North Carolina Medicaid Bulletin

Published as an Informational Service to Medicaid Providers by the Division of Medical Assistance and EDS, Fiscal Agent for the N.C. Medicaid Program

Number 12 December 2004

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

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Attention: All Physicians, Chiropractors, Dentists, Osteopaths, Optometrists and Podiatrists

New Guidelines for Enrollment

Effective January 1, 2005, new providers will enroll directly with the Division of Medical Assistance (DMA) to participate in the Medicaid program. If you are currently enrolled as a Medicaid provider you will continue to be enrolled. Blue Cross Blue Shield of North Carolina has processed enrollment for these practitioners for many years, but will no longer do so after December 31, 2004.

Applications, agreements, change forms and instructions are available on the DMA website at http://www.dhhs.state.nc.us/dma/prov.htm. Physician-type providers download and complete these forms to enroll in the Medicaid program. You will also be able to change your existing enrollment information, including addresses, by downloading and completing the DMA enrollment changes forms from the DMA website.

Provider Services
DMA, 919-855-4050

Attention: All Providers

General Medicaid Seminars Rescheduled

The General Medicaid Seminars scheduled for January 2005 have been rescheduled for February 2005. The dates, locations and registration form will be in the January 2005 general Medicaid bulletin.

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

Attention: All Providers

NCLeads Update

Information related to the implementation of the new Medicaid Management Information System, *NCLeads*, scheduled for implementation in mid 2006 can be found online at http://ncleads.dhhs.state.nc.us. Please refer to this website for information, updates, and contact information related to the *NCLeads* system.

Thomas Liverman, Provider Relations
Office of MMIS Services
919-855-3112

Attention: Mental Health Centers/LME's, Local Health Departments/CDSA's and Physician Practices

Clarification for Seminar Attendees

The December Seminars for Outpatient Behavioral Health Services for Direct Enrolled Mental Health Practitioners does not affect your practices. The policy changes for your groups are tentatively scheduled for implementation July 1, 2005. Seminars that address these changes will be conducted mid-2005.

Please refer to the December 2004 Special Bulletin VII, *Outpatient Behavioral Health Services Provided by Direct Enrolled Providers* for detailed information. The special bulletin will be available on DMA's website beginning December 2004 at http://www.dhhs.state.nc.us/dma/bulletin.htm.

Behavioral Health Services
DMA, 919-855-4290

Attention: Direct Enrolled Independent Mental Health Therapists and Multi-Specialty Mental Health Groups

Seminar Schedule for the Expansion of Provider Type for Outpatient Behavioral Health Services

The seminars for Outpatient Behavioral Health Services for Direct Enrolled Mental Health Therapists affect the providers listed below who are not employed by Mental Health Centers/LME's, Local Health Departments/CDSA's and Physician Practices. Providers of these types who currently contract with Mental Health Centers/LME's, Local Health Departments/CDSA's or Physician Practices must direct enroll if qualified and bill to Medicaid if qualified. This seminar will focus on the expansion of access to services for Medicaid eligible recipients by increasing participation in the provider community and expanding the age groups that may be served. The affected providers include:

- Licensed or Certified Psychologists
- Licensed Clinical Social Workers
- Certified Clinical Nurse Specialists in Psychiatric Mental Health Advanced Practice
- Nurse Practitioners Certified as Clinical Nurse Specialists in Psychiatric Mental Health Advanced Practice
- Licensed Psychological Associates
- Licensed Professional Counselors
- Licensed Marriage and Family Therapists
- Certified Clinical Addictions Specialists
- Certified Clinical Supervisors

Please refer to the December 2004 Special Bulletin VII, *Outpatient Behavioral Health Services Provided by Direct Enrolled Providers* for detailed information. The special bulletin will be available on DMA's website beginning December 2004 at http://www.dhhs.state.nc.us/dma/bulletin.htm.

Behavioral Health Services
DMA, 919-855-4290

Attention: All Providers

Automated Voice Response System Instructions

The Automated Voice Response (AVR) system allows enrolled providers to readily access detailed information pertaining to the N. C. Medicaid program. Using a touch-tone telephone, providers may inquire about the following:

N.C. MEDICAID PROGRAM AUTOMATED VOICE RESPONSE SYSTEM
24 Hours per Day
1-800-723-4337
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

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

Refer to the following transaction codes and information before placing your call. 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, Managed Care Status, Transfer of Assets Information, and CAP program enrollment	Provider Number, MID or SSN#, DOS, and "FROM DOS" **Note:** Response includes: HMO or Carolina Access PCP Name, Phone#
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.

