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North Carolina Medicaid Bulletin

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

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

Attention: All Providers

A Reminder about Preadmission Screening and Annual Resident Reviews

The Preadmission Screening and Annual Resident Review (PASARR) is a federal requirement for every individual who applies to or resides in a Medicaid certified nursing facility (NF), regardless of the source of payment for NF services (42 CFR 483).

The Division of Medical Assistance contracts with First Health Services Corporation to manage the Level I and Level II evaluations in North Carolina. Level II face-to-face, in-depth screens are federally mandated to be performed onsite and prior to admission for all mentally ill (MI), mentally retarded (MR), and related condition (RC) applicants to Medicaid-certified nursing facilities (preadmission screen). Subsequent assessments, known as Annual Resident Reviews (ARRs), are conducted annually thereafter for MI, MC, and RC recipients.

The onsite evaluator schedules an appointment for the evaluation at a time and location that is convenient to both the individual referral source and the evaluator. On the day of the scheduled evaluation, the evaluator contacts the referral source to verify that the time and location is convenient for all participating parties.

The evaluator presents an authorization letter to the referral source at the beginning of the evaluation and explains the evaluation process. In order for the evaluator to complete the evaluation, he/she has the authority to obtain collaborative information by interviewing the recipient; conferring with all available resources such as family, friends, and staff; and reviewing the recipient's medical records. A copy of the recipient's history and physical or other information can be prepared ahead of time as this documentation is part of the screening process.

Linda Perry, RN, Long-Term Care Consultant, Medical Policy Section
Deborah Ireland, RNC, Long-Term Care Consultant, Medical Policy Section
DMA, 919-857-4020

Attention: All Providers

Proposed Medical Coverage Policies

In accordance with Session Law 2003-284, 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
2501 Mail Service Center
Raleigh, NC 27699-2501

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

Medicaid Contact Information

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

Telephone Contact List

Topic	Phone Number	Other Resources
Accident Related Issues	DMA Third Party Recovery 1-919-733-6294	**Third Party Recovery "Accident" Information Report** http://info.dhhs.state.nc.us/dma/forms.html
Advanced Directives	DMA Medical Policy 1-919-857-4020	**Information on Advanced Directives is also available from the N.C. Extension Service** http://www.ces.ncsu.edu/depts/fcs/slide3/slide1.htm
Automatic Deposits (Electronic Funds Transfer)	EDS Electronic Commerce Services 1-800-688-6696 or 1-919-851-8888	**Automatic Deposit (EFT) Form** http://www.dhhs.state.nc.us/dma/forms.html
Baby Love	DMA Medical Policy 1-919-857-4020	**Baby Love Program** http://www.dhhs.state.nc.us/dma/babylove.html
Billing Issues/Claim Inquiries	EDS Provider Services 1-800-688-6696 or 1-919-851-8888	
Carolina ACCESS	DMA Managed Care 1-919-857-4022	**Managed Care Program** http://www.dhhs.state.nc.us/dma/mangcarewho.html
Carolina ACCESS Enrollment Verification	AVR system 1-800-723-4337	**Using AVR to Check CA Enrollment – July 2001 Special Bulletin II** http://www.dhhs.state.nc.us/dma/bulletin/htm
Checkwrite Information	AVR system 1-800-723-4337	**Online Checkwrite Schedule** http://www.dhhs.state.nc.us/dma/2003check.htm **Using AVR to Access Checkwrite Schedule – July 2001 Special Bulletin II** http://www.dhhs.state.nc.us/dma/bulletin.htm
Claims Status	AVR system 1-800-723-4337	**Using AVR to Check Claim Status – July 2001 Special Bulletin II** http://www.dhhs.state.nc.us/dma/bulletin.htm
Community Alternatives Program Retroactive Requests	DMA Community Care 1-919-857-4021	
Coverage Issues	EDS Provider Services 1-800-688-6696 or 1-919-851-8888	**Medicaid Medical Coverage Policies** http://www.dhhs.state.nc.us/dma/mp/mpindex.htm
Denials for Eligibility	DMA Claims Analysis Unit 1-919-857-4018	
Denials for Reasons other than Eligibility or Private Insurance	EDS Provider Services 1-800-688-6696 or 1-919-851-8888	**Medicaid Claim Adjustment Forms** http://www.dhhs.state.nc.us/dma/forms.html
Drug Utilization Review	DMA Program Integrity 1-919-733-3590	**Drug Utilization Review Section** http://www.dhhs.state.nc.us/dma/pipage3.htm

Telephone Contact List, continued

Topic	Phone Number	Other Resources
Electronic Claims Submission	EDS Electronic Commerce Services 1-800-688-6696 or 1-919-851-8888	**Electronic Commerce Services Agreement Form** http://www.dhhs.state.nc.us/dma/forms.html
Electronic Funds Transfer (Automatic Deposits)	EDS Electronic Commerce Services 1-800-688-6696 or 1-919-851-8888	**Automatic Deposit (EFT) Form** http://www.dhhs.state.nc.us/dma/forms.html
Electronic Data Interchange (EDI)	EDS Electronic Commerce Services 1-800-688-6696 or 1-919-851-8888	
Eligibility Information – current day	AVR system 1-800-723-4337	**Using AVR to Check Eligibility Status – July 2001 Special Bulletin II** http://www.dhhs.state.nc.us/dma/bulletin.htm
Eligibility Information for dates of service over 12 months	DMA Claims Analysis Unit 1-919-857-4018	
Enrollment – Providers (including Carolina ACCESS)	DMA Provider Services 1-919-857-4017	**Provider Enrollment Packages** http://www.dhhs.state.nc.us/dma/provenroll.htm
Fee Schedules	DMA Financial Operations 1-919-857-4015 Fax: 919-715-0896	**Fee Schedule Request Form** http://www.dhhs.state.nc.us/dma/forms.html **DME, HIT, Orthotics and Prosthetics, and Home Health Fee Schedules** http://www.dhhs.state.nc.us/dma/fee/fee.htm
Forms	EDS Provider Services 1-800-688-6696 or 1-919-851-8888	**Most forms, including blank claim forms, are available online** http://www.dhhs.state.nc.us/dma/forms.html
Fraud and Abuse – Pharmacy	DMA Program Integrity 1-919-733-3590	**Pharmacy Review Section** http://www.dhhs.state.nc.us/dma/pipage3.htm#dur
Fraud and Abuse – Other	DMA Program Integrity 1-919-733-6681	**Program Integrity** http://www.dhhs.state.nc.us/dma/pi.html
Health Care Connection	DMA Managed Care 1-919-857-4022 or 1-704-373-2273	**Managed Care Program** http://www.dhhs.state.nc.us/dma/mangcarewho.html
Health Check	DMA Managed Care 1-919-857-4022	**Health Check Billing Guidelines – April 2003 Special Bulletin II** http://www.dhhs.state.nc.us/dma/bulletin/.htm
Health Insurance Payment Program	DMA Third Party Recovery 1-919-733-6294	
HMO Risk Contracting	DMA Managed Care 1-919-857-4022	**Managed Care Program** http://www.dhhs.state.nc.us/dma/mangcarewho.html
Medicaid Bulletins	EDS Provider Services 1-800-688-6696 or 1-919-851-8888	**General and Special Bulletins are available online** http://www.dhhs.state.nc.us/dma/bulletin.htm
Medicare Crossovers	EDS Provider Services 1-800-688-6696 or 1-919-851-8888	

