Number 12 *December 1999*

North Carolina Medicaid Bulletin

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

Attention: All Providers

Holiday Observance

The Division of Medical Assistance (DMA) and EDS will be closed on the following dates for the observance of holidays.

Dates Closed	Holiday Observance
Friday, 12/24/99	Christmas
Monday, 12/27/99	Christmas
Friday, 12/31/99	New Year's Day
Monday, 1/17/00	Martin Luther King Jr's. Birthday

Attention: All Providers Performing Laboratory Services

Clinical Laboratory Improvements Amendment (CLIA)

Effective for claims received on and after January 14, 2000, providers must enter the complete CLIA number of the laboratory performing the service on the claim. The complete CLIA number is 10 bytes in length with the third character an alpha and the other 9 bytes numerical, (example, 34D1000000). Claims that do not have the complete CLIA number in block 23 will be denied.

- Paper claim submitters, it is located in block 23 on the HCFA-1500 claim form
- ECS submitters, it is located in the HCFA 1500 specs in record type 1R beginning at byte 26
- Tape providers, it is located in record type I beginning at byte 132

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

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

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

Attention: All Providers

Update on Year 2000 Activities

TIME is RUNNING OUT: Procedures and processes have been established for all types of electronic and paper submitters. Providers are reminded that they must be Y2K compliant by the last week in December. Based upon current statistics, only 89 submitters have passed the Y2K testing. Providers need to act quickly, there is a limitation on the ability for EDS to test submitters who wait until the last moment.

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

NECS Submitters

The current NECS software is being replaced by window-like software to be renamed the North Carolina Electronic Claims Submission (NCECS) software. Contact the ECS department for information on how to obtain this software.

Tape Submitters

EDS sent providers specifications for the new format in February 1999. All tape submitters must pass testing with EDS before Y2K compliant claims will be accepted. **Providers should insure that testing is completed before December 31, 1999.**

ECS Submitters

EDS sent providers specifications for the new format in March 1999. All ECS submitters must pass testing with EDS before Y2K compliant claims will be accepted. **Providers should insure that testing is completed before December 31,1999.**

Paper Submitters

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

ANSI 837 Submitters

EDS is accepting ANSI formats from non-NCECS submitters beginning with the 4th calendar quarter of 1999. Coordination on testing for this must be done with the ECS unit since Y2K testing will have a priority.

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

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

Attention: All Providers

North Carolina Electronic Claims Submission Software (NCECS)

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

NEW INFORMATION: Based upon problems discovered internally, EDS has improved and corrected the NCECS product in several areas. This will include the following improvements:

- Providers will be able to print copies of the prepared claims
- Problems with the listing of recurring values will be fixed (i.e. allow multiple same last recipient names in drop down lists)
- The software no longer requires the patient status entry in Form Locator 22 of the UB-92. This change allows providers to follow the specific billing instructions for their services.
- Enhancement of the changing dates of service function to allow mass change of dates of service for multiple recipients – this feature is often needed by the nursing home provider

The modifications are on a diskette that has been mailed with instructions to each NCECS user. Providers who have installed the NCECS software from the CD-ROM need to be sure that they have also installed the modifications from the update diskette. Providers who have not received the diskette should contact the ECS Unit, EDS, at 1-800-688-6696 or 919-851-8888.

Minimal PC requirements for the use of NCECS include:

- Pentium series recommended; 486 machines will function
- minimum of 32 megabytes of memory
- minimum 20 megabytes of hard drive storage
- a browser such as Microsoft Internet Explorer (version 3.0 or higher) or Netscape (version 3.0 or higher)
- a modem – minimal 2400 baud rate; at least 9600 baud rate recommended
- CD ROM drive – recommended – NCECS software is normally distributed on CD ROM. 3.5 inch Diskettes can be provided upon request

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

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

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

Attention: All Providers

Y2K Contingency Plan for Recipient Eligibility Verification

Individuals approved for Medicaid receive monthly identification cards as proof of their eligibility. This card contains information necessary for claims filing, including the recipient Medicaid ID number (MID), date of birth, third party insurance and Medicare coverage, enrollment in Medicaid managed care, and the eligible dates for which the card is valid. Recipients receive Medicaid ID cards at the beginning of every month. Providers are encouraged to request recipients to bring and show their card to verify eligibility before services are rendered. A photocopy of the card is proof that the recipient was eligible on the date of that service in case a claim denies for an eligibility reason.