Example: "V" is on key #8 in the third position, thus 83.

Note: Refer to the **July 2001 Special Bulletin II,** ***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: All Providers

Checkwrite Schedule Reminder

The calendar of electronic cut-off and checkwrite dates published in the general Medicaid bulletin applies to all claims submitted for processing regardless of whether the claims are submitted on paper or electronically.

Approximately 40 percent of electronic claims are received on Fridays. This increased volume may result in slower response times when attempting to transmit files via modem or keying claims via the NCECS-Web tool. Providers are strongly encouraged to submit electronic claims earlier in the week to avoid potential submission delays and reduce the risk of delay in processing and payment of claims.

The electronic cutoff and checkwrite schedule is available on DMA's website at http://www.dhhs.state.nc.us/dma/2003check.htm.

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

Attention: All Providers

Clinical Coverage Policies

The following new or amended clinical coverage policies are now available on the Division of Medical Assistance's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm:

5 – Durable Medical Equipment
8D-1 – Psychiatric Residential Treatment Facilities for Children Under the Age of 21
8D-2 – Residential Treatment Services
A3 – Prior Authorization for Outpatient Pharmacy Point of Sale Medications

The clinical coverage policies for local education agency services, independent practitioner services, and outpatient specialized therapies have been renumbered as follows:

Policy Name	Old Policy Number	New Policy Number
Outpatient Specialized Therapies	8F	10A
Independent Practitioners	8G	10B
Local Education Agencies	8H	10C

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

Gina Rutherford, Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

Contacting EDS Provider Services and Electronic Commerce Services

EDS Provider Services and Electronic Commerce Services are available Monday through Friday from 8:00 a.m. to 4:30 p.m. to assist providers with questions. Each department is responsible for specific aspects of Medicaid claim processing.

EDS Provider Services is available to assist with coverage, billing and administrative questions which include the following:

- Billing and denials
- Claims processing
- Explanation of Remittance and Status Reports and EOB codes
- Electronic Funds Transfer
- Changes to Provider information

To reach EDS Provider Services, call 1-800-688-6696, select option 3 from the menu.

Electronic Commerce Services is available to assist with electronic claims submission questions which include the following:

- Functionality of NCECS-Web
- Electronic claim formats
- HIPAA compliance
- NCECS-Web log-in assistance and assignment of passwords
- Trading Partner Agreements
- Electronic claims testing
- Interactive Eligibility

To reach Electronic Commerce Services, call 1-800-688-6696, select option 1 from the menu.

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

Attention: All Providers

Electronic Adjustments

With the implementation of HIPAA compliant claim formats, adjustments can now be filed electronically, regardless of claim type and original claim format. Filing adjustments electronically results in quicker resolution and correct payment. Electronic adjustments are submitted in the form of claim voids and replacements:

- Professional (CMS-1500) and Dental (ADA) void and replacement claims are filed using the Claim Submission Reason Indicator. A value of 7 indicates a replacement claim and a value of an 8 indicates a void claim. Institutional (UB-92) void and replacement claims are filed based on the third digit of the Type of Bill on the claim. Institutional providers use a value of 7 to indicate a replacement claim and a value of an 8 to indicate a voided claim.

Listed below are examples of each of the adjustment types that may be submitted:

Void Claim
When a provider submits a claim as a void, the system searches for the original ICN (indicated on the void claim) to recoup any and all previous payment.

Example: A provider mistakenly files a claim for an office visit for Mr. Smith. The claim should have been submitted for his wife, Mrs. Smith. The claim for Mr. Smith is received, processed, and paid by Medicaid. The provider notices the billing error when the RA is received and shows payment made for Mr. Smith. The provider can have the original claim voided by resubmitting the original claim changing the Claim Submission Reason 8 including the original ICN from the RA showing payment for Mr. Smith.

Replacement Claim

When filing a replacement claim, include Claim Submission Reason Indicator 7, the original ICN of the previously processed claim, and corrected claim information. The claim associated with the original ICN will be recouped and the corrected claim will be processed in its place. If for any reason the corrected claim denies, the previously processed claim will not be recouped.

