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee.

If you are a foreign person, use the appropriate Form W-8. See **Pub. 515,** Withholding of Tax on Nonresident Aliens and Foreign Corporations.

Note: *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

What is backup withholding? Persons making certain payments to you must withhold and pay to the IRS 31% of such payments under certain conditions. This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

If you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return, payments you receive will not be subject to backup withholding. **Payments you receive will be subject to backup withholding if:**

1. You do not furnish your TIN to the requester, or

2. You do not certify your TIN when required (see the Part III instructions on page 2 for details), or

3. The IRS tells the requester that you furnished an incorrect TIN, or

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the Part II instructions and the separate **Instructions for the Requester of Form W-9.**

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

Cat. No. 10231X Form **W-9** (Rev. 12-2000)

Specific Instructions

Name. If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first and then circle the name of the person or entity whose number you enter in Part I of the form.

Sole proprietor. Enter your **individual** name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, **enter the owner's name on the "Name" line.** Enter the LLC's name on the "Business name" line.

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Part I—Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box.

If you are a **resident alien** and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see **How to get a TIN** below.

If you are a **sole proprietor** and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are an **LLC** that is **disregarded as an entity** separate from its owner (see ***Limited liability company (LLC)*** above), and are owned by an individual, enter your SSN (or "pre-LLC" EIN, if desired). If the owner of a disregarded LLC is a corporation, partnership, etc., enter the owner's EIN.

Note: *See the chart on this page for further clarification of name and TIN combinations.*

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get **Form SS-5,** Application for a Social Security Card, from your local Social Security Administration office. Get **Form W-7,** Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN or **Form SS-4,** Application for Employer Identification Number, to apply for an EIN. You can get Forms W-7 and SS-4 from the IRS by calling 1-800-TAX-FORM (1-800-829-3676) or from the IRS's Internet Web Site at **www.irs.gov**.

If you do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: *Writing "Applied For" means that you have already applied for a TIN* ***or*** *that you intend to apply for one soon.*

Part II—For U.S. Payees Exempt From Backup Withholding

Individuals (including sole proprietors) are **not** exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends. For more information on exempt payees, see the separate Instructions for the Requester of Form W-9.

If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding. Enter your correct TIN in Part I, write "Exempt" in Part II, and sign and date the form.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

Part III—Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 3, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required).

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item **2** in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item **2** of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified state tuition program payments, IRA or MSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to give your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA or MSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 31% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Sole proprietorship	The owner [3]
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name, but you may also enter your business or "DBA" name. You may use either your SSN or EIN (if you have one).

[4] List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note: *If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.*

NOTIFICATION OF CHANGE IN PROVIDER STATUS

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

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

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

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

Effective Date of Change _____

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

Name of Individual Provider to be Deleted from Group _____

Provider Number for Individual Provider to be Deleted from Group _____

Contact Name _____ Contact Telephone Number ( ) _____
Signature of Owner or Authorized Agent _____
Print Name and Title of Owner or Authorized Agent _____

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

Revised 12/02

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

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

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

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

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

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

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

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

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

Report all changes to your HMO.
HMO Providers

Report all changes to the Division of Medical Assistance using this form.
HMO Risk Contracting Managed Care Plans

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

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

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

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

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

**A copy of the *Carolina ACCESS Provider Information Change Form* is available on the Internet at www.dhhs.state.nc.us/dma or by calling DMA Provider Services at 919-857-4017.

Revised 12/02

CAROLINA ACCESS PROVIDER INFORMATION CHANGE FORM

For DMA Office Use Only

EIS_____EDS_____ACCESS_____COUNTY_____

Date:_____

CA Practice Name:_____

CA Practice Provider Number:_____ **County:**_____

This CA practice requests the following change(s) be made to their CA application and information contained in CA databases:

Change **CA practice name** to:_____
Please make change effective for CA (date):_____

Change **CA practice provider number** to:_____ Make change effective for CA (date):_____
Reason for number change:_____
_____

Terminate CA practice provider number effective (date):_____ Reason:_____
_____

Change **enrollment restriction information (i.e., ages 15 and up only)**:_____
_____
New enrollment restriction code(s):_____

Delete provider(s) from practice:_____
_____
_____

Add participating provider(s) to practice: (Note: Medical license number of all new provider(s) **and** individual Medicaid provider number of new physician(s) **must** be included.)

Provider Name	**Title**	**License Number**	**Individual Medicaid Provider Number (MDs Only)**

Change **CA practice site address** to:_____
_____

Change **CA practice mailing address** (if different from site address) to:_____
_____

Change **telephone** number to:_____ Change **after-hours** telephone number to:_____

Change **enrollment limit** from:_____ to:_____ (Note: maximum 2000 per participating provider in this practice.)

Change **contact person** to:_____ Title:_____

Add county(ies) served:_____ **Delete county(ies) served**:_____

Comments/Other:_____
_____
_____

Form Completed By:_____ **Title:**_____

Note: Please fax form to the **DMA Provider Services** at **(919) 715-8548** Changes will be entered in the database(s) and changes made to the CA application on file.

(Revised 10/01)

This form is intended for use when making a change in the information originally provided on the Carolina ACCESS (CA) PCP application. Providers are also responsible for ensuring that information on file with the **Medicaid** program for their practice or facility remains up-to-date. (Please refer to the January 2001 Special Bulletin I, *Provider Enrollment Guidelines* for information on notifying Medicaid of a change within your practice.) Medicaid bulletins and other valuable information are available on the Division of Medical Assistance's Internet web site at http://www.dhhs.state.nc.us/dma.

Multiple changes may be indicated on the same change form. The following information **must** be included for each change request:

- CA practice name
- CA practice provider number
- Name and title of the person at the practice requesting the change

Fax the completed form to DMA Provider Services at (919) 715-8548. **Note:** It is not necessary to fax the back of the form (instructions) with the change form.

When changing a CA practice provider number, the reason for the number change **must** be provided. When terminating a CA practice provider number, DMA will disenroll all enrollees from your practice effective on the first day of the next calendar month provided that the request is received prior to the 12th working day before the last day of the month. Requests received after that day will be made effective on the first day of the month following the next calendar month. Therefore, enrollees **may** remain enrolled **through the end of the month** following the notification of changes. Providers will be notified of the effective date of the termination.

