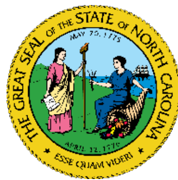


# NC Medicaid Bulletin
# August 2018

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*Providers are responsible for informing their billing agency of information in this bulletin.*
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## Attention: All Providers

# NPI Exemption List will cease on Aug. 31, 2018 for Clinical Pharmacist Practitioners (CPPs), Residents and Interns

As previously communicated in the July 2018 North Carolina Medicaid Special Bulletin, the NPI Exemption List will cease Aug. 31, 2018, for Clinical Pharmacist Practitioners (CPPs), Residents and Interns. CPPs will be able to enroll in Medicaid through NCTracks as an ordering, prescribing, referring (OPR) or rendering provider working under the direction or supervision of a licensed physician. CPPs can submit claims under the **taxonomy code 1835P0018X** effective July 29, 2018.

In accordance with the North Carolina State Plan, Section 4.19-B, Section 5, Page 1g, CPPs are reimbursed at the lower of usual and customary charges or the appropriate fee from the North Carolina Medicaid Clinical Pharmacist Practitioner Services Fee Schedule. The Fee Schedule is posted on the North Carolina Medicaid website prior to the effective date at https://dma.ncdhhs.gov/providers/fee-schedule-index.

Claims submitted prior to July 29, 2018, with a CPP's NPI and taxonomy as the billing provider will be denied with Explanation of Benefits (EOB) 01877- PROVIDER IS NOT AUTHORIZED TO ACT AS A BILLING PROVIDER.

Providers with questions regarding the Fee Schedule may contact Medicaid Provider Reimbursement.

**NC Medicaid Provider Reimbursement, 919-814-0060**

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## Attention: All Providers

# Clinical Coverage Policies

The following new or amended combined North Carolina Medicaid and NC Health Choice clinical coverage policies are available on Medicaid's website at http://dma.ncdhhs.gov/:

- 1D-2, Sexually Transmitted Disease Treatment Provided in Health Departments – 08/01/2018
- 1D-3, Tuberculosis Control and Treatment Provided in Health Departments – 08/01/2018

These policies supersede previously published policies and procedures.

**NC Medicaid Clinical Policy and Programs, 919-855-4260**

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## Attention: All Providers

# NCTracks Provider Training Available in August 2018

Registration is open for the August 2018 instructor-led provider training courses listed below. Slots are limited.

WebEx courses can be attended remotely from any location with a telephone, computer and internet connection. Onsite courses include hands-on training and are limited to 45 participants. They are offered in-person at the CSRA facility at 2610 Wycliff Road in Raleigh.

Following are details on the courses, including dates, times and how to enroll.

### Submitting Medical Prior Approvals (Onsite)

Tuesday, Aug. 14, 2018, 9:30 a.m.–Noon

This course shows authorized users how to electronically submit and inquire about prior approvals for different kinds of medical services.

After completing this course, authorized users will be able to:

- Submit Prior Approvals electronically
- Conduct electronic inquiries about Prior Approvals

### Submitting Institutional Prior Approvals (Onsite)

Thursday, Aug. 16, 2018, 9:30 a.m.–Noon

This course will cover submitting Prior Approval Requests, with a focus on Nursing Facilities, to help ensure compliance with Medicaid clinical coverage policy and medical necessity, inquiring about those requests to determine their status.

After completing this course, authorized users will be able to:

- Submit Prior Approvals
- Inquire about Prior Approvals

### New Office Administrator (WebEx)

Friday, Aug. 17, 2018, 9–11 a.m.

This course shows authorized users the process for changing the current Office Administrator (OA) to a new Office Administrator for an Individual Provider or Organization with a National Provider Identification (NPI) number or Atypical Provider.

At the completion of training, authorized users will be able to:

- Update the Office Administrator for an Individual Provider or Organization
- Upgrade existing Users to Managing Relationships

### Submitting Dental/Ortho Prior Approvals (WebEx)

Monday, Aug. 20, 2018, 9 a.m.–Noon

This course shows authorized users how to electronically submit and inquire about prior approval requests for dental and orthodontic procedures.