Example: A provider bills for one 15 minute unit of therapy when 1 hour of therapy (four 15 minute units) should have been billed. Medicaid processes and pays the original claim for one 15 minute unit. The provider notices the billing error when the RA is received and shows payment made for one 15 minute unit. If the provider billed for the balance of the missing units, the claim would likely deny as a duplicate. Instead, a corrected claim for the entire four 15 minute units can be submitted, with Submission Reason code 7 and the ICN from the original claim. The system will recoup the original claim and process the correct claim for four units.

Reminder: Void and replacement adjustments can only be performed on paid claims. Denied claims do not require adjustment; simply correct the errors indicated by the Explanation of Benefits code (EOB) and resubmit the claim.

Questions regarding these types of adjustment can be addressed by EDS Provider Services at 1-800-688-6696, select option 3 from the menu.

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

Attention: All Providers

Influenza Vaccine Coverage – Billing Guidelines

North Carolina faces a shortage of influenza vaccine this year due to the loss of approximately one half of the United States' supply of trivalent inactivated vaccine for the 2004-2005 influenza season. As a result of this shortage, the N.C. Medicaid program and the N.C. Division of Public Health are following the CDC recommendations for prioritizing the use of the remaining vaccine supplies.

CDC urges vaccination of the following priority groups:

- all children aged 6-23 months
- adults aged > 65 years
- persons aged 2-64 years with underlying chronic medical conditions
- all women who will be pregnant during influenza season
- residents of nursing homes and long-term care facilities
- children 6 months-18 years of age on chronic aspirin therapy
- health care workers providing direct patient care
- out-of-home caregivers and household contacts of children aged <6 months

Information regarding the risk categories pertinent to influenza vaccine can be accessed online at http://www.cdc.gov/nip/ACIP/default.htm.

The following CPT procedure codes are used to bill the injectable vaccine:

Code	Description
90655	Influenza virus vaccine, split virus, preservative free, for children 6-35 months of age, for intramuscular use
90657	Influenza virus vaccine, split virus, for children 6-35 months of age, for intramuscular use
90658	Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use

Reimbursement for the Injectable Vaccine for Recipients through Age 18

The Immunization Branch distributes childhood vaccines to local health departments, hospitals, and private providers to be used in accordance with the N.C. Universal Childhood Vaccine Distribution Program/Vaccine for Children (UCVDP/VFC) coverage criteria and state law/administrative code. The N.C. Medicaid program does not routinely reimburse for vaccines that are supplied through UCVDP/VFC for recipients through 18 years of age. However, due to the shortage of the influenza vaccine for the 2004-2005 flu season, Medicaid **will** reimburse providers who have purchased a supply of the injectable vaccine because the supply of free vaccine has been exhausted when it is used for recipients through 18 years of age. Reimbursement for purchased vaccine will be made for dates of service October 1, 2004 through March 31, 2005.

Modifier SC, medically necessary service or supply, must be used to denote that the vaccine administered was purchased and not obtained from the UCVDP/VFC program. Modifier SC will only be effective for this time period and will only be applicable for recipients through age 18. Providers must bill one of the following code combinations when purchased influenza vaccine was administered to a recipient less than 19 years of age, when the UCVDP/VFC vaccine was exhausted:

1. CPT code 90655 appended with the SC modifier
2. CPT code 90657 appended with the SC modifier
3. CPT code 90758 appended with the SC modifier

Reimbursement for the Injectable Vaccine for Recipients 19 Through 20 Years of Age

Providers may bill Medicaid for influenza vaccine for high-risk adults 19 and 20 years of age using CPT code 90658 without modifier SC.

Reimbursement for the Injectable Influenza Vaccine for Recipients 21 Years of Age and Older

All providers may bill Medicaid for influenza vaccine for high-risk adults $\geq$ 21 years of age using CPT code 90658 and for the administration fee using CPT code 90471. An Evaluation and Management (E/M) code cannot be reimbursed to any provider on the same day that injection administration fee codes (90471 or 90471 and 90472) are reimbursed, unless the provider bills an E/M code for a separately identifiable service by appending modifier 25 to the E/M code.