Measures have been taken by the Division of Medical Assistance and Electronic Data Systems to ensure no loss of computer service due to Year 2000; however **the recipient's Medicaid ID card will play a more critical role in January 2000 should system problems arise**. If the Automated Voice Response System is down, or if pharmacies are unable to access Point of Sale Software, the Medicaid ID card may be the provider's only means to verify that the recipient is eligible for a January 2000 date of service. If the recipients medical need is urgent and he has failed to take his January MID card, the county DSS in the recipients county of residence may be contacted for verification. For recipients whose eligibility is approved after January 1, but the approval cannot be entered into the state's computer system due to year 2000 problems, a written notice of approval will be issued to the recipient in lieu of an MID card by the county DSS. This notice can be used as proof of eligibility for the eligible dates specified on the notice. Providers should bill claims for services provided using the written notice as proof of eligibility after 1/20/2000 to allow time for system updating.

Recipients will be notified through the use of an insert for the January Medicaid card mailing that they must show their Medicaid card to providers during the month of January 2000 in order to receive services. Recipients may also show a county issued card or county issued client notice as proof of eligibility. Providers are advised to make copies of all cards or notices for their records.

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

Attention: Optical Providers

Procedure for Checking Medicaid Eyeglass Order Status

The optical provider is responsible for checking the status of Medicaid eyeglass orders for any recipient experiencing delivery delays. The provider should not communicate or imply to a recipient that the status of Medicaid orders cannot be accessed by the provider's office.

As stated in the May 1999 manual on page 6, under the section entitled "Contractor", when an order is not received within 10 working days of the EDS prior approval date, the optical provider should contact Nash Optical Plant. If Nash Optical Plant does not have a record of the order, contact EDS Prior Approval Unit and request that an EDS copy of the authorization be sent to the contractor. The contractor cannot accept a provider copy or fax copy of the authorized prior approval form. Eyeglass orders may only be fabricated from the yellow contractor copy or an EDS copy.

Ronda B. Owen, Optician Medical Policy,
DMA, 919-857-4038

Nash Optical Plant
1-888-388-1353

EDS Prior Approval Unit
1-800-688-6696

Attention: Optical Providers

Hurricane Floyd Update

Nash Optical Plant Eyeglass Delays

On September 15, 1999, Governor Hunt issued a statement for all non-critical employees at Nash Correctional Institution to leave the facility due to the impending hurricane. Nash Optical Plant is located in Nash County, one of our State's most impacted areas. Nash Optical Plant also was closed September 16th and 17th due to the devastation in that area. During the hurricane aftermath, the Rocky Mount water treatment plant was adversely affected by the flooding. Subsequently, Nash Correctional Institution was evacuated on September 18th due to water contamination.

During this evacuation period, Nash Optical Plant implemented an emergency operation plan. North Carolina Medicaid eyeglass orders were forwarded to several emergency back-up laboratories. Additional time was required for shipping orders to and from Nash Optical Plant and the laboratories. These laboratories also had the task of continuing to process their own workflow, as well as the additional orders for the North Carolina Medicaid Visual Services Program. Subsequently, Nash Optical Plant experienced some delay in the delivery of eyeglasses to providers.

Although understandable delays were created, the emergency back-up laboratories did outstanding work, for which the State of North Carolina is grateful. The Nash Correctional Institution population returned to the facility on October 4th and Nash Optical Plant was operating with a full staff by October 11, 1999.

To date, Nash Optical Plant is current in the fabrication of Medicaid eyeglass orders and no emergency back-up laboratory support is necessary.

Replacement of Visual Aids Lost/Damaged Due to Hurricane Floyd

A waiver regarding replacement visual aids for Hurricane Floyd victims was established on September 24, 1999. Providers should continue to follow the instructions detailed below for any request regarding replacement visual aids lost or damaged due to Hurricane Floyd:

WAIVER: Letter from Department of Social Services Caseworker requesting replacement is NOT required.

WAIVER: Mailing prior approval (PA) to EDS is NOT required.

- Complete the PA as usual

- In "block 15" write a description of damage and that damage/loss is due to Hurricane Floyd
  EXAMPLE: Glasses lost due to FLOYD
  Frame front broken due to FLOYD
  Contact lenses damaged due to FLOYD

- Fax PA to RONDA OWEN at (919)733-2796

Each PA faxed with documentation of specific damage/loss will receive RUSH status and be processed with the highest priority. Please do NOT fax any PAs unrelated to Hurricane Floyd.

Attention: Optical Providers

Dispensing Fee Adjustments

The following dispensing fee adjustments are effective with the date of service November 1, 1999.