At the end of this training the user will be able to:

- Submit dental prior approvals requests
- Inquire about dental prior approval requests

### Submitting Dental/Ortho Claims (WebEx)

Monday, Aug. 20, 2018, 1–4 p.m.

This course will focus on how to submit a Dental and Orthodontic Claims.

At the end of training, as an authorized user, you will be able to manage the following:

- Create a Dental Claim via the NCTracks web portal
- Save a Draft Claim
- Use Claims Draft Search
- Submit a Dental Claim
- View results of a Claim submission

### Reverification Overview (Webex)

Tuesday, Aug. 28, 2018, 1–2:30 p.m.

This course serves as a refresher for the steps taken by the provider to complete the Re-Verification process through NCTracks.

At the end of training, you will be able to:

- Explain why provider Re-Verification is requested and what the process entails
- Complete the Re-Verification process in NCTracks
- Update Owners and Managing Relationships if necessary while completing the Re-Verification application process

### Training Enrollment Instructions

Providers can register for these courses in SkillPort, the NCTracks Learning Management System. Logon to the secure NCTracks Provider Portal and click Provider Training to access SkillPort. Open the folder labeled **Provider Computer-Based Training (CBT) and Instructor Led Training (ILT)**. The courses can be found in the sub-folders labeled **ILTs: Onsite** or **ILTs: Remote via WebEx**, depending on the format of the course.

Refer to the Provider Training page of the public Provider Portal for specific instructions on how to use SkillPort. The Provider Training page also includes a quick reference about downloading Java, which is required for the use of SkillPort.

**CSRA, 1-800-688-6696**

### Attention: All Providers

## Avoid Delays in the Processing of Provider Enrollment Applications

**Note:** This article was originally published in the February 2018 Medicaid Bulletin.

If a provider's enrollment application or Manage Change Request (MCR) does not contain errors, it will process more quickly. The NCTracks Enrollment Team identified commons errors that cause delays in processing applications and MCRs. Common errors include:

- **Supporting documentation not attached** – If supporting documentation is required, it must be uploaded and attached prior to submission (including license/certification/accreditation). For guidance on how to attach supporting documentation, refer to section 3.30.1 of Participant User Guide PRV111 Provider Web Portal Applications on the secure NCTracks Provider Portal.

- **Name on application** – Name on application should match National Plan and Provider Enumeration System (NPPES) National Provider Identifier (NPI).

- **Incomplete Exclusion Sanction information** – The Exclusion Sanction questions must be answered. On question K, **all** convictions (misdemeanors and felonies) must be disclosed regardless of how old the conviction is. (The only exception to this requirement is minor traffic offenses, such as a speeding ticket, expired registration, etc.) The questions must be answered for the enrolling provider and the practice's owners and agents in accordance with 42 CFR 455.100; 101; 104; 106 and 42 CFR 1002.3.

  If the answer to any of the Exclusion Sanction questions is "yes," then documentation regarding the disposition of the action must be attached to the application. If a provider submits a written attestation, it must be on company letterhead and signed and dated by the person to whom the attestation applies. For a complete list of questions, go to the Provider User Guides and Training page of the NCTracks Provider Portal and open either the *How to Enroll in North Carolina Medicaid as an Individual Practitioner* or *How to Enroll in North Carolina Medicaid as an Organization* user guides, both of which are located in the **Enrollment and Re-Verification** section. These documents contain the list of sanction questions.

- **Failure to upload Electronic Fingerprinting Submission Release of Information Form (Evidence)** – The form must be signed and dated by each person required to submit fingerprints. It must also be signed and dated by the law enforcement agency collecting the fingerprints. Providers must upload the Release of Information Form into NCTracks by the deadline on the notification letter.

- **Fingerprinting Card should not be mailed to address on the evidence form** – If the applicant opts to do a Fingerprint Card, it must be mailed to the State Bureau of Investigation (SBI) for processing at NCSBI/Applicant Unit, 3320 Garner Road, Raleigh, NC 27626.