FluMist Intranasal Vaccine

The N.C. Medicaid program is also responding to the vaccine shortage by covering the FluMist intranasal influenza vaccine for healthy recipients ages 5 years through 49 years who are household contacts of medically high-risk Medicaid recipients. The coverage is effective with date of service October 1, 2004. FluMist is **only** covered when it is dispensed at the local health department according to the guidelines from the Advisory Committee on Immunization Practices. This policy will remain in effect through March 31, 2005.

The inactivated influenza vaccine is preferred over LAIV, known commercially as FluMist, for household members, health-care workers, and others who have close contact with severely immunosupressed persons (e.g., patients with hepatopoietic stem cell transplants) during those periods when the person requires care in a protective environment.

No preference exists, however, for inactivated influenza vaccine use by some members of the last two high-risk groups mentioned above. Health-care workers providing direct patient care, and out-of-home caregivers and household contacts of children aged <6 months may be candidates for the FluMist vaccine.

The following people **should not receive** the intranasal FluMist vaccine:

1. people less than 5 years of age
2. people 50 years of age and over
3. people with a medical condition that places them at high risk for complications from influenza, including those with chronic heart or lung disease, such as asthma or reactive airways disease; people with medical conditions such as diabetes or kidney failure; or people with illnesses that weaken the immune system, or who take medications that can weaken the immune system
4. children or adolescents receiving aspirin
5. people with a history of Guillain-Barré syndrome (a rare disorder of the nervous system)
6. pregnant women
7. people with a history of allergy to any of the components of LAIV or to eggs

Billing Reminders for Vaccine Supplied Through VFC

Medicaid does not reimburse for influenza vaccine that is supplied through UCVDP/VFC for recipients through 18 years of age. Report CPT code 90655 or 90657 for children ≥ 6 months through 35 months of age and CPT code 90658 for children ≥ 3 years of age through 18 years of age. Providers may bill for an administration fee using CPT code 90471 or 90471 and 90472, as appropriate. Local health departments, however, may only bill CPT code 90471 with the EP modifier for any visit other than a Health Check screening.

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

Attention: All Providers

Medicare Override and Medicare Payment on UB92 Claims

Condition codes D7 and D9 are only used on the UB-92 claim form to indicate Medicare non-covered services when requesting a Medicare override. Code D7 indicates the service is non-covered by Medicare Part A code. D9 indicates the service is non-covered by Medicare Part B. These condition codes should not be listed on claims submitted to Medicaid when Medicare has made a payment.

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

Attention: All Providers

Provider Participation Exclusions

The N.C Medicaid Provider Participation Agreement requires providers to "comply with federal and state laws, regulations, state reimbursement plan and policies governing the services authorized under the Medicaid Program and this agreement…" Because Medicaid is a federal health care program, providers who are excluded by the Centers for Medicare and Medicaid Services Office of Inspector General are under federal law prohibited from participation.

Please refer to http://oig.hhs.gov/fraud/docs/alertsandbulletins/effected.htm for the September 1999 Special Advisory Bulletin titled, "The Effect of Exclusion from Participation in Federal Health Care Programs." Providers should pay particular attention to the prohibition from employing individuals who have been excluded by the OIG and the resulting Civil Monetary Penalties that could result from submitting claims for services rendered by these individuals.

Provider Services
DMA, 919-855-4050

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.

How to Correct Tax Information

All providers are required to complete a W-9 form for each provider for which **incorrect** information is not file. A copy of a W-9 is on the next page. Correct information must be received by **December 15, 2004**. The procedure for submitting corrected tax information to the Medicaid program is outlined below:

- All 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 address listed below:

  Division of Medical Assistance
  Provider Services
  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 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

- All providers, including Managed Care providers, must report changes to DMA Provider Services using the Notification of Change in Provider Status form.
- Carolina ACCESS 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 appropriate 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.

A copy of the Notification of Change in Provider Status Form and a copy of the Carolina ACCESS Provider Information Change Forms are available on 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)

Attention: Adult Care Home Providers

Adult Care Home Resident Assessment Requirements for Reimbursement of Personal Care Services

According to the adult care home licensure rules 10A NCAC 13F .0801 and 13G .0801, adult care home providers must assure an assessment of new residents within 72 hours of admission; within 30 days of admission; within 10 days following a significant change in the resident's condition; and at least annually. The initial assessment within 72 hours of admission is to be completed using the Resident Register. All other assessments for adult care home residents must be completed using the Adult Care Home Personal Care Services Physician Authorization and Plan of Care form (DMA - 3050R) or a Department approved equivalent.