When adding a participating provider to a practice, the provider's title (e.g., M.D., N.P., Midwife, P.A.) and the medical license number must be included for **all** new providers. The physician's individual Medicaid provider number **must** also be included on the form. For nurse practitioners, midwives, or physician assistants only the license number is required. If any of the required information is missing from the change form, the provider(s) cannot be listed as a CA provider with the practice.

A new CA application is required when any of the following occurs:

- The provider or representative who signed the CA Agreement is no longer with the practice.
- The practice has had a change in ownership.
- All the providers in the practice have changed since the original application and Agreement were signed.
- Multiple change forms have been submitted and the original application is no longer valid.

If a change form is submitted, but it is deemed appropriate to request a new CA application, the provider will be contacted by DMA

Note: When a new CA application and Agreement are sent to replace an existing application on file and the provider ID number is changing with the new application, a change form requesting the termination or cross referencing of the old number should be submitted together with the new application. This will prevent problems with management fee(s) and claim(s) payment(s). A new CA application can be obtained by calling DMA Provider Services at 919-857-4017.

Enrollment Restriction Codes

01 No restriction
02 Established patients only
06 MPW only (pink card)
07 Dialysis patients-including nephrology-only (in same or contiguous counties)
08 Chronic infectious disease patients only (in same or contiguous counties)
09 Oncology patients only (in same or contiguous counties)
10 Established patients and siblings
11 Newborns only
14 Two track clinics: facilities serving two distinct populations
15 Age restriction

Please call DMA Provider Services at 919-857-4017 if there are questions about the change form or the Carolina ACCESS application process.

Attention: All Providers

Medical Coverage Policies

Updated policies for the following programs are now located on the Division of Medical Assistance's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm:

1A Physicians

- **1A-1** Compression Sleeves/Stockings
- **1A-2** Preventive Medicine Annual Health Assessment
- **1A-3** Noninvasive Pulse Oximetry

1D Clinics

- **1D-1** Refugee Health Assessments Provided in Health Departments
- **1D-2** Sexually Transmitted Disease Treatment Provided in the Health Department
- **1D-3** TB Control and Treatment Provided in Health Departments

1M Baby Love/Child Service Coordination

- **1M-1** Child Service Coordination
- **1M-2** Childbirth Education
- **1M-3** Health and Behavior Intervention
- **1M-4** Home Visit for Newborn Care and Assessment
- **1M-5** Home Visit for Postnatal Assessment and Follow-up Care
- **1M-6** Maternal Care Skilled Nurse Home Visit
- **1M-7** Baby Love Maternal Outreach Worker Program
- **1M-8** Maternity Care Coordination

4A Dental Services

4B Orthodontic Services

8F Outpatient Specialized Therapies

8G Independent Practitioners

8I Psychological Services Provided by Health Departments and School-Based Health Centers Sponsored by Health Departments to the Under 21 Population

These policies supersede previously published policies and procedures. Providers may contact EDS at 1-800-688-6696 or 919-851-8888 with billing questions.

Darlene Creech, Medical Policy Section
DMA, 919-857-4020

Attention: Health Check Providers

Health Check Hearing and Vision Screening

Health Check follows the *Recommendations for Preventive Pediatric Health Care* from the American Academy of Pediatrics for hearing and vision screening requirements as well as for other screening components. The *Recommendations* may be accessed at http://www.aap.org/policy/re9939.html.

In accordance with the periodicity schedule and the *Recommendations for Preventive Pediatric Health Care*, objective hearing screenings using electronic equipment (i.e., audiometer) must be performed at birth, 4 years, 5 years, 6 years, 9 years, 12 years, 15 years, and 18 years. Health Check hearing screenings must be indicated on the claim with CPT code 92551. Subjective screenings (e.g., rattling coins in a cup) must be performed at interperiodic visits.

Objective vision screenings (i.e., Snellen chart), following the guidance of the periodicity schedule and the *Recommendations,* are required at periodic visits at ages 3 years, 4 years, 5 years, 6 years, 9 years, 12 years, 15 years, and 18 years. CPT code 99173 must be on the claim. Subjective screenings (i.e., tracking) must be performed at interperiodic visits.

If hearing and vision screenings cannot be performed during a periodic visit due to a condition such as deafness or blindness and the claim is denied, the denied claim may be submitted through the adjustment process with supporting medical record documentation attached.

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

Attention: Adult Care Home Providers

Revised Assessment and Care Plan Form

A new version of the Adult Care Home Personal Care Physician Authorization and Care Plan form (DMA-3050-R) and instructions are now available on the Division of Medical Assistance (DMA) website at http://www.dhhs.state.nc.us/dma. Providers may begin using the form on December 1, 2002. However, providers may continue to use the current version of the form (DMA-3050) until June 30, 2003. The DMA-3050 will no longer be a valid assessment form after June 30, 2003.

A copy of the form and instructions are available beginning on page 15. Providers can also obtain copies of the form by calling EDS at 1-800-688-6696 or 919-851-8888.

Bill Hottel, Medical Policy, Adult Care Home Services Unit
DMA, 919-857-4020

ADULT CARE HOME
PERSONAL CARE PHYSICIAN AUTHORIZATION AND CARE PLAN

Assessment Date ___/___/___
Reassessment Date ___/___/___
☐ Significant Change___/___/___

RESIDENT INFORMATION

(Please Print or Type)

RESIDENT _____ SEX (M/F) ____ DOB ____/____/____ MEDICAID ID NO. _____

FACILITY _____

ADDRESS _____

_____PHONE _____ PROVIDER NUMBER _____

DATE OF MOST RECENT EXAMINATION BY RESIDENT'S PRIMARY CARE PHYSICIAN _____/_____/_____

ASSESSMENT

1. MEDICATIONS – Identify and report all medications, including non-prescription meds, that will continue upon admission:

Name	Dose	Frequency	Route	(✓) If Self-Administered
				☐
				☐
				☐
				☐
				☐
				☐
				☐
				☐

2. MENTAL HEALTH AND SOCIAL HISTORY: (If checked, explain in "Social/Mental Health History" section)

☐ Wandering
☐ Verbally Abusive
☐ Physically Abusive
☐ Resists care
☐ Suicidal
☐ Homicidal
☐ Disruptive Behavior/ Socially Inappropriate