Telephone Contact List, continued

Topic	Phone Number	Other Resources
NCECS-Web	EDS Electronic Commerce Services 1-800-688-6696 or 1-919-851-8888	**To access NCECS-Web** https://webclaims.ncmedicaid.com/ncecs
Preadmission Screening and Annual Resident Review (PASARR)	First Health Services Corporation 1-800-639-6514	
Preadmission Review for Inpatient Psychiatric Admissions/ Continued Stay	ValueOptions 1-888-510-1150	**ValueOptions North Carolina Service Center** http://www.valueoptions.com/provider/nc_medicaid/main.htm
Prior Approval	EDS Prior Approval Unit 1-800-688-6696 or 1-919-851-8888 AVR system 1-800-723-4337	**Using AVR to Check PA Status – July 2001 Special Bulletin II** http://www.dhhs.state.nc.us/dma/bulletin.htm
Prior Authorization for Outpatient Specialized Therapies	DMA Medical Policy 919-857-4040 Medical Review of NC 1-800-228-3365	**Outpatient Specialized Therapies – Medical Coverage Policy 8F** http://www.dhhs.state.nc.us/dma/mp/mpindex.htm **Medical Review of NC** http://www.MRNC.org
Prior Authorization for Prescription Drugs	ACS State Healthcare 1-866-246-8505	**Prior Authorization for Prescription Drugs – April 2002 Special Bulletin II** http://www.dhhs.state.nc.us/dma/bulletin.htm **NC Medicaid Pharmacy Program** http://www.dhhs.state.nc.us/dma/pharmpa.htm **ACS State Healthcare website** http://www.ncmedicaidpbm.com/
Private Insurance Update	DMA Third Party Recovery 1-919-733-6294	
Procedure Code Pricing	AVR system 1-800-723-4337	**Using AVR to Check Procedure Codes – July 2001 Special Bulletin II** http://www.dhhs.state.nc.us/dma/bulletin.htm
Provider Enrollment	DMA Provider Services 1-919-857-4017	**Provider Enrollment Packages** http://www.dhhs.state.nc.us/dma/provenroll.htm
Rate Setting and Reimbursement	DMA Financial Operations 1-919-857-4015	
Third Party Insurance Code Book	DMA Third Party Recovery 1-919-733-6294 Fax: 1-919-715-4725	**Third Party Insurance Codes** http://www.dhhs.state.nc.us/dma/tpr.html
Time Limit Overrides	DMA Claims Analysis Unit 1-919-857-4018	

The **Automated Voice Response (AVR) system** allows enrolled providers to readily access detailed information pertaining to the North Carolina Medicaid program. AVR is available 24 hours per day (except 1:00 a.m. to 5:00 a.m. on the 1st, 2nd, 4th, & 5th Sunday, and 1:00 a.m. to 7:00 a.m. on the 3rd Sunday) by calling 1-800-723-4337. Using a touch-tone telephone, providers may inquire about the following:

- ☎ Current Claim Status
- ☎ Procedure Code Pricing
- ☎ Hospice Participation
- ☎ Managed Care Enrollment *(Carolina ACCESS, ACCESS II or HMO)*
- ☎ Checkwrite Information
- ☎ Prior Approval Information
- ☎ Refraction Benefit Limitation
- ☎ Drug Coverage Information
- ☎ Recipient Eligibility Verification
- ☎ Dental Benefit Limitations

Refer to the following transaction codes and information before placing your call. (**Note:** Providers will be allowed up to 15 transactions per call.)

Transaction	Description	Required Information
1	Verify Claim Status	Provider Number, MID, "FROM DOS", Total Billed Amount
2	Checkwrite Information	Provider Number
3	Drug Coverage	Provider Number, Drug Code, and DOS
4	Procedure Code Pricing and Modifier Information	Provider Number, Procedure Code, Type of Treatment Code or Modifier Code
5	Prior Approval	Provider Number, Procedure Code, Type of Treatment Code or Modifier Code and MID
6	Recipient Eligibility and Coordination of Benefits and Managed Care Status	Provider Number, MID or SSN#, DOS, and "FROM DOS" **Note**: Response includes: HMO or Carolina ACCESS PCP Name, Phone Number; Transfer of Assets Information
7	Sterilization Consent or Hysterectomy Statement	Provider Number, MID, and DOS
9	To Repeat Options 1-7	

Alphabetic Data Table

The following table is a reference for using alphabetic data. Use the numeric codes to identify the letters necessary. Be sure to press the asterisk (*) key before entering the numeric codes.

A – *21	E – *32	I – *43	M – *61	Q – *11	U – *82	Y – *93
B – *22	F – *33	J – *51	N – *62	R – *72	V – *83	Z – *12
C – *23	G – *41	K – *52	O – *63	S – *73	W – *91	
D – *31	H – *42	L – *53	P – *71	T – *81	X – 92	

The alphabetic code is represented by two digits. The first digit is the sequential number of the telephone key pad where the alphabetic character is located. The second digit is the position of the alphabetic character on the key. For example, "V" is on key #8 in the third position, thus 83.