DISPENSING FEES

EYEGLASS LENSES

CODE	DESCRIPTION	ALLOWABLE
V0500	Single vision lens (1)	$8.13
V0290	Bifocal or balance lens (1)	12.20
V0640	Trifocal lens (1)	16.27
V1110	Cataract lens (1)	22.50
	Bill one lens as 1 unit Bill two lenses (a pair) as 2 units	

FRAMES AND REPAIRS (To Include Adjustment)

CODE	DESCRIPTION	ALLOWABLE
V0140	Dispense frame	$ 8.13
V0131	Dispense frame front	8.13
V2030	Dispense temple (1)	3.25
	Bill one temple as 1 unit Bill two temples (a pair) as 2 units	

CONTACT LENSES

CODE	DESCRIPTION	ALLOWABLE
V0320	Dispense contact lens (1) Bill 1 unit	$ 97.61
V0330	Dispense contact lenses (2) Bill 1 unit	169.19

REPLACEMENT CONTACT LENSES

CODE	DESCRIPTION	ALLOWABLE
Y5513	Dispense new Rx lens for previous contact lens wearer Bill one lens as 1 unit	$52.06
Y5514	Dispense replacement (previous Rx) contact lens to previous contact lens wearer Bill one lens as 1 unit	26.03

Note: Dispensing fees include K-readings, fitting measurements, training, etc.

TELESCOPIC AND MICROSCOPIC AIDS

CODE	DESCRIPTION	ALLOWABLE
Y5511	Monocular	$45.55
Y5512	Binocular	65.07

VISUAL AIDS

Materials are to be billed at invoice cost and an invoice must be submitted with the claim.

CODE	DESCRIPTION	ALLOWABLE
V0730	Not otherwise classified (frame, lenses, special services) Bill 1 unit only	Attached Invoice Cost
Y5534	Supply uncut lens/lenses Bill 1 or 2 units	Attached Invoice Cost
Y5535	Edge and mount single vision lens/lenses Bill 1 or 2 units	$1.63 Per Unit
Y5536	Edge and mount multifocal lens/lenses Bill 1 or 2 units	$3.25 Per Unit

Note: Provider's supply of Medicaid lenses/frames requires justification and prior approval.

CONTACT LENS

CODE	DESCRIPTION	ALLOWABLE
V0310	Standard hard contact lens, monocular	Attached Invoice Cost
V0300	Standard soft contact lens, monocular Bill 2 units for binocular lenses	Attached Invoice Cost
V2599	Care kit for soft contact lenses	Attached Invoice Cost

SUBNORMAL VISUAL AIDS

CODE	DESCRIPTION	ALLOWABLE
V2600	Magnifiers/Readers	Attached Invoice Cost
Y5516	Telescopic glasses	Attached Invoice Cost
Y5517	Microscopic glasses	Attached Invoice Cost
Y5518	Loupes	Attached Invoice Cost
V1035	Temporary/ loaner cataract glasses to include dispensing fee	$25.00 Maximum

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

Attention: Physicians, all specialties, Optometrists, Podiatrists, **Nurse Practitioners, Multi-specialty Clinics, CRNA's, Nurse Midwives, Portable X-ray, Ambulatory Surgery Centers**

Modifier 50 – Bilateral Procedure

To assist in billing modifier 50 use the following guidelines:

1. When the CPT description includes "bilateral" or "unilateral or bilateral" in the description of the code, **do not** append modifier 50. The fee schedule allowable, established by the Relative Value Units, is based on the procedure being performed bilaterally. Therefore no additional payment is allowed

2. When the procedure is performed on both sides of the body and the CPT description does not state "bilateral" or "unilateral or bilateral" in the description, check the procedure code list in the April, 1999 Modifier Special Bulletin on page 43. Medicaid bases this list on the Medicare Physician Fee Schedule Data Base used by Medicare. Append modifier 50 to the procedure code with a unit of "**1**" on the first claim detail and bill the amount charged for a bilateral procedure (refer to Question #12 in the Modifier Question and Answer article in this issue).

Medicaid will not reimburse more than the billed amount. Therefore, when determining the billed amount, make certain the amount is what would be billed if performing the procedure bilaterally, instead of unilaterally.

Example of correct billing of Modifier 50:

24A	B	C	D	E	F	G
DOS	**POS**	**TOS**	**Procedure code/Mod**	**Diagnosis code**	**Charges**	**Days or units**
042899	**21**		**27524 50**		**$1295.18**	**1**

Examples of incorrect billing of Modifier 50:

C	B	C	D	E	F	G
DOS	**POS**	**TOS**	**Procedure code/Mod**	**Diagnosis code**	**Charges**	**Days or units**
042899	**21**		**2752450**		**$647.59**	**2**

C	B	C	D	E	F	G
DOS	**POS**	**TOS**	**Procedure code/Mod**	**Diagnosis code**	**Charges**	**Days or units**
042899	**21**		**27524**		**$647.59**	**1**
042899	**21**		**2753450**		**$647.59**	**1**

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

Attention: Physicians, all specialties, Optometrists, Podiatrists, Nurse Practitioners, Multi-specialty Clinics, CRNA's, Nurse Midwives, Portable x-ray, Ambulatory Surgery Centers

Modifiers RT and LT

To assist in billing Medicaid with modifiers RT (Right), and LT (Left), use the following guidelines. Because Medicaid is not recognizing modifier 22, the following lists were created from the Resource Based Relative Value System (RBRVS).