☐ Injurious to:
☐ Self ☐ Others ☐ Property

Is the resident currently receiving medication(s) for mental illness/behavior?
☐ YES ☐ NO

Is there a history of:
☐ Substance Abuse
☐ Developmental Disabilities (DD)
☐ Mental Illness

Is the resident currently receiving Mental Health, DD, or Substance Abuse Services (SAS)? ☐ YES ☐ NO

Has a referral been made? ☐ YES ☐ NO

If YES:

Date of Referral _____

Name of Contact Person _____

Agency _____

Social/Mental Health History: _____

_____

_____

_____

_____

_____

_____

_____

Resident _____

3. AMBULATION/LOCOMOTION: ☐ No Problems ☐ Limited Ability ☐ Ambulatory w/ Aide or Device(s) ☐ Non-Ambulatory
Device(s) Needed _____
Has device(s): ☐ Does not use ☐ Needs repair or replacement

4. UPPER EXTREMITIES: ☐ No Problems ☐ Limited Range of Motion ☐ Limited Strength ☐ Limited Eye-Hand Coordination
Specify affected joint(s) _____ ☐ Right ☐ Left ☐ Bilateral
☐ Other impairment, specify _____
_____
Device(s) Needed _____ Has device(s): ☐ Does not use ☐ Needs repair or replacement

5. NUTRITION: ☐ Oral ☐ Tube (Type) _____ Height _____ Weight _____
Dietary Restrictions: _____
_____
_____
_____
Device(s) Needed _____
Has device(s): ☐ Does not use ☐ Needs repair or replacement

6. RESPIRATION: ☐ Normal ☐ Well Established Tracheostomy ☐ Oxygen ☐ Shortness of Breath
Device(s) Needed _____ Has device(s): ☐ Does not use ☐ Needs repair or replacement

7. SKIN: ☐ Normal ☐ Pressure Areas ☐ Decubiti ☐ Other _____
Skin Care Needs _____
_____
_____

8. BOWEL: ☐ Normal ☐ Occasional Incontinence (less than daily) ☐ Daily Incontinence
☐ Ostomy: Type _____ Self-care: ☐ YES ☐ NO

9. BLADDER: ☐ Normal ☐ Occasional Incontinence (less than daily) ☐ Daily Incontinence
Catheter: Type _____ Self-care: ☐ YES ☐ NO

10. ORIENTATION: ☐ Oriented ☐ Sometimes Disoriented ☐ Always Disoriented

11. MEMORY: ☐ Adequate ☐ Forgetful – Needs Reminders ☐ Significant Loss – Must Be Directed

12. VISION: ☐ Adequate for Daily Activities ☐ Limited (Sees Large Objects) ☐ Very Limited (Blind); Explain_____
Uses: ☐ Glasses ☐ Contact Lens ☐ Needs repair or replacement
Comments _____
_____

13. HEARING: ☐ Adequate for Daily Activities ☐ Hears Loud Sounds/Voices ☐ Very Limited (Deaf); Explain _____
☐ Uses Hearing Aid(s) ☐ Needs repair or replacement
Comments _____

14. SPEECH/COMMUNICATION METHOD: ☐ Normal ☐ Slurred ☐ Weak ☐ Other Impediment ☐ No Speech
☐ Gestures ☐ Sign Language ☐ Writing ☐ Foreign Language Only _____ ☐ Other ☐ None
☐ Assistive Device(s) (Type _____) Has device(s): ☐ Does not use ☐ Needs repair or replacement

Resident _____

CARE PLAN

15. IF THE ASSESSMENT INDICATES THE RESIDENT HAS MEDICALLY RELATED PERSONAL CARE NEEDS REQUIRING ASSISTANCE, SHOW THE PLAN FOR PROVIDING CARE. CHECK OFF THE DAYS OF THE WEEK EACH ADL TASK IS PERFORMED AND RATE EACH ADL TASK BASED ON THE FOLLOWING PERFORMANCE CODES: **0 -** INDEPENDENT, **1 -** SUPERVISION, **2 -** LIMITED ASSISTANCE, **3** - EXTENSIVE ASSISTANCE, **4** - TOTALLY DEPENDENT. (PLEASE REFER TO YOUR ADULT CARE HOME PROGRAM MANUAL FOR MORE DETAIL ON EACH PERFORMANCE CODE.)

ACTIVITIES OF DAILY LIVING (ADL) *DESCRIBE THE SPECIFIC TYPE OF ASSISTANCE NEEDED BY THE RESIDENT AND PROVIDED BY STAFF, NEXT TO EACH ADL:*	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	**PERFORMANCE CODE**
EATING								
TOILETING								
AMBULATION/LOCOMOTION								
BATHING								
DRESSING								
GROOMING/PERSONAL HYGIENE								
TRANSFERRING								

OTHER: (Include Licensed Health Professional Support (LHPS) Personal Care Tasks, as listed in Rule 42C .3703, and any other special care needs)

ASSESSOR CERTIFICATION

I certify that I have completed the above assessment of the resident's condition. I found the resident needs personal care services due to the resident's medical condition. I have developed the care plan to meet those needs.

☐ Resident/responsible party has received education on Medical Care Decisions and Advance Directives prior to admission.

_____ Name _____ Signature _____ Date

PHYSICIAN AUTHORIZATION

I certify that the resident is under my care and has a medical diagnosis with associated physical/mental limitations warranting the provision of the personal care services in the above care plan.

☐ The resident may take therapeutic leave as needed.

_____ Name _____ Signature _____ Date

INSTRUCTIONS FOR COMPLETING THE *REVISED* ADULT CARE HOME PERSONAL CARE PHYSICIAN AUTHORIZATION AND CARE PLAN (DMA-3050-R)

The block in the upper right hand corner of the form denotes the type of assessment that is completed: Include Assessment date, Reassessment date, or Significant Change. Refer to the glossary in the Adult Care Home Services manual for the definition of significant change.

RESIDENT INFORMATION: In the Resident Information area include the resident's name as it appears on the blue Medicaid ID card. Complete all information.

DATE OF MOST RECENT EXAMINATION: Includes a yearly physical by the resident's attending physician.

ASSESSMENT:

1. **MEDICATIONS:** List the name of each medication, include non-prescription meds that the resident will continue upon admission. Check appropriate box for self-administered.