The DMA-3050R form is available on the Division of Medical Assistance's website at http://www.dhhs.state.nc.us/dma/forms.html.

Doug Barrick, Policy Coordinator
DFS, 919-855-3765
Julie Budzinski, Adult Care Home Consultant
DMA 919-855-4260

Attention: CMS-1500 Billers

Medicare Crossover Reminder

Effective with dates of service September 6, 2004, Medicare began automatic crossover of CMS-1500 professional claims to Medicaid for payment. If your claims do not automatically crossover from Medicare, please refer to the August 2004 Special Bulletin V. This special bulletin provides details on filing Medicare crossover claims to Medicaid for dates of service before and after this change. Claims that fail to crossover from Medicare may be billed using the NCECS-Web tool as an alternative to filing the claims on paper. Filing the crossover claims via the Web tool results in reduced processing time and quicker adjudication.

To verify whether you are set up for Medicare crossover, please contact EDS Provider Services at 1-800-688-6696, select option 3 from the menu.

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

Attention: Community Alternatives Program Providers

Reimbursement Rate Increase for Private Duty Nursing Services

Effective with date of service October 1, 2004, the Medicaid maximum reimbursement rate for In-Home Private Duty Nursing is being changed to $9.11 per 15 minute unit. This is an annual rate increase per the state plan.

Procedure Code	Description	Reimbursement Rate
T1000	CAP/C Nursing Services	$9.11/15 min unit
T1005TD	CAP/AIDS Respite Care – Nursing Level RN	$9.11/15 min unit
T1005TE	CAP/AIDS Respite Care – Nursing Level LPN	$9.11/15 min unit
T1005TD	CAP-MR/DD Respite Care – Nursing Level	$9.11/15 min unit
T1005TE	CAP-MR/DD Respite Care – Nursing Level LPN	$9.11/15 min unit

Pat Jeter, Rate Setting
DMA, 919-855-4200

Attention: Hospice Providers

Billing for Hospice Services Rendered in a Nursing Facility

Effective on date of services February 1, 2005 and after, claims submitted for reimbursement of hospice services provided to a nursing facility resident must include the nursing facility's provider number on the hospice service's claim.

This changed applies only to the revenue code 659; the nursing facility's provider number should be listed in form locater 82 on the UB-92 claim and providers using the NCECS-Web tool should list the nursing facility's skilled provider number in the field title Attending Physician ID (UPIN). Hospice providers will be reimbursed at 95 percent of the nursing facility rate for revenue code 659.

Note: Billing claims for revenue code 659 without entering the nursing facility's provider number will be denied.

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

Attention: Local Education Agencies

Revision to the Certification of Non-Federal Match Form

The Certification of Non-Federal Match Form and instructions for Local Education Agencies has been revised. The revised form, effective October 1, 2004, is available in clinical coverage policy 10C (previously number 8H) on the Division of Medical Assistance's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm.

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

Attention: Nursing Facility Providers

MDS Validation Program Correction

The article published in the November 2004 general Medicaid bulletin on the MDS Validation Program incorrectly defined MDS as Medical Data Sets. MDS is actually the acronym for Minimum Data Set. Refer to the next page for a copy of the corrected article.

MDS Validation Program Oversight and Administration
Margaret Comin, RN, Unit Manager
DMA, 919-857-4048

Attention: Nursing Facility Providers

Minimum Data Set Validation Program for Nursing Facilities

On October 1, 2004, the Division of Medical Assistance (DMA) will begin a new Medical Data Sets (MDS) Validation Program as a component of the Medicaid Case Mix Reimbursement System. All facilities participating in the Medicaid Case Mix Reimbursement System are required to participate in the MDS Validation Program. The overall goal of the Case Mix Reimbursement System is to align payments with the level of care needed by the residents in the facility. Completion of the MDS reports is a very important function of the nursing facility staff and ensures that the nursing facility receives accurate payments from the N.C. Medicaid program.

The MDS Validation Program provides DMA and the nursing facility with assurance that the Medicaid payments are accurately based on the recorded medical and functional needs of the nursing facility resident as documented in the medical record. The MDS Validation Program replaces the FL2 and FL12 utilization review program performed by the facility staff and contract physicians, which was discontinued as of September 30, 2003.