Listed below are "bilateral" procedures designated by a "2" in the RBRVS whose relative value units reflect both the right and left being performed as part of the procedure.

Modifiers RT or LT must be appended to these codes if the procedure is performed only on one side. Medicaid reimbursement will be based on the procedure being performed as unilateral only.

27392	27395	33976	33978	35549	40701	40702	40843	42507	42508
42509	42510	51575	51585	51595	54130	54135	55041	55815	55865
56312	56313	56632	57109	57112	58950	58951	58952	70330	71060
71110	71111	73050	73520	73565	73700	73701	73702	73720	73725
75662	75671	75680	75716	75724	75733	75743	75803	75807	75822
75833	75842	76094	76102	76516	76519	93875	93880	93922	93923
93924	93925	93930	93965	93970					

Listed below are codes also designated by a "2" in the RBRVS but described by CPT as "unilateral and bilateral". Appending either modifier RT or LT to these codes provides additional information regarding the procedure but does not affect reimbursement.

51820	52290	52300	52301	54430	55200	55250	55300	55450	58600
58605	58700	58720	58800	58805	58900	58920	58925	61000	61001
61253	63045	63046	63047	63048	69210	76645	92081	92082	92083
92265									

Procedure code 32001, "Total lung lavage (Unilateral)" can be billed with modifiers RT or LT as information.

The above two lists are the only procedure codes in which modifier RT or LT can be appended. For procedures that are not listed above and are performed bilaterally, refer to the article on modifier 50 on page 8 of this bulletin.

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

Attention: All Providers

Medicaid Fair Update

Thanks to everyone who attended this year's Medicaid Fair in September. This year's participation of 2,000 was the highest that we have ever had and we received many positive comments from the participants. Please watch future bulletins for dates of the next Medicaid Fair.

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

Attention: All Providers

Modifier Questions and Answers

Providers, during the Medicaid Fair, asked the following questions. The answers are being provided to assist in billing Medicaid.

1. Question: Can Modifier 78 or 79 be billed with Anesthesia?

   Answer: No. Modifier 78 and 79 are billed with the surgical procedure with only one unit. Anesthesia is billed with multiple time units.

2. Question: Can modifiers WJ or W3 be billed? If not, can the system ignore them?

   Answer: No. The system will deny unrecognized modifiers. Refer to the April 1999 Special Bulletin for the list of recognized modifiers.

3. Question: Has the implementation of modifiers had any impact on Medicare crossover billing?

   Answer: No. Crossover billing is the same now as prior to modifier implementation.

4. Question: Does a "complete" surgery need a modifier?

   Answer: No. When a provider performs the surgery **and** is responsible for the follow-up during the entire post-operative period, the provider is not to append modifier 54 or 55. Billing without modifier 54 or 55 indicates the provider is billing the "complete" or "global" package.

5. Question: What modifier is used with assistant surgeon? What is the reimbursement?

   Answer: Both modifiers 80 and 82 denote assistant at surgery services. Both are reimbursed at 16% of the fee schedule allowed amount. Modifier 80 is appended to a procedure code to denote assistant at surgery services if the surgery is approved for assistant at surgery coverage. In teaching hospitals, where an approved training program exists, it is required that a qualified resident assist at surgery except in unusual circumstances. In such circumstances, when a qualified resident is not available to perform the service, the provider appends modifier 82.

6. Question: Are endoscopy codes billed with Modifier 51?

   Answer: No. Although endoscopy codes are subject to multiple pricing processing after endoscopy pricing, providers must not append modifier 51 to endoscopy codes. The Medicaid system calculates the endoscopy multiple procedure pricing for the provider. If modifier 51 is appended to endoscopy codes, the claim will deny.

7. Question: When is modifier 26 used?

   Answer: Certain procedure codes are a combination of the physician component and the technical component. When the physician component can be billed separately, modifier 26 is appended. When there is a specific code that covers the physician component, through its description, such as CPT 93018, modifier 26 can not be billed. Instead, the code is billed with no modifier.

8. Question: Are there specific modifiers used for dialysis codes?

   Answer: No. There are no specific modifiers for CPT codes 90935, 90937, 90945 and 90947. These codes are acceptable with applicable modifiers, but there is no specific modifier particular only to them.

9. Question: Does a fetal non-stress test require a modifier if two are done but on different dates of service?

   Answer: No. A fetal non-stress test, CPT code 59025, does not require a modifier if performed on different dates of service.

10. Question: When a recipient is in a car accident and has third party insurance, what is the correct billing? Are modifiers required?