2. **MENTAL HEALTH AND SOCIAL HISTORY:** Identify by checking the appropriate box. Review records from discharging facility to monitor if there was any indication about history of injury to self, property, or others. Include meds for mental illness/behavior, and include if there is a history of Mental Illness, Developmental Disabilities, or Substance Abuse.

   - **Is the resident currently receiving Mental Health (MH), Developmental Disabilities (DD), or Substance Abuse Services (SAS)?** If a referral has been made for an evaluation, indicate the date of referral, name of contact person at the agency, and the agency name.

   - **Social/Mental Health History:** Include any history that can be gathered from assessment by the resident, family, friends, etc. that provide information about the resident's preferences, activities and living status. This is also an area that needs to identify any Mental Health history such as institutionalization, out patient, compliance history, police record, etc.

TOP OF SECOND PAGE: RESIDENT_____: Place name as on Medicaid ID card in this blank.

3. **AMBULATION/LOCOMOTION:** Check applicable block and list devices needed.

4. **UPPER EXTREMITIES:** Check applicable box and list devices needed.

5. **NUTRITION:** Check appropriate box. Indicate height and weight. Include any restrictions to diet, i.e. NAS, soft, etc.

6. **RESPIRATION:** Check appropriate box. Indicate any devices needed.

7. **SKIN:** Check appropriate box. Explain in detail treatment necessary and include any MD orders for skin care.

8. **BOWEL:** Check appropriate box. Indicate if the resident is independent of activity. Explain what resident needs from staff.

9. **BLADDER:** Check appropriate box. Indicate if the resident is independent of activity. Explain what residents need from staff.

10. **ORIENTATION:** Check appropriate box.

11. **MEMORY:** Check appropriate box.

12. **VISION:** Check appropriate box. Expand on concerns in comments area.

13. **HEARING:** Check appropriate box. Expand on concerns in comments area.

14. **SPEECH/COMMUNICATION METHOD:** Check appropriate box.

TOP OF THIRD PAGE: RESIDENT_____: Place name as on Medicaid ID card in this blank.

CARE PLAN:

15. Refer to the Adult Care Home Services manual for more detail on Performance Codes.

ACTIVITIES OF DAILY LIVING: Include a description of the specific type of assistance provided by staff next to each ADL and code the activity in the Performance Code area. In Other, list any Licensed Health Professional Support tasks as well as any special care needs in this area.

ASSESSOR CERTIFICATION: Check box for Medical Care Decisions and Advance Directives education. Signature of assessor certifies that the care plan is developed based on assessment findings.

PHYSICIAN AUTHORIZATION: The form is forwarded to the attending physician. The physician's authorization certifies that the individual is under the physician's care and has a medical diagnosis that warrants the provision of personal care services as indicated in the care plan. The physician prints his/her name, signs, and dates the form. The physician also may indicate and provide standing orders for an individual to take therapeutic leave by checking the block.

Attention: Ambulance Providers

New Ambulance Billing Guidelines

Effective with date of service December 31, 2002, the N.C. Medicaid program will end-date the following codes: A0320, A0322, A0324, A0326, A0330, A0380, A0390, A0090, and A0040. Providers must bill the replacement codes listed in the following table, effective with date of service January 1, 2003. **N.C. Medicaid reimburses for the level of care provided to the recipient. Call Reports must validate the level of care provided to the recipient.**

Old Code	Description	New Code	Description
A0320	BLS non-emergency	A0428	Ambulance service, basic life support, non-emergency (BLS)
A0322	BLS emergency	A0429	Ambulance service, basic life support, emergency (BLS-Emergency)
A0324	ALS non-emergency	A0426	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS 1)
A0326	ALS non-emergency, specialized services rendered	A0426	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS 1)
A0330	ALS emergency	A0427 A0433	Ambulance service, advanced life support, emergency transport, level 1 (ALS 1-Emergency) Advanced life support, level 2 (ALS 2)
A0380	BLS ground mileage, emergency	A0425	Ground mileage, per statute mile
A0390	ALS ground mileage, emergency	A0425	Ground mileage, per statute mile
A0090	Non-emergency ground mileage	A0425	Ground mileage, per statute mile
A0040	Helicopter lift-off	A0431	Ambulance service, conventional, air services, transport, one-way (Rotary Wing)

As noted above, **A0425 must be used when billing for ground mileage with basic life support (BLS) or advanced life support (ALS) services**. Other codes currently in place for ambulance services should continue to be billed until further instructions are published. These codes are Y0001, Y0002, Y0050, Y0060, Y0070, Y0003, and Y0004. Other billing instructions detailed in the 1999 *N.C. Medicaid Ambulance Service Manual* still apply (available on the DMA website at http://www.dhhs.state.nc.us/dma).

Basic Life Support

Definition: BLS is transportation by ground ambulance vehicle **and** the provision of medically necessary supplies and services, including BLS ambulance services as defined by the state. The ambulance must be staffed by an individual who is qualified in accordance with state and local laws as an Emergency Medical Technician - Basic (EMT-Basic). These laws may vary from state to state or within a state. For example, only in some jurisdictions is an EMT - Basic permitted to operate limited equipment onboard the vehicle, assist more qualified personnel in performing assessments and interventions, and establish a peripheral intravenous (IV) line. According to the N.C. Office of Emergency Medical Services, monitoring or establishing a peripheral IV must be performed by an EMT - Intermediate or a Paramedic, and is, therefore, an ALS service.

Note: Even if local protocols require an ALS response for all calls, N.C. Medicaid pays only for the level of service provided, and then only when the service is medically necessary.

Advanced Life Support Assessment

Definition: An ALS assessment is an assessment performed by an ALS crew as part of an **emergency response** that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment.

Advanced Life Support Intervention

Definition: An ALS intervention is a procedure that is, in accordance with state and local laws, beyond the scope of practice of an EMT - Basic.

An ALS intervention must be medically necessary to qualify as an intervention for payment of an ALS level of service. An ALS intervention applies only to ground transports.

Advanced Life Support, Level 1

Definition: ALS Level 1 (ALS 1) is the transportation by ground ambulance vehicle **and** the provision of **medically necessary supplies and services** including the provision of an ALS assessment **or** at least one ALS intervention.

Advanced Life Support, Level 2

Definition: ALS Level 2 (ALS 2) is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including:

1. at least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids such as 5 percent Dextrose in Water, Saline and Lactated Ringer's), **or**
2. ground ambulance transport and the provision of at least one of the ALS 2 procedures listed below.