DMA has contracted with Myers and Stauffer, LLP, to provide registered nurse reviewers to conduct onsite MDS reviews of each nursing facility in North Carolina. The reviews were scheduled to begin on October 1, 2004. All of the reviews will be completed by September 30, 2005. This first year (October 1, 2004 through September 30, 2005) of reviews are considered as **educational** reviews and are intended to assist facility staff in understanding the process and the requirements for MDS supportive documentation.

Important Definitions for the MDS Validation Program

RUG-III Reimbursement System – Medicaid uses the RUG III system to assign the facility Case Mix Index (CMI) rate. RUG III groups classify residents into 34 groups that use similar quantities of resources defined as nursing time, therapy time, and nursing assistant time. There are 108 MDS 2.0 elements that determine the RUG III classification system.

Case Mix – refers to a combination of different individual resident profiles seen in a specific setting or facility.

Case Mix Index (CMI) – each RUG-III group is assigned a weight, or numeric score, which reflects the relative resources predicted to provide care to the resident. The higher the case mix index, the greater the resource requirement for the resident.

Resident Roster – identifies all non-discharged residents and includes information on the MDS RUG-III elements transmitted on the sample set of assessments. In addition, it provides a summary of the number of MDS records in each RUG-III category.

Supportive Documentation Guidelines

DMA uses the Supportive Documentation Guidelines approved by the Centers for Medicare and Medicaid Services (CMS) to define the supporting documentation necessary to verify a RUG-III item during an MDS review.

MDS Validation Program Protocols

1. The list of residents or resident roster is produced on a Case Mix Index Report (CMI Report) every quarter on the "snapshot date" and sent to the facility. The "snapshot dates" are March 31, June 30, September 30, and December 31. For a facility review occurring in October 2004, the review sample will be drawn from the CMI Report dated June 30, 2004. For a facility review, occurring in February 2005, the review sample will be drawn from the CMI Report of residents in the facility dated September 30, 2004.

2. The sample will be drawn from all residents listed on the final CMI report regardless of payer source.

3. Both the primary and expanded samples shall include a minimum of 80 percent Medicaid recipients.
4. In the second year of case mix reviews, facilities will experience an expanded review when the primary assessment sample results in an unsupported percent are equal to or greater than the state threshold. This expanded review will include an additional 10 percent of the residents on the final CMI report or an additional 10 assessments, whichever is greater.

5. The results of the MDS Validation Program may result in re-rugging and a change in the case mix index rate for the nursing facility, as defined below.

MDS Review Process
1. Nursing facilities will be notified by the contract nurse reviewers both by phone and by fax three (3) business days prior to the visit.

2. An entrance conference will be held with the nursing facility administrator, the MDS coordinator, and any other facility personnel the administrator selects to discuss the overall objectives of the review and to allow the facility personnel to ask questions.

3. The nurse reviewer will prepare a list of the MDS's and resident records selected for review and ask the facility personnel to pull the records. If possible, the primary sample will include at least one assessment from each of the seven RUG-III classification groups.

4. The review begins immediately after the entrance conference. The reviewers will use the MDS documentation guidelines as issued by CMS (http://www.cms.hhs.gov/medicaid).

5. The reviewer will verify the MDS items and determine if the RUG-III category reported on the Final Case Mix Report is supported with documentation in the medical record.

6. Documentation for the activities of daily living (ADL's) must reflect 24/7 of the observation periods to verify the submitted values on the MDS.

7. Immediately following the review of the MDS assessments, the medical records, and other supportive documentation, the nurse reviewers will hold an exit interview with the facility staff to review preliminary results. Any unresolved issues or trends will be identified and discussed.

8. No supporting documentation will be accepted after the close of the exit conference.

9. A case mix review summary letter will be mailed to the provider by the nurse reviewers from Myers and Stauffer indicating the results of the review.

10. DMA reserves the right to conduct follow-up reviews as needed. These reviews would occur no earlier than 120 days following the exit interview.

Delinquent MDS Assessment:
Any assessment with an R2b date greater than 121 days from the previous R2b date will be deemed delinquent and assigned a RUG-III code of BC1, which is the lowest possible case mix index.

Unsupported MDS Assessment
The MDS is unsupported when the MDS nurse reviewers do not find adequate documentation for the RUG-III Classification level in the patient record. An unsupported MDS assessment can result in a different RUG-III classification from the one submitted by the facility.

