



June 2013 Medicaid Bulletin

In This IssuePage

All Providers:

NCTracks: The New Multi-payer System for N.C. DHHS coming on July 1, 2013....	2
2013 NCTracks Provider Checkwrite Schedule Available.....	3
Provider Affiliation is Needed for NCTracks.....	5
Updated EOB Code Crosswalk to HIPAA Standard Codes.....	6
Clinical Coverage Policies.....	6
Payment Error Rate Measurement (PERM) In North Carolina.....	7
Termination of Inactive N.C. Medicaid and N.C. Health Choice Provider Numbers.....	8
NC Medicaid EHR Incentive Program: June 2013 Update.....	9
Maintaining the Security and Accessibility of Records after a Provider Agency Closes.....	11
Receiving Email Alerts through NCTracks.....	13
17 Alpha Hydroxyprogesterone Caproate (17P), Injection from Bulk Powder: Billing Guideline Update Regarding Rebate Labelers.....	13
NCFast Implementation.....	14

Behavioral Health Providers:

Enrollment in N.C. Medicaid and N.C. Health Choice.....	17
---	----

Community Care of N.C./Carolina Access

Enrolling Beneficiaries with a CCNC/CA Medical Home at the Provider's Office.....	15
The Process for Referring a CCNC/CA Beneficiary to Another Provider.....	16

In This IssuePage

Federally Qualified Health Centers/ Rural Health Centers (FQHC/RHC) Providers

FQHC/RHC Clinic Providers Rebilling T1015 modifiers HI or SC.....	17
---	----

ICF/IDD Providers:

Prior Approval for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) for ages 0-3.....	18
--	----

Local Management Entities-Managed Care Organizations (LME-MCO):

Enrollment in N.C. Medicaid and N.C. Health Choice.....	17
Prior Approval for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) for ages 0-3.....	18

N.C. Health Choice Providers:

Receiving Email Alerts through NCTracks.....	13
--	----

N.C. Innovations:

Enrollment in N.C. Medicaid and N.C. Health Choice.....	17
---	----

Personal Care Service Providers:

Personal Care Services (PCS) Program Highlights.....	19
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Attention: All Providers**NCTracks: The New Multi-payer System for N.C. DHHS Coming on July 1, 2013**

Note to Providers: This article was originally published in March 2013.

NCTracks is a multi-payer system that will consolidate several claims processing platforms into a single solution for multiple divisions within the N.C. Department of Health and Human Services (DHHS), including the Division of Medical Assistance, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, the Division of Public Health, and the Office of Rural Health and Community Care.

The new NCTracks system will go live on July 1, 2013. In advance of that date, there are a number of things that providers can do to prepare for the transition, including taking advantage of upcoming training opportunities.

For more information, visit www.ncmmis.ncdhhs.gov/communication.asp and sign up to receive the *NCTracks Connections* newsletter. Also, see the *April 2013 Special Bulletin - Cutoff Dates for Transition from Legacy Claims Processing and Payment Systems to NCTracks* (www.ncdhhs.gov/dma/bulletin/pdfbulletin/0413_Special_Bulletin_NCTracks.pdf).

NCTracks Communications Team

N.C. Office of MMIS Services (OMMISS), 919-647-8300

Attention: All Providers**2013 NCTracks Provider Checkwrite Schedule Available**

NCTracks will go live July 1, replacing the 35-year-old N.C. Medicaid Management Information System (MMIS) and other N.C. Department of Health and Human Services (DHHS) systems that process and pay claims for mental health, public health and rural health services.

The first NCTracks checkwrite will be July 9, but will apply only to pharmacy point-of-sale (POS) providers. All other providers will receive their first claims payments through NCTracks the following week with a checkwrite on July 17 and electronic funds transfer (EFT) on July 18th (see chart on following page).

The last checkwrite for N.C. Medicaid and N.C. Health Choice (NCHC) providers under the Legacy MMIS is June 27 with EFT on June 28. The cutoff date for claims submission in that checkwrite cycle is June 20.

Although NCTracks will pay claims on a weekly cycle, DHHS and its fiscal agent, CSC, determined that a first checkwrite for all providers could not be accomplished during the first week of operations. Pharmacy POS claims presented a special case involving the real-time nature of processing and the need to avoid blackouts. NCTracks will process the POS claims backlogged since June 20 plus new claims submitted by July 5 for a July 9 checkwrite and EFT on July 10.