Application of ALS 2:

- Medications that are administered by means other than intravenous do not qualify to determine whether the ALS 2 level rate is payable. For example, intramuscular/subcutaneous injection, oral, sublingual or nebulized medications do not qualify (this is not an all-inclusive list).

- A single dose of medication administered fractionally (i.e., one-third of a single dose quantity) on three separate occasions does not qualify for the ALS 2 payment rate. The criterion of multiple administrations of the same drug requires a suitable quantity and amount of time between administrations that is in accordance with standard medical practice guidelines. The fractional administration of a single dose (for this purpose meaning a standard or protocol dose) on three separate occasions does not qualify for ALS 2 payment. In other words, the administration of 1/3 of a qualifying dose three times does not equate to three qualifying doses for purposes of indicating ALS 2 care. One-third of X given three times might = X (where X is a standard/protocol drug amount), but the same sequence does not equal three times X. Thus, if three administrations of the same drug are required to show that ALS 2 care was given, each of those administrations must be in accord with local protocols. The run will not qualify on the basis of drug administration if that administration was not according to protocol.

    - An example of a single dose of medication administered fractionally on three separate occasions that would not qualify for the ALS 2 payment rate would be the use of intravenous (IV) epinephrine in the treatment of pulseless Ventricular Tachycardia/Ventricular Fibrillation (VF/VT) in the adult patient. Administering this medication in increments of 0.25 mg, 0.25 mg, and 0.50 mg would not qualify for the ALS 2 level of payment. This medication, according to the American Heart Association (AHA), Advanced Cardiac Life Support (ACLS) protocol, calls for epinephrine to be administered in 1 mg increments every 3 to 5 minutes. Therefore, in order to receive payment for an ALS 2 level of service, three separate administrations of epinephrine in 1 mg increments must be administered for the treatment of pulseless VF/VT.

    - A second example that would not qualify for the ALS 2 payment level is the use of adenosine in increments of 2 mg, 2 mg, and 2 mg for a total of 6 mg in the treatment of an adult patient with Paroxysmal Supraventricular Tachycardia (PSVT). According to ACLS guidelines, 6 mg of adenosine should be given by rapid intravenous push (IVP) over 1 to 2 seconds. If the first dose does not result in the elimination of the PSVT within 1 to 2 minutes, 12 mg of adenosine should be administered by IVP. If the PSVT persists, a second 12 mg dose of adenosine can be administered for a total of 30 mg of adenosine. Three separate administrations of the drug adenosine in the dosage amounts outlined in the later case would qualify for ALS 2 payment.

For purposes of this definition, the ALS 2 procedures are:

1. manual defibrillation/cardioversion.
2. endotracheal intubation.
3. central venous line.
4. cardiac pacing.
5. chest decompression.
6. surgical airway.
7. intraosseous line.

Endotracheal intubation is one of the services that qualifies for the ALS 2 level of payment. It is, therefore, not necessary to consider medications administered by endotracheal intubation for the purpose of determining whether the ALS 2 rate is payable. The monitoring and maintenance of an endotracheal tube that was previously inserted prior to the transport also qualifies as an ALS 2 procedure.

Advanced Life Support Personnel

Definition: ALS personnel are individuals trained to the level of EMT - Intermediate or Paramedic.

Emergency Medical Technician - Intermediate

Definition: An EMT - Intermediate is an individual who is qualified, in accordance with state and local laws, as an EMT - Basic and who is also certified in accordance with state and local laws to perform essential advanced techniques and to administer a limited number of medications.

Emergency Medical Technician - Paramedic

Definition: An EMT - Paramedic possesses the qualifications of the EMT - Intermediate and, in accordance with state and local laws, has enhanced skills that include being able to administer additional interventions and medications.

Emergency Response

Definition: An emergency response is a BLS or ALS 1 level of service that has been provided in immediate response to a 911 call or the equivalent. An immediate response is one in which the ambulance provider/supplier begins as quickly as possible to take the steps necessary to respond to the call.

Fixed Wing Air Ambulance

Definition: Fixed Wing (FW) air ambulance is the transportation by an FW aircraft that is certified by the Federal Aviation Administration (FAA) as an FW air ambulance and the provision of medically necessary services and supplies.

Rotary Wing Air Ambulance

Definition: Rotary Wing (RW) air ambulance is the transportation by a helicopter that is certified by the FAA as an RW ambulance, including the provision of medically necessary supplies and services.

Loaded Mileage

Definition: Loaded Mileage is the number of miles that the Medicaid beneficiary is transported in the ambulance vehicle. For N.C. Medicaid, the ambulance provider's base area is the county in which they are located. Ground mileage is considered "outside base area mileage" that begins at the provider's county line.

Application: Payment is made for each loaded mile. Air mileage is based on loaded miles flown, as expressed in statute miles. For air ambulance, the point of origin includes the beneficiary loading point and runway taxiing until the beneficiary is offloaded from the air ambulance.

Point of Pick-Up

Definition: Point of Pick-Up is the location of the recipient at the time he/she is placed on board the ambulance.

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

Attention: Health Check Providers

Health Check Lead Screening

Federal regulations state that all Medicaid-enrolled children are required to have a blood lead test at 12 and 24 months of age. Children between 36 and 72 months of age must be tested if they have not been previously tested. Providers should perform a lead screening when it is clinically indicated.

Medical follow-up begins with a blood lead level greater than or equal to 10 ug/dL. Capillary blood level samples are adequate for the initial screening test. Venous blood level samples should be collected for confirmation of all elevated blood lead results.

Blood Lead Concentration	Recommended Response
<10 ug/dL	**Rescreen at 24 months of age.**
10 to 19 ug/dL	**Confirmation (venous) testing should be conducted within 3 months.** If confirmed, repeat testing should be conducted every 2 to 4 months until the level is shown to be <10 ug/dL on three consecutive tests (venous or fingerstick). The family should receive lead education and nutrition counseling. A detailed environmental history should be taken to identify any obvious sources of exposure. If the blood lead level is confirmed at ≥10 ug/dL, environmental investigation will be offered.
20 to 44 ug/dL	**Confirmation (venous) testing should be conducted within 1 week.** If confirmed, the child should be referred for medical evaluation and should continue to be retested every 2 months until the blood lead level is shown to be <10 ug/dL on three consecutive tests (venous or fingerstick). Environmental investigations are required and remediation for identified lead hazards shall occur for all children less than 6 years old with confirmed blood lead levels >20 ug/dL.
≥45 ug/dL	**The child should receive a venous lead test for confirmation as soon as possible**. If confirmed, the child must receive urgent medical and environmental follow-up. Chelation therapy should be administered to children with blood lead levels in this range. Symptomatic lead poisoning or a venous lead level >70 ug/dL is a medical emergency requiring inpatient chelation therapy.