    Answer: Yes. Bill the primary insurance source first listing, on the same claim, all the procedures performed. After receiving notification of insurance disposition, the claim with all the procedures performed is submitted to Medicaid on the same claim form. Include the insurance payment and/or denial. Modifiers are required if applicable to the service billed.

11. Question: When nerve conduction tests are performed on both legs, is modifier 50 billed?

    Answer: No. Nerve conduction CPT codes 95900, 95903, 95904, and 95937 are not valid when billed with modifier 50, even when the tests are performed on both legs. Nerve conduction tests can be performed on all extremities at the same session and are often billed with multiple units.

12. Question: Is a Type of Treatment required to be billed when using a modifier?

    Answer: Type of Treatment is no longer required for providers who bill modifiers. However, if a Type of Treatment is billed, the modifier must match Type of Treatment billed. For example, if the provider bills a Type of Treatment "04" (previously recorded on the Remittance Advice as Type of Service "05"), the procedure code must have modifier 26 appended to indicate that the professional component was performed. If the provider bills a Type of Treatment "31", (previously recorded on the Remittance Advice as Type of Service "3"), the procedure code requires no modifier since this indicates the complete, or global, service was rendered.

13. Question: What is the difference between Medicaid and Medicare's billing of modifier 50?

    Answer: Although Medicare allows the option of billing modifier 50 either on the first detail or on the first and second detail, the Medicaid system requires that the procedure code with modifier 50 appended be billed with one unit on the first detail only.

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

Attention: Physicians, Podiatrists, Nurse Practitioners, Multi-specialty Clinics, CRNAs, Nurse Midwives, Portable x-ray, Ambulatory Surgery Centers

Modifier 51 and Incorrect Primary Procedures

When a provider has appended modifier 51 incorrectly to the primary procedure and, as a result, the provider has received a payment of 50% of the allowed amount, the provider can request a full recoupment of all paid details. The provider should then resubmit a new day claim without appending modifier 51 to the primary procedure code and append modifier 51 to the secondary codes. Because claim history will indicate that a recoupment is in process, the provider does not have to delay submitting the new day claim awaiting the recoupment on the RA.

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

Attention: All Providers

Resubmission vs. Filing Adjustment

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

(Last Revision 10/13/99)

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

1175	2024	5216	7788	7936	7972	8904	9219	9256
1177	2027	5221	7794	7937	7973	8905	9220	9257
1178	2235	5222	7900	7938	7974	8906	9221	9258
1181	2236	5223	7901	7939	7975	8907	9222	9259
1183	2237	5224	7904	7940	7976	8908	9223	9260
1184	2238	5225	7905	7941	7977	8909	9224	9261
1186	2335	5226	7906	7942	7978	9036	9225	9263
1197	2911	5227	7907	7943	7979	9054	9226	9264
1198	2912	5228	7908	7944	7980	9101	9227	9265
1204	2913	5229	7909	7945	7981	9102	9228	9266
1232	2914	5230	7910	7946	7982	9103	9229	9267
1233	2915	6703	7911	7947	7983	9104	9230	9268
1275	2916	6704	7912	7948	7984	9105	9231	9269
1278	2917	6705	7913	7949	7985	9106	9232	9272
1307	2918	6707	7914	7950	7986	9174	9233	9273
1324	2919	6708	7915	7951	7987	9175	9234	9274
1350	2920	7700	7916	7952	7988	9180	9235	9275
1351	2921	7701	7917	7953	7989	9200	9236	9291
1355	2922	7702	7918	7954	7990	9201	9237	9295
1380	2923	7703	7919	7955	7991	9202	9238	9600
1381	2924	7704	7920	7956	7992	9203	9239	9611
1382	2925	7705	7921	7957	7993	9204	9240	9614
1400	2926	7706	7922	7958	7994	9205	9241	9615
1404	2927	7707	7923	7959	7996	9206	9242	9625
1442	2928	7708	7924	7960	7997	9207	9243	9630
1443	2929	7709	7925	7961	7998	9208	9244	9631
1502	2930	7712	7926	7962	7999	9209	9245	9633
1506	2931	7717	7927	7963	8174	9210	9246	9642
1513	2944	7733	7928	7964	8175	9211	9247	9684
1866	3001	7734	7929	7965	8326	9212	9248	9801
1868	3002	7735	7930	7966	8327	9213	9249	9804
1873	3003	7736	7931	7967	8400	9214	9250	9806
1944	5001	7737	7932	7968	8401	9215	9251	9807
1949	5002	7738	7933	7969	8901	9216	9252	9919
1956	5201	7740	7934	7970	8902	9217	9253	9947
1999	5206	7741	7935	7971	8903	9218	9254	9993

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

Attention: All Providers

Tax Identification Information

Alert - Tax Update Requested

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

H*ow to verify tax information*

The last page of the Medicaid Remittance and Status (RA) report indicates the provider tax name and number (FEIN) Medicaid has on file. Refer to the Medicaid RA throughout the year for each provider number to ensure Medicaid has the correct tax information on file. The tax information needed for a group practice is as follows: (1) Group tax name and group tax number; (2) Attending Medicaid provider numbers in the group. If a Medicaid RA is needed, call Provider Services 919-851-8888 or 1-800-688-6696 to verify the tax information on file for each provider number.
Providers should complete a special W-9 (see next page) for all provider numbers with **incorrect** information on file. Instructions for completing the special W-9 are listed below.