Note: Refer to the **July 2001 Special Bulletin, *Automated Voice Response System Provider Inquiry Instructions*** for detailed instructions on using the AVR system. This special bulletin is available on DMA's website at http://www.dhhs.state.nc.us/dma/bulletin.htm.

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

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

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

EDS Address List

CMS-1500 Claims EDS PO Box 30968 Raleigh, NC 27622	**Prior Approval Requests** EDS PO Box 31188 Raleigh, NC 27622
Pharmacy Claims EDS PO Box 300001 Raleigh, NC 27622	**Drug Rebates** EDS PO Box 300002 Raleigh, NC 27622
Medicare/Medicaid (Part B Only) EDS PO Box 30968 Raleigh, NC 27622	**Nursing Home Claims – (Medicare/Medicaid Part B Only)** Attn: Nursing Home Claims EDS PO Box 300009 Raleigh, NC 27622
Adjustments EDS PO Box 300009 Raleigh, NC 27622	**Medicare Crossovers (Part A Only)** EDS PO Box 300011 Raleigh, NC 27622
UB-92 Claims EDS PO Box 300010 Raleigh, NC 27622	**All Other Claims** EDS PO Box 300011 Raleigh, NC 27622
Returned Checks EDS PO Box 300011 Raleigh, NC 27622	**Sterilization Consent Forms** EDS PO Box 300012 Raleigh, NC 27622
Hysterectomy Statements EDS PO Box 300012 Raleigh, NC 27622	**General Correspondence** (Name of EDS Employee) EDS PO Box 300009 Raleigh, NC 27622

When sending Certified mail, UPS or Federal Express, send to:

EDS
4905 Waters Edge Drive
Raleigh, NC 27606

DMA Address List

Carolina ACCESS Division of Medical Assistance 2501 Mail Service Center Raleigh, NC 27699-2501	**Claims Analysis and Medicare Buy-in** Division of Medical Assistance 2501 Mail Service Center Raleigh, NC 27699-2501
Community Care Program Division of Medical Assistance 2501 Mail Service Center Raleigh, NC 27699-2501	**Eligibility Unit** Division of Medical Assistance 2501 Mail Service Center Raleigh, NC 27699-2501
Financial Operations Division of Medical Assistance 2501 Mail Service Center Raleigh, NC 27699-2501	**Managed Care** Division of Medical Assistance 2501 Mail Service Center Raleigh, NC 27699-2501
Medical Policy/Utilization Control Division of Medical Assistance 2501 Mail Service Center Raleigh, NC 27699-2501	**Program Integrity** Division of Medical Assistance 2501 Mail Service Center Raleigh, NC 27699-2501
Provider Services Division of Medical Assistance 2501 Mail Service Center Raleigh, NC 27699-2501	

Note: Beginning September 1, 2003, the Division of Medical Assistance consolidated the mail service center addresses for each section or unit, **except Third Party Recovery**, into one mail service center address. Providers must include the name of the section to ensure that correspondence is routed correctly.

Medicaid Credit Balance Reports and correspondence addressed to the Third Party Recovery Unit must be addressed to:

Third Party Recovery Unit
Division of Medical Assistance
2508 Mail Service Center
Raleigh, NC 27699-2508

If you do not know which DMA section or unit's address to use, send correspondence to the following general address:

(Name of DMA employee)
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501

When sending Certified mail, UPS or Federal Express, send to:

Division of Medical Assistance
1985 Umstead Drive
Raleigh, NC 27626

Gina Rutherford, Provider Services
DMA, 919-857-4017

Attention: All Providers

Medical Coverage Policies

The following new or amended medical coverage policies are now available on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm:

A2 - Over-the-Counter Medications

1A1 - Compression Garments

1A2 - Preventive Medicine Annual Health Assessment

1A3 - Noninvasive Pulse Oximetry

1A5 - Case Conference for Sexually Abused Children

1A8 - Hyperbaric Oxygenation Therapy

1A9 - Blepharoplasty/Blepharoptosis Eyelid Repair

1D1 - Refugee Health Assessments Provided in Health Departments

1D2 - Sexually Transmitted Disease Treatment Provided in Health Department

1D3 - TB Control and Treatment Provided in Health Department

8F - Outpatient Specialized Therapies

8G - Independent Practitioners

8H - Local Education Agencies

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

8J - Children's Development Service Agencies

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: 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 28 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, 2003**. 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 forms 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.
- Carolina ACCESS (CA) providers must also submit a Carolina ACCESS Provider Information Change form to DMA Provider Services at the address listed below.

Provider Services
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501

Refer to the following instructions for completing the W-9. Additional instructions can be found on the IRS website at http://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 insert 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.
- CA providers must also 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. CA providers must also report changes to DMA Provider Services using the Carolina ACCESS Provider Information Change form.

A copy of the Notification of Change in Provider Status is available on page 17. A copy of the Carolina ACCESS Provider Information Change form is available on page 19. Both forms can also be obtained from DMA's website at http://www.dhhs.state.nc.us/dma/forms.html.

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

Form **W-9**
(Rev. January 2003)
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.

Print or type See **Specific Instructions** on page 2.

Name

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ► ..... ☐ Exempt from backup withholding

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

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

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 3.** 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 3.

Note: *If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.*

Social security number
___ ___ ___ – ___ ___ – ___ ___ ___ ___

or

Employer identification number
___ ___ – ___ ___ ___ ___ ___ ___ ___

Part II 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 4.)

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 obtain 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.

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

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

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

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

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.*

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

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Cat. No. 10231X Form **W-9** (Rev. 1-2003)

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

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

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 30% of such payments (29% **after** December 31, 2003; 28% **after** December 31, 2005). 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.

You will **not** be subject to backup withholding on payments you receive 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 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 II instructions on page 4 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 instructions below 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.

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 entered 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.

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.