Valid claims submitted by midnight on a Friday (midnight Thursday for mental health, public health and rural health claims) will be processed for a checkwrite the following Tuesday, and funds transferred to bank accounts on Wednesday, except in cases of a holiday. This allows 50 checkwrites annually, with anticipated exceptions being the last week of June (end of the fiscal year) and the week of Christmas (Dec. 23-27). **NCTracks has scheduled a checkwrite the week of Thanksgiving (Nov. 25-29).**

The NCTracks checkwrite schedule for July-December, 2013 is below. A schedule for 2014 will be available in the fall.

NOTE: Any claim left pending by a provider during the last checkwrite cycle of Legacy MMIS systems will be denied, and those claims must be resubmitted in NCTracks. For additional information, refer to the April 23, 2013 [Special Bulletin](#) outlining cutoff dates and other transition information.

For more information about NCTracks, including a checklist of required actions providers must take prior to go-live on July 1, 2013, visit www.ncmmis.ncdhhs.gov.

CSC, 866-844-1113

NCTracks Checkwrite Schedule, July – December 2013

Cutoff Date	Checkwrite Date	EFT Effective Date
7/5/2013 *	7/9/2013	7/10/2013
7/12/2013	7/16/2013	7/17/2013
7/19/2013	7/23/2013	7/24/2013
7/26/2013	7/30/2013	7/31/2013
8/2/2013	8/6/2013	8/7/2013
8/9/2013	8/13/2013	8/14/2013
8/16/2013	8/20/2013	8/21/2013
8/23/2013	8/27/2013	8/28/2013
8/30/2013	9/4/2013	9/5/2013
9/6/2013	9/10/2013	9/11/2013
9/13/2013	9/17/2013	9/18/2013
9/20/2013	9/24/2013	9/25/2013
9/27/2013	10/2/2013	10/3/2013
10/4/2013	10/8/2013	10/9/2013
10/11/2013	10/15/2013	10/16/2013
10/18/2013	10/22/2013	10/23/2013
10/25/2013	10/29/2013	10/30/2013
11/1/2013	11/5/2013	11/6/2013
11/8/2013	11/13/2013	11/14/2013
11/15/2013	11/19/2013	11/20/2013
11/22/2013	11/26/2013	11/27/2013
11/29/2013	12/3/2013	12/4/2013
12/6/2013	12/10/2013	12/11/2013
12/13/2013	12/17/2013	12/18/2013
12/27/2013	12/31/2013	1/2/2014

* The first checkwrite date applies to pharmacy point of sale providers only.

Attention: All Providers**P**rovider Affiliation Information is Needed for NCTracks

For NCTracks, the multi-payer replacement Medicaid Management Information System (MMIS) that goes live on July 1, 2013, there is information that needs to be obtained and/or confirmed from participating healthcare providers. Among this information is provider affiliation.

Affiliation information is gathered as part of the new provider enrollment, re-enrollment, and provider re-credentialing processes. Groups that have already re-credentialed with the Enrollment, Verification, and Credentialing (EVC) system should have designated their affiliated rendering/servicing providers, and no further action is required.

Provider affiliation determines on behalf of which individual providers a group can bill and receive payment. Missing and or/inaccurate provider affiliation information in the current and new NCTracks system can result in claims processing delays, misdirected payments, or claims denials. Therefore, it is important that the information is captured or updated as soon as possible. Providers that need to update their provider affiliations can do so on or after July 1 using the NCTracks Provider Portal at www.nctracks.nc.gov.

After go-live, providers will have until July 30, 2013 to complete the provider affiliation process. Failure to complete the affiliation process will result in claim denials.

If you have questions regarding provider affiliation or the provider recredentialing process, call the EVC Help Desk at 866-844-1113.

**Provider Services
DMA, 919-844-4050**

Attention: All Providers**Updated EOB Code Crosswalk to HIPAA Standard Codes**

The list of standard national codes used on the Electronic Remittance Advice (ERA) has been cross-walked to Medicaid Explanation of Benefit (EOB) codes as an informational aid to research adjudicated claims listed on the Remittance and Status Report (RA).

Two lists are available on the N.C. Division of Medical Assistance (DMA) Website at www.ncdhhs.gov/dma/hipaa/EOBcrosswalk.htm.

The first list provides a cross-walk for RAs produced **prior to** July 1, 2013, in the Legacy Medicaid Management Information System (MMIS+). The Legacy MMIS crosswalk has been further subdivided based on claims types – Institutional, Professional, Dental, and Pharmacy.