- Fill in the North Carolina Medicaid Provider Name Block (**this must be completed)**
- Fill in the North Carolina Medicaid Provider Number (**this must be completed)**
- Part I Correction field - Indicate tax identification number exactly as the IRS has on file for the provider's business. Do not insert a Social Security Number unless the business is a sole proprietorship or individually owned and operated
- Part II Correction field - Indicate tax name exactly as the IRS has on file for the provider's business
- Part III - Indicate the appropriate type of organization for the provider's business. If a Social Security Number is indicated as the tax identification number, select individual/sole proprietor as the type of organization
- Part IV - An authorized person **MUST** sign and date this form,or it will be returned as incomplete and the tax data on file with Medicaid ***will not*** be updated

Send completed and signed forms by December 17, 1999 to:

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

Change of ownership

Contact DMA Provider Enrollment at 919-857-4017 to report all changes in business ownership. If necessary, a new Medicaid provider number will be assigned and Provider Enrollment will ensure the correct tax information is on file for Medicaid payments. If DMA is not contacted and the incorrect provider number is used, that provider will be ***liable for taxes*** on income not necessarily received by the provider's business. DMA will assume no responsibility for penalties assessed by the IRS or for misrouted payments prior to written receipt of notification of ownership changes.

Group practice changes

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

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

Special W-9

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

Provider Name: _____ Provider Number: _____

Part I. Provider Taxpayer Identification Number:

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

Correction Field (please write clearly in black ink):

_____

Employer Identification Number/Taxpayer Identification Number

_____

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

Part II. Provider Tax Name:

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

Correction Field: _____

Part III. Type of Organization - Indicate below:

___ Corporation/Professional Association _____Individual/Sole Proprietor _____ _____ Partnership
___ Other: _____ _____Government:

Part IV. Certification

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

_____

Signature Title Date

EDS Office Use Only

Date Received: Name Control: _____Date Entered:_____

Attention: Dental Providers

New Reimbursement for Fluoride Varnishes Effective April 1, 1999

Effective with date of service April 1, 1999, DMA added coverage for fluoride varnishes for children under age 21. This will be covered as a routine service. Fluoride varnishes have been proven effective in the prevention of early childhood caries, especially for children age nine (9) months to thirty-six (36) months of age. DMA allows reimbursement only for the application of fluoride varnish under code 01203. It is not to be used for topical gels, rinses, and foams. Bill as follows:

Procedure Code	Description	Indicator
01203	Topical application of fluoride (prophylaxis not included) - child * allowed for the application of fluoride varnish only * not allowed for topical gels, rinses, and foams * must be applied to all teeth erupted on the date of service * limited to recipients under 21 years old * any fluoride application (01201, 01205, or 01203) allowed two (2) times per year at six (6) month intervals for the same provider * not allowed on the same date of service as 01201 or 01205	R (Routine Service)

Reimbursement: $15.00 for the entire mouth

The fluoride varnish should be applied to clean, dry teeth. The dentist will determine how the teeth will be prepared prior to the varnish application. If the prophylaxis is rendered on the same date of service, it is billed under one of the following codes:

Procedure Code	Description	Indicator
01110	Prophylaxis - adult * limited to recipients 13 years and older * allowed two (2) times per year at six (6) month intervals for the same provider	R (Routine Service)
01120	Prophylaxis - child * limited to recipients under 13 years old * allowed two (2) times per year at six (6) month intervals for the same provider	R (Routine Service)

Other topical applications of fluoride (topical gels, rinses, and foams) typically rendered as an office procedure in conjunction with the prophylaxis will continue to be billed under the following codes:

Procedure Code	Description	Indicator
01201	Topical application of fluoride (including prophylaxis) - child * limited to recipients under 13 years old * allowed two (2) times per year at six (6) month intervals for the same provider	R (Routine Service)
01205	Topical application of fluoride (including prophylaxis) - adult * limited to recipients 13 to 21 years old * allowed two (2) times per year at six (6) month intervals for the same provider	R (Routine Service)

Topical fluoride (gels, rinses, and foams) remains not covered when provided as a separate procedure. Fluoride is also not covered for recipients age 21 and older.

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

Attention: All Physicians

Injectable Drug List Changes

An updated injectable drug list was published in the October 1999 Medicaid Bulletin. The following changes have been made since that time. Please make the changes on the published list for future reference.