Note: *You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).*

Exempt From Backup Withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note: *If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.*

Exempt payees. Backup withholding is **not required** on any payments made to the following payees:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2);

2. The United States or any of its agencies or instrumentalities;

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities;

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities; or

5. An international organization or any of its agencies or instrumentalities.

Other payees that **may be exempt** from backup withholding include:

6. A corporation;

7. A foreign central bank of issue;

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States;

9. A futures commission merchant registered with the Commodity Futures Trading Commission;

10. A real estate investment trust;

11. An entity registered at all times during the tax year under the Investment Company Act of 1940;

12. A common trust fund operated by a bank under section 584(a);

13. A financial institution;

14. A middleman known in the investment community as a nominee or custodian; or

15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt recipients listed above, **1** through **15.**

If the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt recipients except for **9**
Broker transactions	Exempt recipients **1** through **13.** Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt recipients **1** through **5**
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt recipients **1** through **7** [2]

[1] See **Form 1099-MISC**, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are **not exempt** from backup withholding: medical and health care payments, attorneys' fees; and payments for services paid by a Federal executive agency.

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 a single-owner **LLC** that is disregarded as an entity separate from its owner (see **Limited liability company (LLC)** on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

Note: *See the chart on page 4 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 or get this form on-line at **www.ssa.gov/online/ss5.html**. You may also get this form by calling 1-800-772-1213. Use **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 Web Site at **www.irs.gov**.

If you are asked to complete Form W-9 but 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.*

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

Part II. 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). Exempt recipients, see **Exempt from backup withholding** on page 2.

Signature requirements. Complete the certification as indicated in **1** through **5** below.

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 tuition program payments (under section 529), IRA or Archer MSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

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 or single-owner LLC	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Sole proprietorship or single-owner LLC	The owner [3]
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	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.*

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide 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 Archer 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. We may also disclose this information to other countries under a tax treaty, or to Federal and state agencies to enforce Federal nontax criminal laws and to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 30% 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.

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, 2501 Mail Service Center, Raleigh, NC 27699-2501**

Revised 09/03

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 (919-715-7625).**
ACCESS II Providers

Report all changes to the N.C. Office of Research, Demonstrations, and Rural Health Development (919-715-7625).
Providers (except chiropractors, dentists, optometrists, osteopaths, medical doctors, podiatrists) must also report changes to the Division of Medical Assistance using this form.
ACCESS II 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 09/03

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: Area Mental Health Centers/Local Management Entities and Hospitals

Criterion #5 Services – Authorization Process

Effective December 1, 2003, ValueOptions is responsible for authorizing Criterion #5 services. ValueOptions follows the same procedure that is currently in place for authorizing Criterion #5 services. To request authorization, please contact Tania Walker, ValueOptions, at 919-941-6126 or through the customer service telephone line at 1-888-510-1150, ext. 6126.

Criterion #5 services can only be provided if community placement is not available at the discharge date and both the hospital and the Area Mental Health Center/Local Management Entity are actively working on discharge planning.

To qualify for Medicaid coverage for continued post-acute stay in an inpatient psychiatric facility, a patient must meet all of the conditions specified in Item (5), (a-d), of the N.C. Medicaid Criteria for Continued Acute Stay in an Inpatient Psychiatric Facility (N.C. Administrative Code 10A: 22O.0113).

Note: The references in this rule to HRI-R High and authorization by the Child and Family Services Section of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services are being revised to reflect current language and status.

Carolyn Wiser, Behavioral Health Services
DMA, 919-857-4040

Attention: Community Alternatives Program Case Managers

Automated Voice Response System Changes

As a result of the implementation of population groups (pop groups) for recipients enrolled in the Community Alternatives Programs (CAP), the Automated Voice Response (AVR) system (1-800-723-4337) was updated effective October 29, 2003. There are two specific options that have changed: eligibility and pricing.

- When verifying eligibility (option 6), AVR now identifies the specific pop group in which the recipient is enrolled (i.e., CAP/DA, CAP/C, CAP/MR-DD or CAP/AIDS). Previously, AVR only acknowledged that the recipient was enrolled in CAP, but did not specify in which CAP program.

- When verifying the rate (option 4) for a specific CAP code, AVR prompts the provider to specify the CAP program for which the service code rate is being verified. It is important to listen to all of the sub-options for the pricing option on the main menu when verifying rates for CAP service codes. An additional sub-option has been added to request rate information for CAP service codes.

Refer to the **July 2001 Special Bulletin, *Automated Voice Response System Provider Inquiry Instructions*** for detailed instructions on using the AVR system. This special bulletin is available on DMA's website at http://www.dhhs.state.nc.us/dma/bulletin.htm.

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

Attention: Area Mental Health Centers/Local Management Entities

Out-of-State Youth Residential Placements

Effective December 1, 2003, ValueOptions began evaluating and authorizing requests for out-of-state placement in residential facilities for Medicaid recipients under the age of 21 years who are residents of North Carolina.

ValueOptions will follow the current procedure and protocol established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS). (Refer to the MH/DD/SAS website at http://www.dhhs.state.nc.us/mhddsas/childandfamily/index.htm for more information.) Providers must contact Tania Walker, ValueOptions, at 919-941-6126 or through the customer service telephone line at 1-888-510-1150, ext. 6126 before considering out-of-state placement.

Carolyn Wiser, Behavioral Health Services
DMA, 919-857-4040

Attention: Adult Care Home Providers

Personal Care Service Rate Increase

A rate increase to the Basic ACH/PC has been calculated and approved for reimbursement of Personal Care Services provided on or after January 1, 2004. The reimbursement rates effective on January 1, 2004 are:

Procedure Code	Description		Old Rate	New Rate
W8251	Basic ACH/PC	Facility Beds 1 - 30	$ 14.71	$ 16.74
W8258	Basic ACH/PC	Facility Beds 31 and Above	16.11	18.34
W8255	Enhanced ACH/PC	Ambulation and Locomotion	2.64	2.64
W8256	Enhanced ACH/PC	Eating	10.33	10.33
W8257	Enhanced ACH/PC	Toileting	3.69	3.69
W8259	Enhanced ACH/PC	Eating and Toileting	14.02	14.02
W8299	Enhanced ACH/PC	Assessment Fees - Miscellaneous	0.15	0.15

All "Enhanced ACH/PC" rates will remain at the rates published in the October 2003 general Medicaid bulletin. The transportation rate will remain at $0.60 per Medicaid resident per day.