State Laboratory of Public Health for Blood Lead Screening

The State Laboratory Services of Public Health will analyze blood lead specimens for all children less than 6 years of age at no charge. To obtain information regarding free blood lead screening process and supplies contact the State Laboratory at 919-733-3937. Providers requiring results of specimens from children outside this age group also need to contact the State Laboratory of Public Health.

Note: When the above laboratory tests are processed in the provider's office, Medicaid will not reimburse separately for these procedures. Payment for these procedures is included in the reimbursement for a Health Check screening.

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

Attention: Health Departments

Family Planning Billing Clarification

Reimbursement of any of the following CPT codes used for family planning services is limited to once per 365 days. The FP modifier must be appended to the appropriate code.

99383	99384	99385	99386	99387
99393	99394	99395	99396	99397

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

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

Medical Nutrition Therapy Diagnosis Code Clarification

When medical nutrition therapy services (CPT 97802 and 97803) are provided to a pregnant or postpartum recipient, providers must use the appropriate diagnosis code from the list below. This applies to all pregnant and postpartum recipients, regardless of their age.

Code	Description
V22.0	Supervision of normal first pregnancy
V22.1	Supervision of other normal pregnancy
V22.2	Pregnant state, incidental
V23.0	Pregnancy with history of infertility
V23.1	Pregnancy with history of trophoblastic disease
V23.2	Pregnancy with history of abortion
V23.3	Grand multiparity
V23.4	Pregnancy with other poor obstetric history
V23.5	Pregnancy with other poor reproductive history
V23.7	Insufficient prenatal care
V23.81	Elderly primigravida
V23.82	Elderly multigravida
V23.83	Young primigravida
V23.84	Young multigravida
V23.89	Other high-risk pregnancy
V23.9	Unspecified high-risk pregnancy
V24.2	Routine postpartum follow-up

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

Attention: Health Departments

Billing Instructions for Procedure Code T1002

Effective with date of service December 1, 2002, do not append modifier 25 to procedure code T1002 when billing for public health nurse services or to procedure codes for other services rendered on the same date of service as T1002. If a separately identifiable service is rendered on the same day as T1002, bill the appropriate code with the diagnosis that supports the need for the additional service.

Note: Procedure code T1002 cannot be billed on the same day that a preventive medicine service is provided.

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

Attention: Durable Medical Equipment Providers

Code Deletions and Additions to the Orthotic and Prosthetic Fee Schedule

Based upon technological advances and coding changes from the Centers for Medicare and Medicaid Services (CMS), the following codes will be deleted from the Orthotic and Prosthetic Fee Schedule effective with date of service December 1, 2002: L5660, L5662, L5663, L5664.

The following codes have been provided by CMS as replacements for the deleted codes and are effective with date of service December 1, 2002.

Code	Description	Maximum Reimbursement Rate
K0556	Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism	$564.04
K0557	Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism	470.02
K0558	Addition to lower extremity, below knee/above knee, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use HCPCS codes K0556 or K0557)	999.64
K0559	Addition to lower extremity, below knee/above knee, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use HCPCS codes K0556 or K0557)	999.64
L5671	Addition to lower extremity, below knee/above knee suspension locking mechanism (shuttle, lanyard or equal), excludes socket insert	456.12

Prior approval is required. Providers are expected to bill their usual and customary rates.

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

Attention: Hospice Providers

Reimbursement Rate Increase for Hospice Services

Effective with date of service January 1, 2003, the maximum allowable rate for the following hospice services will increase. The hospice rates are as follows:

		Routine Home Care	**Continuous Home Care**	**Inpatient Respite Care**	**General Inpatient Care**	**Hospice Intermediate R & B**	**Hospice Skilled R & B**
Metropolitan Statistical Area	SC	RC 651 Daily	RC 652 Hourly (1)	RC 655 Daily (2) (3) (4)	RC 656 Daily (3) (4)	RC 658 Daily (5)	RC 659 Daily (5)
Asheville	39	$112.65	$27.37	$122.89	$500.95	$96.80	$128.77
Charlotte	41	113.78	27.65	123.87	505.67	96.80	128.77
Fayetteville	42	111.21	27.02	121.66	495.00	96.80	128.77
Greensboro/ Winston-Salem/ High Point	43	115.48	28.06	125.32	512.69	96.80	128.77
Hickory	44	114.04	27.71	124.09	506.74	96.80	128.77
Jacksonville	45	99.46	24.17	111.59	446.39	96.80	128.77
Raleigh/Durham	46	117.81	28.62	127.32	522.35	96.80	128.77
Wilmington	47	114.40	27.79	124.39	508.21	96.80	128.77
Rural	53	107.09	26.02	118.13	477.96	96.80	128.77
Goldsboro	105	108.54	26.37	119.38	483.98	96.80	128.77
Greenville	106	113.39	27.55	123.53	504.04	96.80	128.77
Norfolk Currituck County	107	107.46	26.11	118.45	479.49	96.80	128.77
Rocky Mount	108	111.89	27.19	122.24	497.83	96.80	128.77

Note: Providers must bill their usual and customary charges. Adjustments will not be made to previously processed claims.