The second list provides a cross-walk for Remittance and Status Reports (RAs) produced **after** July 1, 2013 in the NCTracks system.

Note: As of July 1, CSC will obtain the toll-free number previously used by HP Enterprise Services.

HP Enterprise Services (before June 28) and CSC (after July 1): 1-800-688-6696

Attention: All Providers**Clinical Coverage Policies**

The following new or amended combined N.C. Medicaid and N.C. Health Choice clinical coverage policies are available on the Division of Medical Assistance (DMA) Website at www.ncdhhs.gov/dma/mp/:

- *1L-2, Moderate (Conscious) Sedation, AKA Procedural Sedation and Analgesia (PSA) (5/1/13)*
- *8A, Enhanced Mental Health and Substance Abuse Services (5/1/13)*
- *8E, Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities (5/1/13)*
- *Enhanced Mental Health and Substance Abuse Services (Date of Termination 4/30/2013)*

These policies supersede previously published policies and procedures.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers**P**ayment Error Rate Measurement (PERM) in North Carolina

The last in a series of 2013 Payment Error Rate Measurement (PERM) Provider Education Webinar/conference calls will be on **Tuesday, July 2, 2013**, 3:00 - 4:00 p.m. EST

The Webinar, titled “Provider Education Calls,” will allow participants to learn more about the PERM process and provider responsibility. It can be accessed at the following Website: www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/PERM/Provider_Education_Calls.html.

PERM is an audit program that was developed and implemented by the Centers for Medicare & Medicaid Services (CMS) to comply with the Improper Payments Information Act (IPIA) of 2002. PERM examines eligibility determinations and claims payment made to Medicaid and Children’s Health Insurance Programs (CHIP) for accuracy, and to ensure states only pay for appropriate claims. In North Carolina, CHIP is called N.C. Health Choice (NCHC). North Carolina’s next PERM cycle is federal fiscal year 2013 (October 1, 2012 – September 30, 2013).

A+ Government Solutions is the Review Contractor for the federal fiscal year 2013 PERM cycle and will start requesting documentation from selected providers in June 2013.

Throughout the cycle, A+ Government Solutions will be responsible for collecting Medicaid and NCHC policies; conducting data processing reviews; requesting medical records from providers; conducting medical reviews; and hosting the State Medicaid Error Rate Findings (SMERF) Website. States can use the Website to track medical records requests, view review findings, request different resolutions or appeals on identified errors, and more.

Providers can find more information at the following sites:

- CMS Website: www.cms.gov/PERM/.
- CMS PERM “Providers” Web page: www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/PERM/Providers.html.
- Central PERM email for providers: PERMProviders@cms.hhs.gov.

Program Integrity
DMA, 919-814-0000

Attention: All Providers**T**ermination of Inactive N.C. Medicaid and N.C. Health Choice Provider Numbers

Note to Providers: This article originally ran in September 2011.

This is a reminder notice to all providers. The N.C. Division of Medical Assistance (DMA) updated policy terminates inactive providers to reduce the risk of fraudulent and unscrupulous claims, as announced in the [July 2011 Medicaid Bulletin](#).

N.C. Medicaid and N.C. Health Choice (NCHC) provider numbers that do not reflect any billing activity within the previous 12 months will be terminated.

If providers **cannot** attest that they have provided services to N.C. Medicaid or NCHC recipients in the previous 12-month period, their provider numbers will be terminated. A new enrollment application, agreement to re-enroll and appropriate fees must be submitted to CSC for any provider who was terminated. **As a result, a lapse in provider eligibility may occur.**

Terminated providers who wish to re-enroll can reach CSC by phone at 1-866-844-1113 or by email at NCTracksProvider@nctracks.com.

Termination activity occurs on a quarterly basis with provider notices being mailed out on April 1, July 1, October 1, and January 1 of each year with termination dates of May 1, August 1, November 1, and February 1, respectively. These notices are sent to the current mailing address listed in the provider's file. **Providers are reminded to update their contact and ownership information in a timely manner by submitting a Medicaid Provider Change form found at www.nctracks.nc.gov/provider/400_Ops_EPF_ChangeForm.pdf.**

**Provider Services
DMA, 919-855-4050**

Attention: All Providers**NC Medicaid EHR Incentive Program – June 2013 Update****Change in NC-MIPS Help Desk**

Beginning June 1, 2013, for all correspondence with the N.C. Medicaid EHR Incentive Program – including program and attestation inquiries, submitting signed attestations and supporting documentation – providers should use the phone number, email address, and U.S. mailing address listed below:

Email: NCMedicaid.HIT@dhhs.nc.gov
Phone Number: 919-814-0180
Mailing Address: NC Medicaid EHR Incentive Program
2501 Mail Service Center
Raleigh, NC 27699-2501

Note: Starting June 1, 2013, the N.C. Medicaid EHR Incentive Program will no longer receive documentation via fax.