- **Choosing the incorrect taxonomy code** – The taxonomy code selected must accurately reflect the type of provider. The provider must meet the enrollment qualifications for the taxonomy code selected and possess the required licensure and/or credentials. Providers who are uncertain which taxonomy code to select should consult the *Provider Permission Matrix* (and instruction sheet) on the Provider Enrollment page of the NCTracks Provider Portal. For additional guidance, refer to *How to View and Update Taxonomy on the Provider Profile in NCTracks* on the Provider User Guides and Training page of the NCTracks provider portal.

- **NCID misuse** – This continues to be an issue on applications and may result in adverse action on the provider's application and record. Refer to the article *Using NCIDs Properly in NCTracks* in the December 2016 Medicaid Bulletin.

- **Inaccurate entry of name, Social Security number (SSN) and date of birth (DOB) on applications** – This continues to be an issue that impacts the integrity of the application and Participation Agreement, and may result in adverse action on the application.

For assistance with NCID and PIN, refer to the Getting Started web page on NCTracks and the NCTracks NCID Fact Sheet.

Providers with questions can contact the CSRA Call Center at 1-800-688-6696 (phone), 1-855-710-1965 (fax) or NCTracksProvider@nctracks.com.

**CSRA, 1-800-688-6696**

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## Attention: All Providers

# Update to Acute Inpatient Hospital Services Clinical Policy 2A-1

Medicaid has been made aware of reimbursement delays when claims for medical services are billed for inpatient services with a psychiatric diagnosis as the primary diagnosis.

The following clarifications were added to the policy in Attachment B, Behavioral Health Claims:

- Submit claims to the Prepaid Inpatient Health Plan (PIHP) for reimbursement when a Medicaid beneficiary is receiving psychiatric care in a general hospital, with a psychiatric Diagnosis Related Group (DRG), while waiting for an inpatient psychiatric bed.

- Refer to clinical coverage policy 8B, *Inpatient Behavioral Health Services*, at https://dma.ncdhhs.gov for behavioral health coverage criteria and billing information for inpatient services in an inpatient psychiatric facility, or in a psychiatric unit of a general hospital for Medicaid beneficiaries.

Additionally, the following clarifications were added:

- In Attachment B, a revision was made to the list of hospitals exempt from the Present on Admission/Hospital-Acquired Conditions indicator to align with Centers for Medicare & Medicaid Services.

- In Attachment C, a requirement was added to include a hospital's license number (that is assigned by the Department of Health and Human Services' Division of Health Service Regulation) on a Utilization Review Plan.

**CSRA, 1-800-688-6696**

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### Attention: All Providers

## Provider Risk Level Adjustment

**Note:** This article was originally published in the May 2018 Medicaid Bulletin.

Federal regulation 42 CFR 455.450 requires a state Medicaid agency to screen all initial provider applications based on a categorical risk level of "limited," "moderate," or "high." This includes applications for new practice locations and any applications received in response to a re-enrollment or re-validation of enrollment request.

Providers are categorized by risk level as outlined in NC General Statute Sec. 108-C3, as amended by Session Law 2018-5 SB 99.

**Note:** The NCTracks Provider Permission Matrix provides a full list of provider types and their assigned risk levels for both enrollment and revalidation.

Further, 42 CFR 455.450(e) mandates that state Medicaid agencies adjust the categorical risk level of providers. Per NC General Statute Sec. 108-C3(g) and amended by Session Law 2018-5 SB 99, the N.C. Department of Health and Human Services (the "Department") must adjust the categorical risk level to "high" for providers who:

- Received a payment suspension based upon a credible allegation of fraud in accordance with 42 CFR 455.23 within the previous 12-month period. The Department shall return the provider to its original risk category no later than 12 months after the cessation of the payment suspension.

- Were excluded, or whose owners, operators, or managing employees were excluded, by the U.S. Department of Health and Human Services Office of Inspector General, the Medicare program, or another state's Medicaid or Children's Health Insurance Program within the previous 10 years.

- Incurred a Medicaid or Health Choice final overpayment, assessment, or fine from the Department more than 20 percent of the provider's payments received from Medicaid and Health Choice in the previous 12-month period. The Department shall return the provider to its original risk category not later than 12 months after the completion of the provider's repayment of the final overpayment, assessment, or fine. (NC General Statute 108-C3(g) (11))

- Were convicted of a disqualifying offense pursuant to G.S. 108C-4, including by owners, operators, or managing employees, but were granted an exemption by the Department within the previous 10 years.