Key to Hospice Rate Table

SC = Specialty Code
RC = Revenue Code

1. A minimum of eight hours of continuous home care per day must be provided.
2. There is a maximum of five consecutive days including the date of admission but not the date of discharge for inpatient respite care. Bill for the sixth and any subsequent days at the routine home care rate.
3. Payments to a hospice for inpatient care are limited in relation to all Medicaid payments to the agency for hospice care. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient respite and general inpatient days may not exceed 20 percent of the aggregate total number of days of hospice care provided during the same time period for all the hospice's Medicaid patients. Hospice care provided for patients with acquired immune deficiency syndrome (AIDS) is excluded in calculating the inpatient care limit. The hospice refunds any overpayments to Medicaid.
4. Date of Discharge: For the day of discharge from an inpatient unit, the appropriate home care rate must be billed instead of the inpatient care rate unless the recipient expires while an inpatient. When the recipient is discharged as deceased, the inpatient rate (general or respite) is billed for the discharge date.
5. When a **Medicare/Medicaid** recipient is in a nursing facility, Medicare is billed for routine or continuous home care, as appropriate, and Medicaid is billed for the appropriate long-term care rate. When a **Medicaid only** hospice recipient is in a nursing facility, the hospice may bill for the appropriate long-term care (SNF/ICF) rate in addition to the home care rate provided in revenue code 651 or 652. See section 8.15.1, page 8-12, of the *N.C. Medicaid Community Care Manual* for details.

Debbie Barnes, Financial Operations
DMA, 919-857-4015

Attention: Hospitals
Utilization Review Plans

According to federal guidelines, 42 CFR 456.101, before a hospital can receive a Medicaid provider number, the Division of Medical Assistance (DMA) must approve the hospital's Utilization Review (UR) Plan. Any major change or qualifying event, such as a change in hospital operations, a change in hospital ownership, an increase or decrease in the number of beds or a change in the hospital's location, requires that a new UR Plan be submitted and approved by DMA at the time of this change. If there is no qualifying event, the hospital's UR Plan must be updated, submitted, and approved every four years.

All UR Plan updates are submitted to:

Hospital Nurse Consultant
Medical Policy Section
Division of Medical Assistance
2511 Mail Service Center
Raleigh, NC 27699-2511

Debbie Garrett, RNC, Medical Policy Section
DMA, 919-857-4020

Attention: Hospital Outpatient Clinics

Clarification of Prior Authorization for Outpatient Specialized Therapy

When requesting prior authorization from Medical Review of North Carolina (MRNC) for outpatient specialized therapy services, the units requested should be based on the Revenue Center (RC) code.

Example: If a recipient is seen for physical therapy two times a week for one hour and the provider is requesting authorization for an 8-week period, providers would request RC 420 for 16 units.

Nora Poisella, Specialized Therapy Services
DMA, 919-857-4040

Attention: Hospitals, Anesthesiologists, and Certified Registered Nurse Anesthetists

Billing for Certified Registered Nurse Anesthetist Services

Effective with date of service February 1, 2003 the following guidelines must be used to bill Certified Registered Nurse Anesthetist (CRNA) services.

A. CRNA performs services <u>without medical direction:</u>

1. CRNA is employed by hospital or facility and no anesthesiologist is present:

The surgeon works in collaboration with the CRNA. The hospital bills the CRNA professional charges on the CMS-1500 claim form using the hospital's professional number in the group area in block 33 and the CRNA's number as the attending number in block 33. Modifier QZ must be appended to the CPT code indicating CRNA services were performed **without** medical direction. The CRNA's professional charges are reimbursed 90 percent of the calculated payment.

The hospital's facility charges are billed on the UB-92 claim form with a Revenue Code (RC) in the 37X range. Only the facility charges are included in the RC code. CRNA professional charges must not be included in the RC code. The surgeon bills for the surgical charges on the CMS-1500 claim form.

2. CRNA is employed by the anesthesiologist:

When the CRNA is employed by an anesthesiologist(s) and renders services without medical direction of an anesthesiologist, the CRNA services are billed on the CMS-1500 claim form using the physician's group number in block 33 and the CRNA's number in the attending field. Modifier QZ is appended to the CPT code to indicate that the service was performed without medical direction.

B. CRNA renders services with medical direction provided by anesthesiologist:

1. CRNA is employed by hospital or facility:

The CRNA professional charges are billed on the hospital's professional claim appending modifier QX to the CPT code, indicating that medical direction **was** provided. When QX is billed, the CRNA's professional charges are paid at 50 percent of the calculated payment. The hospital's professional number is placed in block 33 and the CRNA's attending number is placed in the attending area in block 33.

The hospital's facility charges are billed on the UB-92 claim form with RC in the 37X range. Only the facility charges are included in the RC code.

CRNA professional charges must not be included in the RC code. The anesthesiologist performing medical direction appends either modifier QY or QK to the CPT code on the CMS-1500 claim form. When either modifier is billed, the anesthesiologist receives 50 percent of the calculated payment.

2. CRNA is employed by the anesthesiologist:

When the anesthesiologist provides medical direction of a CRNA that is employed by the physician, the physician bills the medical direction and the CRNA service on separate claims. The medical direction modifier QK or QY is appended to the CPT code on the physician claim. The physician's group number is placed in block 33 of the CMS-1500 claim form with the physician's individual number in the attending area of block 33. The medical direction modifier QX is appended to the CPT code on the CMS-1500 claim for the CRNA service. The physician group number is placed in block 33 and the CRNA number is placed in block 33 in the attending area.

Modifiers YA and QS

Modifiers YA or QS must always be appended to the CPT code when billing for anesthesia services. Anesthesia claims without either YA or QS will deny.

New Modifiers and their Definitions

QX CRNA Service: with medical direction

QZ CRNA Service: without medical direction

QY Medical direction of one CRNA by an anesthesiologist

QK Medical direction of 2, 3 or 4 concurrent anesthesia procedures

Modifier AD for medical direction of more than four CRNAs is not available. When more than four CRNAs are medically directed, this is considered supervision and is not separately reimbursed.

Medical Direction Criteria

To bill for medical direction the anesthesiologist must:

1. perform the pre-anesthesia evaluation and exam;
2. prescribe the anesthesia;
3. participate personally in the induction and emergence of the anesthesia procedure;
4. assure that any part of the anesthesia plan not personally performed by the anesthesiologist is performed by a qualified CRNA;
5. monitor the course of anesthesia administration at frequent intervals;
6. remain physically present to provide diagnosis and treatment in an emergency situation; and
7. provide post anesthesia care.

Documentation of Medical Direction

If a CRNA rendered the service, the service **must** be billed with the applicable modifier, either QZ or QX, to distinguish if the service was provided under medical direction or provided without medical direction. Medical direction must be documented in the medical record. When all the above criteria for medical direction is not met, the CRNA services must be billed on the CMS-1500 claim form with modifier QZ indicating that the CRNA performed services **without** medical direction. Should review of medical records fail to document medical direction, recoupment of paid claims will be initiated and further investigation of the practice will be pursued by the Division of Medical Assistance.