Important Meaningful Use (MU) Medicare Payment Adjustment and Public Health Measure Reporting Updates

The Centers for Medicare & Medicaid Services (CMS) has given states new guidance on the 2014 Stage 2 Meaningful Use (MU) Final Rule, located at www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-21050.pdf. These updates will impact all providers who are participating or plan to participate in the NC Medicaid EHR Incentive Program:

- **Payment Adjustments/Penalties** – Providers who attest to MU in Program Year 2012 but who **do not attest** to MU in Program Year 2013 **WILL** be subject to 2015 Medicare payment adjustments **UNLESS** the provider attests successfully to (and is paid for) MU within the first nine months of 2014 [June 30, 2014 for Eligible Hospitals (EH) and September 30, 2014 for Eligible Professionals (EP)]; and,
- **Menu Exclusions** – Starting in Program Year 2014, for both Stage 1 and 2 MU, meeting the exclusion criteria **will no longer count** as reporting an MU objective from the MU menu measures.

Starting in Program Year 2014, an EP must meet the measure criteria for five objectives in Stage 1 or three menu objectives in Stage 2, **OR** the EP will need to report on all 10 MU menu measures through a combination of meeting the exclusion and meeting the measure.

In other words, beginning in Program Year 2014, to meet the requirements for the Stage 1 MU menu measures, an EP will need to:

- Report on at least **one** public health measure (without taking the exclusion); **OR**,
- Attest to exclusions for **BOTH** public health measures plus:
 - Attest to five total MU menu measures, not counting exclusions; **OR**,
 - Attest to all 10 MU menu measures, counting exclusions.

CMS has issued a Frequently Asked Questions (FAQ) document regarding the new requirements for meeting the MU menu measures at <https://questions.cms.gov/faq.php?faqId=2903>.

For more information about these updates, visit the CMS EHR Incentive Program's Website at www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/ehrincentiveprograms/.

e-CQMs Reported to the State in 2014

Per the Stage 2 Final Rule issued by CMS, all participants in the NC Medicaid EHR Incentive Program who attests to Stage 2 MU will need to submit their Clinical Quality Measures (CQMs) electronically to the state. The state has designated the NC Health Information Exchange (NC HIE) as the vehicle for the state to receive the electronic submission of CQMs.

With support from CMS, N.C. Medicaid will subsidize the HIE cost of connecting those providers who agree to become full participants with the NC HIE. More information will be forthcoming. In the meantime, all questions should be directed to the NC HIE Project Manager, Chris Scarboro, by phone at 919-745-2379 or by email at cscarboro@n3cn.org.

**N.C. Medicaid Health Information Technology (HIT)
DMA, 919-855-4200**

Attention: All Providers**Maintaining the Security and Accessibility of Records after a Provider Agency Closes**

Note to Providers: This article was originally published in February 2013.

All N.C. Medicaid and N.C. Health Choice (NCHC) providers are responsible for maintaining custody of the records and documentation to support service provision and reimbursement of services by the N.C. Division of Medical Assistance (DMA) for at least six years. See [10A NCAC 22F.0107](#) and Section 7 of the N.C. Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement. The Agreement is part of the enrollment application and may be accessed from the [NCTracks Provider Enrollment Web page](#).

Mental Health, Developmental Disabilities, and Substance Abuse (MH/DD/SA) services records are subject to additional retention and management requirements, including those mandated by [S.L. 2009-451](#) (Section 10.68A(a)(5)(j) and (k) for Community Support and Other MH/DD/SA Services and Section 10.68A(a)(7)(h) and (i) for MH Residential Services). MH/DD/SA providers should refer to guidance from Implementation Updates No. 79, No. 72, No. 62, No. 60, and No. 58.

Documentation that is required to be maintained by all providers includes clinical service records, billing and reimbursement records, and records to support staff qualifications and credentials (personnel records).