In these instances, the provider will be notified by the Department and the new risk level will apply to processing enrollment-related transactions. This may include payment of applicable application fees, submission of fingerprints and onsite visits.

Providers with questions can contact the CSRA Call Center at 1-800-688-6696 (phone), 1-855-710-1965 (fax) or NCTracksProvider@nctracks.com.

**NC Medicaid Provider Services, 919-855-4050**

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## Attention: All Providers

# Submit Fingerprinting Criminal Background Check and Related Information by Deadline to Prevent Termination

**Note:** This article was originally published in the June 2018 Medicaid Bulletin with a clarification that only high-risk providers must obtain fingerprints.

Fingerprinting is only required for high-risk providers as identified by 42 CFR 424.518(c), NC General Statute 108C-3g and Session Law 2018-5 SB99. Refer to the *Provider Permission Matrix* under Quick Links on the Provider Enrollment page of NCTracks for more details. High-risk providers will receive a notification through their NCTracks Message Center inbox.

High-risk providers must submit a Fingerprinting Criminal Background Check (FCBC) application **within 30 days of receiving the request notification** to avoid being terminated for cause. After submission of the FCBC application, providers will receive a letter with instructions to complete the fingerprinting process and the Electronic Fingerprint Submission Release of Information (EFSRI) form. If the EFSRI form is not uploaded to the NCTracks provider record **within 30 days**, the provider will be terminated for cause.

More information on the fingerprinting application process, including additional resources, frequently asked questions and locations for fingerprinting services, can be found in the NCTracks Fingerprinting Application Required Job Aid.

**NC Medicaid Provider Services, 919-855-4050**

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## Attention: All Providers

# Re-credentialing and Ongoing Verification Updates

**Note:** This article was originally published in the February 2018 Medicaid Bulletin.

### List of Providers Due for Re-credentialing

A list of providers scheduled for re-credentialing in 2018 is available on the Provider Enrollment Page of the North Carolina Medicaid website under the "Re-credentialing" header. Providers can use this resource to determine their re-credentialing/re-validation due date and which month to begin the re-credentialing process. Organizations and systems with multiple providers may download this list, which includes National Provider Identifier (NPI) numbers and provider names, to compare with their provider list.

**Note:** The terms re-credentialing, re-verification and re-validation are synonymous.

### Changes to Re-credentialing Process

1. Beginning April 29, 2018, the re-credentialing notification and suspension was modified to the following:

   - First notification is sent 70 days prior to the provider re-credentialing due date.
   - If re-credentialing is not submitted, reminders are sent at 50 days, 20 days and 5 days prior to the provider re-credentialing due date.
   - Providers will be suspended if the re-credentialing application is not submitted by their re-credentialing due date.
   - The provider will be terminated from the North Carolina Medicaid and NC Health Choice programs following 50 days of suspension.

2. Re-credentialing is not optional. It is crucial that all providers who receive a notice promptly respond and begin the process.

3. Providers are required to pay a $100 application fee for re-credentialing.

4. The previous rules to extend the re-credentialing due date if a Manage Change Request (MCR) Application is "In Review" has been removed. Therefore, if a change

is required via an MCR, the MCR process must be completed before the re-credentialing due date.

5. The Re-credentialing Application on the NCTracks Provider Portal was modified to display the existing owners and managing employees and allow the provider to edit, end-date or add to the re-credentialing application.

**Note:** Providers must thoroughly review their electronic record in NCTracks to ensure all information is accurate and up-to-date and take any actions necessary for corrections and updates.

If terminated, the provider must submit a re-enrollment application to be reinstated. Re-credentialing does not apply to time-limited enrolled providers, such as out-of-state (OOS) lite providers. OOS providers who enroll using the OOS-lite application must complete the enrollment process every 365 days. OOS providers who are fully enrolled must re-credential every five years.

## Changes to Ongoing Verification Process

Providers must also update their expiring licenses, certifications and accreditations. The system currently suspends and terminates providers who fail to respond within the specified time limits.