Note: The "Enhanced ACH/PC Assessment Fee – Miscellaneous" is only valid for the Level I Mental Health Assessment completed prior to October 1, 2003.

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

Bruce Habeck, Financial Operations
DMA, 919-857-4015

Attention: Area Mental Health Centers and Residential Child Care Treatment Facilities (Level II – IV)

Correction to Billing Unit for HCPCS Code H0040

The billing units listed for HCPCS code H0040, assertive community treatment program, per diem, was stated incorrectly in the **November 2003 Special Bulletin IV, *HIPAA Code Conversions***. The correct billing unit for H0040 is:

1 unit = 1 day
(4 face-to-face contacts
per month minimum)

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

Attention: Carolina ACCESS Primary Care Providers

Carolina ACCESS Web-Based Reports

Carolina ACCESS management reports will soon be available to providers online. PCPs will continue to receive paper copies of their reports during a transition period that will allow providers to become familiar with accessing reports via the web. PCPs will find this web access to be beneficial in the following ways:

- Reports will be available to the PCP immediately and not delayed because of printing or mailing problems.
- Providers can export data to a spreadsheet, which allows for sorting, comparing, and analyzing.
- Security is a primary concern and strict security measures have been taken to ensure the privacy of the health data.
- Reports can be accessed from any computer by using your user ID and password.
- The ability to archive reports on disk and therefore valuable space is not used for retention of reports.

An online tutorial will be available to walk PCPs through the process of accessing their reports.

To protect the identity of Medicaid recipient information and their health care information, a Provider Confidential Information and Security Agreement is now required for all PCPs. The security agreement can be found in the Carolina ACCESS Provider Application and Participation Agreement packet. Providers are being asked to designate a staff person to serve as the Security Contact Person and to supply the contact's social security number in order to confirm the contacts identity. The sole purpose is to match a user name with a social security number and will not be used in any other manner. Information related to the social security number will not be accessible or stored on any web site or shared server. This process is being used to protect PHI system access as well as to protect the user.

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

Attention: Durable Medical Equipment Providers

Change in Code for Durable Medical Equipment Repairs

Effective with date of service January 1, 2004, HCPCS code E1340, "repair or non-routine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes" will replace code W4005, "equipment service or repair." This change is being made to comply with the implementation of national codes mandated by the Health Insurance Portability and Accountability Act (HIPAA).

The maximum reimbursement rate for code E1340 is $11.25 per 15 minutes. Providers must bill their usual and customary rate.

Code E1340 will require prior approval. The coverage policy is as follows:

- **Rental DME:** Service and repairs are provided as part of the rental arrangement with no additional charge to Medicaid.
- **Purchased DME – Warranty:** Service and repairs are handled under any warranty coverage an item may have.
- **Purchased DME – Non-Warranty:** Service or repair is covered only if the equipment is owned by the patient and if the repair is not covered under the warranty. A repair estimate must be provided. The estimate must show a breakdown of the number of hours of labor and the hourly rate. **No charge is allowed for pick-up or delivery or for the assembly of parts or for freight or the provider's travel time or expenses.** The following information must be entered in block 25 of the CMN/PA form:
  1. The description and HCPCS code of the item being serviced or repaired.
  2. The age of the item.
  3. The number of times it has previously been repaired.
  4. The current replacement cost.

Providers who obtained prior approvals for code W4005 for dates of service spanning on or after January 1, 2004 are required to send a copy of the approved Certificate of Medical Necessity and Prior Approval form to EDS requesting a change in the system to code E1340. The requests must be sent to:

Prior Approval Requests
EDS
PO Box 31188
Raleigh, NC 27622

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

Attention: Durable Medical Equipment Providers

Conversions to National Miscellaneous Codes

Effective with date of service January 1, 2004, national miscellaneous HCPCS codes will replace state-created codes as indicated below. The change is being made to comply with the implementation of standard national codes mandated by the Health Insurance Portability and Accountability Act (HIPAA).

New HCPCS Code	Old State-Created Code
A9900	W4046 Disposable electrodes W4120 Disposable bags for Inspirease inhaler system, set of 3 W4153 Tracheostomy ties, twill W4651 Blood glucose test strips W4670 Sterile saline, 3cc vial W4672 Gray adapter for use w/ external insulin pump W4673 Piston rod for use w/ external insulin pump W4678 Replacement battery for portable suction pump
B9998	**Low profile gastrostomy equipment:** W4210 Low profile gastrostomy kit W4211 Low profile gastrostomy extension/replace kit for continuous feed W4212 Low profile gastrostomy extension/replace kit for bolus feed
E1399	**Ambulatory devices:** W4688 Single point cane for weights 251# to 600# W4689 Quad point cane for weights 251# to 600# W4690 Crutches for weights 251# to 600# W4691 Fixed height forearm crutches for weights to 600# W4695 Glides/skis for use w/ walker **Bath equipment:** W4113 Bath or shower seat w/out back W4114 Bath or shower seat w/ back W4115 Bath tub transfer bench W4685 Bath tub transfer bench for weights 251# to 350 # W4686 Bath tub transfer bench for weights 351# to 650 # W4687 Bath seat for weights 251# to 650# **Bariatric replacement mattresses for hospital beds:** W4733 Replacement overszd innerspring matt for hosp bed w/ width to 39” W4734 Replacement overszd innerspring matt for hosp bed w/ width to 48” W4735 Replacement overszd innerspring matt for hosp bed w/ width to 54” W4736 Replacement overszd innerspring matt for hosp bed w/ width to 60” W4737 Trapeze bar, freestanding w/ grab bar for weights 451# to 750#
	Bariatric hospital beds: W4726 Total electric hosp bed weights 351# to 450# w/ matt and side rails W4730 Total elec hosp bed 451# to 1000# w/ width 39”w/ matt & side rails W4731 Total elec hosp bed 451# to 1000# w/ width 48”w/ matt & side rails W4732 Total elec hosp bed 451# to 1000# w/ width 54”w/ matt & side rails