Addition:

Effective with date of service November 1, 1999, the following FDA approved drug was added to the list of injectable drugs covered by the North Carolina Medicaid Program when administered in a physician office for the FDA approved indications.

Code	Description	Unit	Fee
J7513	Daclizumab (Zenapax) 25mg.	1	$ 377.43

Change:

The following rate change is effective with date of service December 1, 1999

Code	Description	Unit	Fee
J7194	Factor IX (Benefix) per I.U.	1	$ .26

Deletion:

The state created code W5180 Dolasetron Mesylate will be end-dated effective with date of service December 31, 1999. The code J1260 must be used when billing the drug beginning with date of service January 1, 2000. See the updated injectable drug list in the October 1999 Bulletin for the reimbursement rate.

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

Attention: Federally Qualified Health Center and Rural Health Center Providers of Maternity Care

Coordination (MCC) Services - Rate Change for MCC Services

Effective with date of service November 1, 1999, maximum reimbursement rates for the basic Maternity Care Coordination Services rates are: W8201 - $89.15, W8202 - $44.56, and Y2044 - $70.50. This applies to only FQHC and RHC providers of MCC Services.

Sherrill Johnson, Rate Setting - Financial Operations
DMA, 919-857-4015

Attention: Durable Medical Equipment (DME) And Home Infusion Therapy (HIT) Providers

Addition of Enteral Categories IV and V to the DME and HIT Fee Schedules

Effective with date of service December 1, 1999, the following codes are being added to the Enteral Nutrition Products category of the DME Fee Schedule and to the Parenteral and Enteral Nutrition Products category of the HIT Fee Schedule:

Code	Description	Billing Unit	Rate
B4154	**Enteral formulae; category IV: defined formal for special metabolic need**	100 calories	$1.12
B4155	Enteral formulae; category V: modular components	100 calories	$ .87

DME providers should refer to Section 7 of the March 1999 DME Manual for information about coverage policies and billing of enteral products. Please note that, as with all DME items, you must have a physician's prescription and a Certificate of Medical Necessity and Prior Approval form must be completed; prior approval is not required for these products.

HIT providers should refer to Section 7 of the Community Care Manual for information about coverage policies and billing of these products.

Providers are reminded to bill their usual and customary rates.

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

Amy Boone, R.N., Medical Policy
DMA, 919-857-4021

Attention: All Providers Billing On Paper Claim Forms

Carbon copies of claims

EDS is scanning all processed paper claims. Carbon copies or photocopies of claims do not produce a legible image. Please submit only the original claim form to EDS for processing to facilitate a clear retrievable claim image for tracking and research.

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

Attention: Hospital Providers

Inpatient Hospital Stays

Under the North Carolina Medicaid hospital inpatient reimbursement plan, a recipient must be admitted as an inpatient and stay past midnight in an inpatient bed in order to be eligible for inpatient hospital reimbursement. The only exceptions to this requirement are recipients who are admitted as an inpatient who die or are transferred to another acute care hospital on the day of admission. Hospital admissions prior to 72 hours after a previous inpatient hospital discharge are subject to review by the Division of Medical Assistance.

Services for recipients admitted and discharged on the same day and who are discharged to home or to a non-acute care facility must be billed as outpatient services. In addition recipients who are admitted to observation status do not qualify as inpatients, even when they stay past midnight. Recipients in observation status for more than 30 hours must either be discharged or converted to inpatient status.

Outpatient services provided by a hospital to recipients within the 24 hour period prior to an inpatient admission in the same hospital that are related to the inpatient admission shall be bundled with the inpatient billing.

When a patient is transferred between hospitals, the transferring hospital shall receive a pro-rated payment equal to the normal DRG payment multiplied by the patient's actual length of stay divided by the geometric mean length of stay for the DRG. When the patient's actual length of stay equals or exceeds the geometric mean length of stay for the DRG, the transferring hospital receives full DRG payment. Transfers are eligible for cost outlier payments. The final discharging hospital shall receive the full DRG payment.

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

Attention: CAP-Aides, DA, MR-DD Providers

Reimbursement Rate Increase

Effective with date of service November 1, 1999, the Medicaid maximum reimbursement rate for procedure codes W8104, W8105 and W8170, Adult Day Health Care, increased to $36.51. Providers are to continue billing their usual and customary amount. No adjustments will be made to previously filed claims.

Cindy Bryan, Financial Operations
DMA, 919-857-4266

Attention: Home Health Providers

Home Health Seminars

Home Health seminars will be held in February 2000. The January Medicaid Bulletin will have the registration form and a list of site locations for the seminars. Please list any issues you would like addressed at the seminars. Return form to:

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

_____

_____

_____

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

Attention: ICF/MR Providers

Individual Visits

EDS is offering individual provider visits for ICF/MR providers. Please complete and return the form below. An EDS Provider Representative will contact you to schedule a visit and discuss the type of issues to be addressed.