Effect of Unsupported Thresholds
1. First year of program (October 2004 through September 2005) – No penalties for unsupported MDS values.

2. Second year of program (October 2005 through September 2006) – 40 percent unsupported MDS values will result in re-rugging of all unsupported MDS assessments and a recalculation of the direct rate. May also result in a retrospective rate adjustment.

3. Third year of the program (October 2006 through September 2007) – 35 percent unsupported MDS values will result in re-rugging of all unsupported MDS assessments and a recalculation of the direct rate. May also result in a retrospective rate adjustment.

4. Fourth and succeeding years of program (October 2007 through September 2008) – 25 percent unsupported will result in the recalculation as above.

The following resources are available to facility staff for questions related to the MDS and MDS Validation Program

MDS State Contact – For all questions related to coding.
Cindy DePorter, Division of Facility Services
919-715-1872, ext. 214

MDS Help Desk
919-715-1872
QUIESHELPDESK@ncmail.net

Myers and Stauffer's Help Desk – For questions other than coding issues.
Documentation Guidelines
1-800-763-2278

MDS Validation Program Oversight and Administration
Margaret Comin, RN, Facility Unit Manager
DMA, 919-855-4350

Attention: Nursing Facility Providers

Nursing Home Claims Denial Codes

Nursing Home claims for dates of service 10/01/03 to 04/30/04 that were processed prior to 07/23/04 were subjected to a retroactive adjustment disbursement in the month of August and October 2004. The Division of Medical Assistance (DMA) had directed its fiscal intermediary to implement a denial code on claims with dates of service 10/01/03 to 4/30/04 effective October 6, 2004. However, because a significant number of claims for dates of service during this period had not been paid by October 6, 2004 DMA has instructed the fiscal intermediary to remove the denial code on claims with dates of service during this period.

Accordingly, any claims for dates of service that were denied because of the denial code now can be resubmitted for normal processing according to fiscal intermediary guidelines for reimbursement. Providers should note that such claims will continue to pay at the rate received prior to the retroactive rate adjustment. Such claims being submitted now will be adjusted by DMA's Rate Setting Section at a later date.

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

Attention: Rural Health Clinic Providers

Negative Reimbursement Amounts on Medicare Remittance Advices

Effective immediately, Rural Health Clinic providers enrolled with Palmetto GBA-Riverbend who has received a negative reimbursement amount on their Medicare remittance advices for claims with dates of service between October 1, 2002 through September 5, 2004 will have those claims processed as if 100 percent of the Medicare allowable was applied towards the deductible. Please refer to the September 2002 Medicare Part B Draft Billing Guidelines, Special Bulletin VI, for detailed instructions for filing these claims. All claims that have been previously received by EDS Provider Services will be processed and time limits will be overridden, as appropriate. If you have not submitted your claim and need a time limit override, these claims must be submitted on a Resolution Inquiry form and received at EDS no later than February 1, 2005.

In order to expedite the processing of any claims not yet received by EDS, please have the Medicare remittance advice attached to the claim form reflect that the Medicare carrier is Palmetto GBA-Riverbend.

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

Proposed Clinical Coverage Policies

In accordance with Session Law 2003-284, proposed new or amended Medicaid clinical 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.

Gina Rutherford
Division of Medical Assistance
Clinical Policy Section
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.

Holiday Closing

The Division of Medical Assistance (DMA) and EDS will be closed Friday, December 24 and Monday, December 27 in observance of the Christmas Holidays. They will also be closed on Friday, December 31, 2004 in observance of New Years Day.

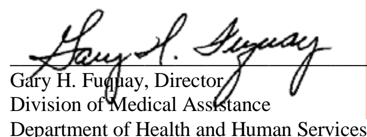
Checkwrite Schedule

November 2, 2004	December 7, 2004
November 9, 2004	December 14, 2004
November 16, 2004	December 22, 2004
November 24, 2004	

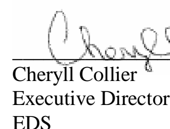
Electronic Cut-Off Schedule

October 29, 2004	December 3, 2004
November 5, 2004	December 10, 2004
November 12, 2004	December 17, 2004
November 19, 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, Director
Division of Medical Assistance
Department of Health and Human Services



Cheryll Collier
Executive Director
EDS