HCPCS Code Conversions, continued

New HCPCS Code	Old State-Created Code
E1399, continued	**Other equipment:** W4001 CO/2 saturation monitor w/ accessories, probes W4002 Manual ventilation bag W4016 Bath seat, pediatric W4047 Miscellaneous pediatric equipment W4633 Eggcrate mattress pad
K0009	**Manual pediatric wheelchairs**: W4122 Pediatric wheelchair, lightweight manual W4123 Pediatric wheelchair, lightweight manual w/ growth system W4124 Pediatric wheelchair, ultra lightweight manual **Manual bariatric wheelchairs:** W4696 Manual wheelchair for weights 451# to 600# W4697 Manual wheelchair for weights 651# and greater
K0014	**Power pediatric wheelchairs:** W4125 Pediatric wheelchair, power, rigid frame W4126 Pediatric wheelchair, power, folding frame **Power bariatric wheelchairs:** W4704 Power wheelchair for weights 251# to 600# W4705 Power wheelchair for weights 651# to 1000# W4706 Power wheelchair for weights 1001# and greater
K0108	W4117 Wheelchair seat width, cost added option from manufacturer W4118 Wheelchair seat depth, cost added option from manufacturer W4119 Wheelchair seat height, cost added option from manufacturer W4128 Solid back equipment with hardware (ea) W4129 Solid seat equipment with hardware (ea) W4130 Contoured or 3-piece head/neck supports with hardware (ea) W4131 Basic head/neck support w/ hardware (ea) W4132 Contoured or 3-piece head/neck supports with adj. hardware (ea) W4133 Basic head/neck support w/ adj. hardware (ea) W4134 Shoulder stabilizers w/ hardware, including pads (pr) W4135 Shoulder stabilizers w/ hardware, including H-strap (ea) W4136 Fixed thoracic supports w/ hardware (pr) W4137 Adjustable thoracic supports w/ hardware (pr) W4138 Hip/thigh supports w/ hardware (pr) W4139 Sub-asis bars w/ hardware (ea) W4140 Abductor pads w/ hardware (pr) W4141 Knee blocks w/ hardware (pr) W4143 Shoe holders w/ hardware (pr) W4144 Foot/legrest cradle (ea) W4145 Manual tilt-in-space option (ea) W4146 Power tilt-in-space option (ea)

HCPCS Code Conversions, continued

New HCPCS Code	Old State-Created Code	
K0108, continued	W4147	Power recline (ea)
	W4148	Modular back w/ hardware (ea)
	W4150	Multi-adj. tray (ea)
	W4151	Specialty controls w/ hardware (ea)
	W4152	Growth kit (ea)
	W4155	Abductor pads w/ hardware (pr)
	Bariatric wheelchair components:	
	W4698	Seat width 21" and 22" for oversized manual wheelchair
	W4699	Seat width 23" and 24" for oversized manual wheelchair
	W4700	Seat width 25" and greater for oversized manual wheelchair
	W4701	Seat depth 19" and 20" for oversized manual wheelchair
	W4702	Seat depth 21" and 22" for oversized manual wheelchair
	W4703	Seat depth 23" and greater for oversized manual wheelchair
	W4707	Seat width 21" and 22" for oversized power wheelchair
	W4708	Seat width 23" and 24" for oversized power wheelchair
	W4709	Seat width 25" and greater for oversized power wheelchair
	W4710	Seat depth 19" and 20" for oversized power wheelchair
	W4711	Seat depth 21" and 22" for oversized manual wheelchair
	W4712	Seat depth 23"and greater for oversized power wheelchair
	W4713	Oversized footplates for weights 301#
	W4714	Swingaway special footrests for weight 401# and greater (pr)
	W4715	Swingaway reinforced legrest elevating for weight 301# to 400# (pr)
	W4716	Swingaway footrests, elevating for weight 401# and greater (pr)
	W4717	Oversized calf pads (pr)
	W4718	Oversized solid seat
	W4719	Oversized solid back
	W4720	Oversized 2" cushion
	W4721	Group 27 Gel cell battery
	W4722	Oversized full support footboard
	W4723	Oversized full support calfboard

An electronic prior authorization system will be implemented in Spring 2004. Until then, the following interim prior approval and claims submission procedures must be followed.

Prior Approval

All of these national miscellaneous HCPCS codes will require prior approval. Requests for prior approvals to purchase equipment must be submitted on a Certificate of Medical Necessity and Prior Approval (CMN/PA) form separately from requests for rental equipment. Both the national miscellaneous HCPCS code and the state-created code must be indicated on the form.

For example, if providing a "Basic head/neck support w/ hardware (ea)" and a "Solid back equipment with hardware (ea)," indicate that you are requesting prior approval for rental of K0108 for W4131, "Basic head/neck support w/ hardware (ea)" and W4128, "Solid back equipment with hardware (ea)." Include the "from" and "to" dates for which the equipment is needed. If using ProviderLink's electronic request form, enter K0108 in the HCPCS code field and W4131 and W4128 in the description field. All existing

documentation requirements remain the same. Please note that prior approval for state-created codes listed under national miscellaneous HCPCS code A9900 and B9998 will be given for a year if the prescribing physician, physician's assistant or nurse practitioner deems them medically necessary for a year.

Claim Submission

When submitting a claim, providers must enter the service request number (SRN) from the approved CMN/PA form in block 23 of the CMS-1500 claim form. **This differs from how providers have billed in the past.** If the SRN is not included on the claim, the claim cannot be processed for payment.

Services approved under the same SRN must be billed together. Electronic claims can continue to be billed if all approved services are billed for the date of service or date of service range. If only part of the approved items are billed, a paper claim must be submitted with a description on the claim of the item that is being dispensed.

Example:

Type of Claim	Electronic	Paper
Dates of Service	03/01/04 – 03/31/04	04/01/04 – 04/30/04
Procedure Billed	K0108 RR	K0108 RR
Services Billed	W4131, "Basic head/neck support w/ hardware (ea)" W4128, "Solid back equipment with hardware (ea)"	W4128, "Solid back equipment with hardware (ea)"

The coverage criteria for these items will not change. Refer to **Medical Coverage Policy #5, Durable Medical Equipment**, on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex for detailed coverage information.