(cut and return registration form only)

ICF/MR Provider Visit Request Form
(No Fee)

Provider Name_____ Provider Number _____

Address _____ Contact Person_____

City, Zip Code_____ County _____

Telephone Number_____ Date _____

List any specific issues you would like addressed in the space provided below.

_____

_____

Return to: Provider Services
EDS
P.O. Box 300009
Raleigh, NC 27622

Attention: Hospice Providers

Hospice Seminar Schedule

Seminars for Hospice providers will be held in January 2000. The primary topic will be the Hospice participation reporting requirements announced in the December Medicaid Special Bulletin to Hospice providers. The agenda will also include updates on overall Hospice policies and procedures, claims filing and adjustments, and Medicaid eligibility. **Due to limited seating, pre-registration is required. Providers not registered are welcome to attend when reserved space is adequate to accommodate**. Please select the most convenient site and return the completed registration form to EDS as soon as possible. Seminars begin at 10:00 a.m. and end at 1:00 p.m. Providers are encouraged to arrive by 9:45 a.m. to complete registration.

Note: Providers should bring the December 1999 Medicaid Special Bulletin on the new Hospice Participation Reporting Requirements and their Community Care Manuals with the October 1999 Revision as a reference source. Additional manuals will be available for purchase at the workshop for $20.00.

Directions are available on page 23 of this bulletin.

Thursday, January, 13, 2000
Catawba Valley Technical College
Highway 64-70
Hickory, NC
Auditorium

Wednesday, January 19, 2000
Martin Community College
Kehakee Park Road
Williamston, NC
Auditorium

Thursday, January 20, 2000
Four Points Sheraton
5032 Market Street
Wilmington, NC

Monday, January 24, 2000
WakeMed
MEI Conference Center
3000 New Bern Avenue
Raleigh, NC
Park at East Square Medical Plaza

(cut and return registration form only)

Hospice Provider Seminar Registration Form

(No Fee)

Provider Name _____ Provider Number _____

Address _____ Contact Person _____

City, Zip Code _____ County _____

Telephone Number _____ Date _____

_____ persons will attend the seminar at _____ on _____

(location) (date)

Return to: Provider Services
EDS
P.O. Box 300009
Raleigh, NC 27622

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

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Directions to the Hospice Seminars

The Registration form for the Hospice workshop is on page 21 of this bulletin.

HICKORY, NORTH CAROLINA

CATAWBA VALLEY TECHNICAL COLLEGE
Thursday, January, 13, 2000

Take I-40 to exit 125 and go approximately 1/2 mile to Highway 70. Head East on Highway 70 and College is approximately 1.5 miles on the right.

WILLIAMSTON, NORTH CAROLINA

MARTIN COMMUNITY COLLEGE
Wednesday, January 19, 2000

Highway 64 into Williamston. College is approximately 1-2 miles west of Williamston. The Auditorium is located in Building 2.

WILMINGTON, NORTH CAROLINA

FOUR POINTS SHERATON
Thursday, January 20, 2000

I-40 East into Wilmington to Highway 17 - just off of I-40. Turn left onto Market Street and the Four Points Sheraton is located on the left.

RALEIGH, NORTH CAROLINA

WAKEMED MEI CONFERENCE CENTER
Monday, January 24, 2000

Directions to the Parking Lot:

Take the I-440 Raleigh Beltline to New Bern Avenue, Exit 13A (New Bern Avenue, Downtown). Go toward WakeMed. Turn left at Sunnybrook road and park at the East Square Medical Plaza which is a short walk to the conference facility. Parking is not allowed in the parking lot in front of the Conference Center. Vehicles will be towed if not parked in the East Square Medical Plaza parking lot located at 23 Sunnybrook Road.

Directions to the Conference Center from Parking Lot:

Cross the street and ascend steps from sidewalk up to Wake County Health Department. Cross Health Department parking lot and ascend steps (with a blue handrail) to MEI Conference Center. Entrance doors at left.

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

Checkwrite Schedule

December 7, 1999	January 12, 2000	February 8, 2000
December 14, 1999	January 19, 2000	February 15, 2000
December 21, 1999	January 27, 2000	February 24, 2000
December 29, 1999		

Electronic Cut-Off Schedule

December 3, 1999	January 7, 2000	February 4, 2000
December 10, 1999	January 14, 2000	February 11, 2000
December 17, 1999	January 21, 2000	February 18, 2000
December 23, 1999		

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

Paul R. Perruzzi, Director
Division of Medical Assistance
Department of Health and Human Services

John W. Tsikerdanos
Executive Director
EDS

EDS

Bulk Rate
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