Guidelines for Billing CRNA Services Without Medical Direction

Provider Rendering Service	Billing Provider	CMS-1500 Claim Form	UB-92 Claim Form	Pricing
CRNA employed by hospital or facility performing **without** medical direction	Hospital facility Charge	No	Bills RC 37X range	Prices DRB or RCC
	CRNA professional charge	Hospital professional number and CRNA number in block 33 Append QZ modifier to CPT code	No	90% of allowable
	Surgeon	Bills CPT code	No	Fee schedule
CRNA employed by anesthesiologist performing **without** medical direction	Hospital facility charge	No	Bills RC 37X range	Prices DRG or RCC
	CRNA professional charge	QZ is appended to the CPT code. Anesthesia group bills group/attending in block 33.	No	50% of allowable
	Anesthesiologist employing CRNA	Anesthesiologist does not bill when services are performed without medical direction.	No	50% of allowable.

Guidelines for Billing CRNA Services With Medical Direction

Provider Rendering Service	Billing Provider	CMS-1500 Claim Form	UB-92 Claim Form	Pricing
CRNA employed by hospital or facility performing **with** medical direction	Hospital facility Charge	No	Bills RC 37X range	Prices DRG or RCC
	CRNA professional charge	Hospital professional number and CRNA number in block 33. Append QX to CPT code.	No	50% of allowable
	Anesthesiologist providing medical direction	If one CRNA append QY to CPT code. If 2, 3, or 4 CRNAs append QK to CPT code	No	50% of allowable
CRNA employed by anesthesiologist performing **with** medical direction	Hospital facility charge	No	Bills RC 37X range	Price DRG or RCC
	CRNA professional charge	QX is appended to the CPT code. Use anesthesiology group/attending number in block 33.	No	50% of allowable
	Anesthesiologist providing medical direction	On separate claim, append QY to the CPT if one CRNA. If 2, 3, or 4 CRNAs, append QK. Bill group/attending number in block 33.	No	50% of allowable

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

Attention: Nursing Facility Providers, CAP/AIDS, CAP/DA, and CAP/C Case Managers, and Hospital Discharge Planners

Requests for Additional Information for Long-Term Care Prior Approval (FL2)

Effective December 1, 2002, requests from the EDS Prior Approval Unit for additional information necessary to complete a review for long-term care prior approval (FL2) are sent directly to the individual provider or Community Alternatives Program (CAP) case manager. The provider or CAP case manager is responsible for responding to the request and providing the information in a timely manner.

Previously, requests for additional information were sent to the recipient's local department of social services (DSS) who then forwarded the request to the appropriate provider or CAP case manager. This process often delayed the return of necessary information and resulted in an increase of retroactive prior approval requests as well as delaying claim payment.

Requests for long-term prior approval can be further expedited by ensuring that the following information is included on the original FL2:

- **Nursing Facilities and Hospitals:** Block 6 of the FL2 form must contain the provider's **complete name and address**.
- **CAP Case Managers:** Block 6 of the FL2 form must contain the **complete address of the CAP agency, including ATTN: CAP Unit**.

If the information in block 6 is missing, the EDS Prior Approval unit will return the request to the local DSS.

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

Attention: Mental Health Providers

ValueOptions Website

Providers can now access flowcharts and forms related to the N.C. Medicaid program on ValueOptions website at http://www.valueoptions.com. Click on "For Providers" then scroll down to the heading "Regional Provider Focus." The link to the N.C. Medicaid Account Information is located under this heading.

The Residential Authorization form is available on this website and has been updated to include a signature and date.

Note: The ValueOptions website also includes links to the Department of Health and Human Services and the Division of Medical Assistance for information specific to Medicaid.

Renee Hamlett
ValueOptions, 919-941-5367

Attention: Optical Providers

Incomplete/Illegible Request for Prior Approval for Visual Aids Forms

Effective December 1, 2002, Nash Optical Plant will return all incomplete or illegible Request for Prior Approval for Visual Aids (PA) forms to the provider with a cover sheet indicating the information that is missing, incomplete or illegible. Please correct or complete the PA and return it to Nash Optical Plant as soon as possible.

Following is an example of the cover sheet:

N.C. DEPARTMENT OF CORRECTIONS
NASH OPTICAL PLANT
P.O. BOX 600
2869 US HWY 64-A
NASHVILLE, NC 27856
1-888-388-1353

The attached request is being returned because pertinent information is missing / incomplete / (illegible) in the category noted below. Please complete and return this request to **Nash Optical Plant**.

_____ Provider Number

_____ Provider Name and Address

_____ Patient Name

__√__ Patient Medicaid Identification (MID) Number

_____ Frame name/size/color

_____ Rx information

_____ Pupillary Distance (PD)

_____ Segment Height/Power/Style

_____ Other _____

NOTE TO ALL OPTICAL PROVIDERS: Please make every effort to complete each Request for Prior Approval for Visual Aids form correctly. Missing, incomplete or illegible information will delay the eyeglass order.

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

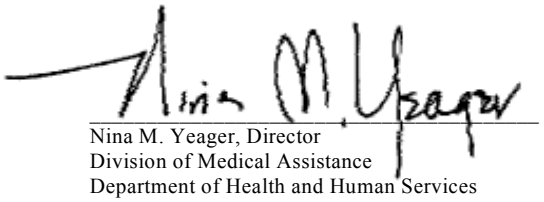
Checkwrite Schedule

December 10, 2002	January 14, 2003	February 11, 2003
December 17, 2002	January 22, 2003	February 18, 2003
December 27, 2002	January 30, 2003	February 27, 2003

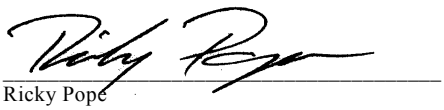
Electronic Cut-Off Schedule

December 6, 2002	January 10, 2003	February 7, 2003
December 13, 2002	January 17, 2003	February 14, 2003
December 20, 2002	January 24, 2003	February 21, 2003
		February 28, 2003

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



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



Ricky Pope
Executive Director
EDS

e

Presorted Standard
U.S. POSTAGE
PAID
Raleigh, N.C.
Permit No. 1087

P.O. Box 300001
Raleigh, North Carolina 27622