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

Attention: Health Check Providers and Laboratory Services

Laboratory Tests are Not Payable on Same Day as Health Check Screening

Health Check screenings require several age-appropriate laboratory tests during a physical examination.

Reimbursement for the laboratory tests is included in the fees paid for the preventive medicine CPT codes for the Health Check screening. The laboratory tests included in the Health Check reimbursement include hemoglobin or hematocrit, lead screening, sickle cell, tuberculin skin test, and urinalysis.

Medicaid will not reimburse separately for laboratory tests listed above on the same date of service as a Health Check screening.

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

Attention: Hospice Providers

Reimbursement Rate Increase for Hospice Services

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

		Routine Home Care	Continuous Home Care	Inpatient Respite Care	General Inpatient Care
Metropolitan Statistical Area	**SC**	**RC 651 Daily**	**RC 652 Hourly**	**RC 655 Daily**	**RC 656 Daily**
Asheville	39	$ 122.14	$ 29.68	$ 131.93	$ 541.45
Charlotte/Gastonia/Rock Hill	41	121.91	29.62	131.73	540.51
Fayetteville	42	113.62	27.61	124.63	506.22
Greensboro/Winston-Salem/High Point	43	117.01	28.43	127.54	520.24
Hickory/Morganton/Lenoir	44	114.83	27.90	125.66	511.19
Jacksonville	45	108.03	26.25	119.84	483.05
Raleigh/Durham/Chapel Hill	46	123.12	29.92	132.77	545.52
Wilmington	47	120.10	29.18	130.18	533.01
Rural counties	53	111.71	27.14	122.99	498.28
Goldsboro	105	113.66	27.62	124.66	506.35
Greenville	106	115.44	28.05	126.19	513.75
Norfolk (Currituck County)	107	110.91	26.95	122.31	494.99
Rocky Mount	108	116.55	28.32	127.14	518.32

Note: At this time, the rates for the following revenue codes have not changed:

RC 658	$ 96.80
RC 659	128.77

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 cap amount for both Medicare and Medicaid for the cap year ending October 31, 2003 is $18,661.29.

4. 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.
5. The hospice refunds any overpayments to Medicaid program.
6. 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.
7. Providers must bill their usual and customary charges. Adjustments will not be accepted.

Carolyn Brown, Financial Operations
DMA, 919-857-4015

Attention: Hospitals and OB/GYN Providers

Delivery Services and Sterilization Procedures for Undocumented Aliens

Undocumented (nonqualified) aliens are eligible to apply for Medicaid emergency medical services only. Section MA-3330, XI of the Family and Children's Medicaid Eligibility manual (available online at http://info.dhhs.state.nc.us/olm/manuals/dma/fcm/man/index.htm) defines emergency services as including vaginal or C-section deliveries. These deliveries are billed with either CPT code 59409 for vaginal delivery or 59514 for C-section delivery. Providers must not bill the following CPT codes for delivery because these codes include antenatal or postpartum services that are not covered by Medicaid for emergency services provided to undocumented aliens.

59400
59410
59510
59515

Undocumented aliens must apply for Medicaid emergency services through the county department of social services in the county where they reside. The application process often begins while the individual is still in the hospital. Eligibility must be approved prior to billing Medicaid for the service.

The N.C. Medicaid program does not include sterilization procedures in the definition of emergency services and, therefore, does not cover sterilizations for undocumented aliens.

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

Attention: Nursing Facility Providers

New Reimbursement Methodology for Nursing Facilities

The Division of Medical Assistance (DMA), upon federal approval, will be transitioning to a new reimbursement methodology for nursing facilities. The State has worked closely with industry representatives to design a reimbursement system that incorporates mutual goals while also providing greater program reimbursement. The new reimbursement system will be patient acuity-based and derived from the 34 RUG Grouper system utilizing the MDS quarterly reports.

Upon implementation of the new reimbursement system, facilities will bill with a single skilled provider number and receive an acuity-adjusted rate on a quarterly basis. The new system will also allow providers to calculate the Medicaid 34 RUG Grouper rate for all of their Medicaid residents.

Funding for this new system is derived from federal matching funds realized through the collection of a provider assessment. A waiver is being reviewed by the Centers for Medicare and Medicaid Services (CMS) to approve the proposed assessment structure.

Once the waiver has been approved, providers will be notified by mail of the implementation date for the new reimbursement methodology. **Until providers receive formal notification from DMA, the current reimbursement rates and procedures remain the same**.

Changes to the State's MDS database to accommodate the new reimbursement methodology will be completed by December 31, 2003. After that date, the MDS database will only accept transmissions from facilities with systems configured for the 34 RUG Grouper system. Providers may contact the Division of Facility Services (DFS) MDS database help desk at 919-715-1872, ext. 212 for additional information.

Carolyn Brown, Financial Operations
DMA, 919-857-4015

Attention: Home Infusion Therapy and Community Alternatives Program for Children Providers

HCPCS Code Change

Due to the implementation of national codes mandated by the Health Insurance Portability and Accountability Act (HIPAA), HCPCS code W9934, Enteral Formulae: Pediatric; Infant and Toddler, will be end-dated effective with date of service December 31, 2003. Please refer to the January 2004 general Medicaid bulletin for information on the replacement billing code and rate.

Beth Karr, Community Care Services
DMA, 919-857-4021

Attention: Pharmacists and Prescribers

Coverage of Over-the-Counter Medications

Effective with date of service October 1, 2003, the N.C. Medicaid program began covering selected over-the-counter (OTC) medications.

Criteria for OTC Drug Coverage

1. The national drug code (NDC) for the OTC medication must be on the North Carolina Division of Medical Assistance Covered Over-the-Counter Medications List;
2. The medication must be dispensed by a pharmacist in the manufacturer's unopened container pursuant to a lawful prescription; and
3. The medication's manufacturer must have a valid rebate agreement with the Centers for Medicaid and Medicare Services (CMS).