With system modifications, the notification, suspension and termination timeline for updating expiring licenses, certification and accreditations will be modified to the following:

1. First notification will be sent 60 days prior to expiration.
2. If the expired item has not been updated, a reminder will be sent on day 30 and day 14, and the final reminder seven days prior to expiration.
3. The provider will be suspended if the expired item has not been updated by the due date. The suspension will remain for 60 days and can be removed at any time if the expired item is updated.
4. The provider's taxonomy code(s) in which the expired item is required will be terminated if the item has not been updated by day 61 after suspension.

Providers with questions about the re-credentialing process can contact the NCTracks Call Center at 1-800-688-6696 (phone), 919-710-1965 (fax) or NCTracksprovider@nctracks.com (email).

**NC Medicaid Provider Services, 919-855-4050**

### Attention: Adult Care Homes and Nursing Facilities

## Pre-Admission Screening and Resident Review (PASRR) Program Update

**Note:** This article was originally published in the June 2018 Medicaid Bulletin.

Beginning Sept.1, 2018, adult care home and nursing home Pre-Admission Screening and Resident Review (PASRR) submissions through Provider Link will **no longer be accepted.** PASRR submissions will be accepted only via NC Medicaid Uniform Screening Tool (NC MUST).

Identify members of your staff who will be submitting PASRR information to the NC MUST application and arrange for them to acquire a North Carolina Identity Management Service NCID.

Once NCIDs are in place, contact DXC Technology at 1-855-883-8018 to secure access to the NC MUST application.

Visit the NC Department of Information Technology NCID Frequently Asked Questions web page for more information about NCID.

Visit the NC MUST website for more information about NC MUST.

**NC Medicaid Long-Term Services and Supports, 919-855-4364**

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### Attention: Physicians, Physician Assistants and Nurse Practitioners

## Burosumab-twza injection, for subcutaneous use (Crysvita®) HCPCS code J3590: Billing Guidelines

Effective with date of service May 1, 2018, the Medicaid and NC Health Choice (NCHC) programs cover burosumab-twza injection, for subcutaneous use (Crysvita) for use in the Physician's Drug Program when billed with HCPCS code J3590 - Unclassified biologics. Crysvita is available as a subcutaneous injection as 10 mg/mL, 20 mg/mL or 30 mg/mL in a single-dose vial.

Crysvita is indicated for the treatment of X-linked hypophosphatemia (XLH) in adult and pediatric patients 1 year of age and older.

The recommended dose for Crysvita is:

- Pediatric XLH: Starting dose regimen is 0.8 mg/kg of body weight rounded to the nearest 10 mg, administered every two weeks. The minimum starting dose is 10 mg up to a maximum dose of 90 mg. Dose may be increased up to approximately

2 mg/kg (maximum 90 mg), administered every two weeks to achieve normal serum phosphorus.

- Adult XLH: Dose regimen is 1 mg/kg body weight rounded to the nearest 10 mg up to a maximum dose of 90 mg administered every four weeks.

See full prescribing information for further detail.

## For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis code required for billing is E83.31 - Familial hypophosphatemia
- Providers must bill with HCPCS code J3590 - Unclassified biologics
- One Medicaid unit of coverage is 10 mg
- The maximum reimbursement rate per unit is $3,672.00
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs are 69794-0102-01, 69794-0203-01 and 69794-0304-01
- The NDC units should be reported as "UN1."
- For additional information, refer to the January 2012 Special Bulletin *National Drug Code Implementation Update.*
- For additional information regarding NDC claim requirements related to the PDP, refer to the PDP Clinical Coverage Policy No. 1B, Attachment A, H.7 on the Medicaid website.
- Providers shall bill their usual and customary charge for non-340-B drugs.
- PDP reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340-B participating providers who have registered with the Office of Pharmacy Affairs (OPA). Providers billing for 340-B drugs shall bill the cost that is reflective of their acquisition cost. Providers shall indicate that a drug was purchased under a 340-B purchasing agreement by appending the "UD" modifier on the drug detail.
- The fee schedule for the Physician's Drug Program is available on the Medicaid PDP web page.

**CSRA, 1-800-688-6696**