OTC medications are subject to the same restrictions and recommendations as any legend drug covered under the Outpatient Pharmacy program. (This decision to allow OTC coverage may provide cost-effective treatment alternatives to more expensive legend drugs covered under Medicaid.) The decision for coverage is based on analysis of the cost savings or potential cost benefit of coverage of the OTC medication and the recommendations of the N.C. Physician Advisory Group (NCPAG), who will continue to consider off-label indications using an evidence-based approach.

Candidate OTC Drug Identification

Drugs may be considered for Medicaid coverage when any of the following criteria are met:

1. A Medicaid covered legend drug is approved by the FDA as an OTC drug that results in a significant cost savings to Medicaid (i.e., OTC version of Prilosec,® which is identical in strength and formulation).
2. An efficacious drug is available only as OTC and not legend, and all other legend treatments are significantly (i.e., >20%) more expensive without a significant increase in effectiveness (i.e., aspirin for cardiovascular disease or Tinactin® or Lotrimin® for ringworm).
3. Coverage for an OTC or a group of OTCs expands treatment options because they have been shown to decrease the total cost of care for certain conditions (i.e., allergy treatments).

Limited pilot studies may be conducted when the cost-saving and utilization effects of adding an OTC medication are uncertain. Monitoring will occur at least annually for each drug on the OTC list to assess total utilization and cost effectiveness. Medications may be removed from the list upon the advice of the NCPAG if an OTC product fails to meet criteria for continued coverage.

Refer to **General Medical Coverage Policy #A-2, Over the Counter Medications**, on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm for detailed information.

Sharman Leinwand, Medical Policy Section
DMA, 919-857-4020

Attention: Hospitals

Update to the Change to Medicare Part B Pricing Policy

In a letter dated September 22, 2003, the Division of Medical Assistance (DMA) provided guidance regarding the overpayments that have been occurring for Medicare primary claims for Part B services. The letter referenced a delay in the HIPAA implementation as a contributing factor to the decision not to change the October 1, 2002 pricing methodology.

DMA has been coordinating with the N.C. Hospital Association (NCHA). We have made the decision to move forward with the new pricing methodology with the December 16, 2003 checkwrite. The updated billing guidance given in the August 2003 and November 2003 general Medicaid bulletins will be effective for all claims filed to EDS for dates of service on or after October 1, 2002 that are entered on or after December 6, 2003.

Please note that this is a delay from the December 1, 2003 date given in the November 2003 general Medicaid bulletin. This delay was enacted to accommodate a request by the NCHA that as much time as possible be allowed for the providers and their software vendors to make necessary software modifications for those still utilizing the tape/CD Remittance Advice. The December 16, 2003 date was chosen to balance this request with the need to have the change in place prior to January 1, 2004. Note that this change to the Remittance Advice (RA) will impact all tape/CD RA providers. Technical specifications have been sent to the software vendors. Please coordinate with them on this to ensure a seamless transition.

In addition, N.C. Medicaid will report to providers a new differential field on the 835, defined as the difference between the Medicaid allowable and the Medicare coinsurance and deductible. Further details and specifications will be sent to all providers currently receiving the 835.

Claims filed to Medicaid when Medicare Part B has made a payment must have the sum of both the coinsurance and the deductible in form locator 55, estimated amount due. Medicaid will begin reimbursing providers the lesser of the coinsurance and deductible or the difference between the Medicaid allowable and the Medicare payment. This change only applies to dates of service on or after October 1, 2002. Providers should refer to the September 2002 Draft Special Bulletin VI (revised November 14, 2002) and the November 2003 general Medicaid bulletin for detailed billing instructions.

The letter from DMA dated September 22, 2003 also provided a timeline and schedule for the overpayment reporting. DMA has worked with the N.C. Hospital Association to determine a revised report schedule, which allows additional processing time for the claims analysis and repayment.

Report Name	Period Covered	Due Date
Report # 1	October 1, 2002 – March 31, 2003	March 31, 2004
Report # 2	April 1, 2003 – June 30, 2003	May 31, 2004
Report # 3	July 1, 2003 – August 31, 2003	July 30, 2004
Report # 4	September 1, 2003 – December 5, 2003	September 30, 2004

Enclosed in the September 22 letter was a CD that contained all outpatient Medicare Part B primary claims processed from October 1, 2002 to August 31, 2003. A fourth CD, containing claims data for September 1, 2003 through December 5, 2003 will be sent in late December. All guidance regarding the report format from the September 22 letter remains the same. Any questions about the report or reporting requirements should be directed to Christie Harris, EDS Provider Services Manager at 1-800-688-6696 or 919-851-8888.

Providers must notify EDS by the due date noted above with either an electronic or paper copy of the enclosed report with a refund check or a letter indicating that no money is owed to Medicaid. When the Medicare coinsurance and deducible is less than the Medicaid payment, providers need to refund the difference between the Medicaid payment indicated on the CD and the Medicare coinsurance and deductible in your records. Note that refund amounts must be indicated by each ICN. Refunds that have been submitted previously through the Credit Balance Report should not be noted on this report. When sending a refund in with the CD, please do not file adjustments. Letters indicating that no money is owed to Medicaid must include the facility name, provider number, contact name, telephone number, and a signed statement indicating that your facility was not overpaid.

Both reports and letters should be mailed to:

EDS
Attn: Cameron Gelfo/Part B Refunds
PO Box 300011
Raleigh, NC 27622

Any requests for exceptions must be sent in writing to:

Gé Brogden, Assistant Director for Budget Management
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501

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

Holiday Closing

The Division of Medical Assistance (DMA) and EDS will be closed on December 24, 25, and 26 in observance of the Christmas holidays.

Checkwrite Schedule

December 9, 2003	January 13, 2004	February 3, 2004
December 16, 2003	January 22, 2004	February 10, 2004
December 29, 2003	January 27, 2004	February 17, 2004

Electronic Cut-Off Schedule

December 5, 2003	January 9, 2004	January 30, 2004
December 12, 2003	January 16, 2004	February 6, 2004
December 19, 2003	January 23, 2004	February 13, 2004

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.

Gary H. Fuquay, Acting Director
Division of Medical Assistance
Department of Health and Human Services

Patricia MacTaggart
Executive Director
EDS