Clinical service records include, but are not limited to:

- Diagnostic testing results (X-rays, lab tests, psychological assessments, etc.)
- Records from other providers used in the development of care plans
- Nurses' notes or progress notes
- Service orders that authorize treatment
- Treatment service or treatment plans
- Billing and reimbursement records should include beneficiary demographic information.

Providers are **required** to arrange for continued safeguarding of the above-described records in accordance with the record retention guidelines. Failure to protect consumer or staff privacy by safeguarding records and ensuring the confidentiality of protected health information is a violation of the [Health Insurance Portability and Accountability Act \(HIPAA\)](#) and [NCGS § 108A-80](#) and may be a violation of the [North Carolina Identity Theft Protection Act](#). Violations will be reported to the Consumer Protection Section of the N.C. Attorney General's Office, the Medicaid Investigations Unit of the N.C. Attorney General's Office and/or the U.S. DHHS Office of Civil Rights, as applicable.

The following sanctions, penalties, and fees may be imposed for HIPAA violations:

- Mandatory investigation and penalties for noncompliance due to willful neglect
- Willful neglect: \$50,000 up to \$1.5 million (\$10,000 up to \$250,000 if corrected within 30 days)
- Enforcement by the State Attorney General along with provisions to obtain further damages on behalf of the residents of the State in monetary penalties plus attorney fees and costs as provided for by the Health Information Technology for Economic and Clinical Health (HITECH) Act.

A provider's obligation to maintain the above-described records is independent from ongoing participation in the N.C. Medicaid or NCHC programs and extends beyond the expiration or termination of the Agreement or contract. See [10A NCAC 22F.0107](#) and Section 8 of the DHHS Provider Administrative Participation Agreement. Provider records may be subject to post-payment audits or investigations after an agency closes. Failure to retain adequate and accessible documentation of services provided may result in recoupment of payments made for those services, termination or suspension of the provider from participation with the N.C. Medicaid or NCHC programs and/or referral to the US DHHS Office of Inspector General for exclusion or suspension from federal and state health care programs.

If another provider takes over the functions of a closing entity, maintenance of the closing entity's records for the applicable beneficiaries may be transferred to the new provider, if the new provider agrees to accept custody of such records in writing and a copy of this agreement is provided to DMA upon request. When custody of records is not transferred, the closing providers should send copies of transitional documentation to the providers who will be serving the beneficiary for continuity of care. Consumer authorization should be obtained as necessary. Copies of records may be provided to the beneficiary directly for coordination of care.

DMA must be notified of changes in provider enrollment status, including changes in ownership and voluntary withdrawal from participation in the N.C. Medicaid and NCHC programs, as indicated on the [NCTracks Reporting a Provider Change Web page](#). Providers who anticipate closure are required to develop and implement a records retention and disposition plan. The plan must indicate how the records will be stored, the name of the designated records custodian, where the records will be located, and the process to fulfill requests for records. Information must be included on how beneficiaries will be informed of the contact information and the process to request their records. The plan should also designate retention periods and a records destruction process to take place when the retention period has been fulfilled and there is no outstanding litigation, claim, audit or other official action. The plan should be on file with the records custodian.

Program Integrity
DMA, 919-647-8000

Attention: All Providers and N.C. Health Choice Providers**R**eceiving Email Alerts Through NCTracks

On July 1, the responsibility for sending email alerts about the N.C. Medicaid and N.C. Health Choice programs will move from HP Enterprise Services to CSC. Such email alerts are sent to providers when there is important information to share between publications of the general Medicaid Provider Bulletins.

Those who currently receive email alerts will continue to receive them from the NCTracks system. Details about how to become a new subscriber after July 1 will be published in the *July 2013 Medicaid Bulletin*.

Email addresses will never be shared, sold or used for any purpose other than Medicaid and NCHC email alerts.

Note: As of July 1, CSC will obtain the toll-free number previously used by HP Enterprise Services.

CSC, 1-800-688-6696

Attention: All Providers**17** Alpha Hydroxyprogesterone Caproate (17P), Injection from Bulk Powder: Billing Guideline Update Regarding Rebate Labelers

The N.C. Medicaid Physician's Drug Program began covering 17P effective with date of service April 1, 2007, for use in pregnant women with a history of a preterm delivery before 37 weeks' gestation but no preterm labor in the current pregnancy.

The compounded 17P must be billed with HCPCS procedure code J3490 (unclassified drugs). Providers must also use rebatable 11-digit National Drug Codes (NDCs) and appropriate NDC units.

Effective with date of service May 9, 2013, labeler 51552 is no longer eligible for rebates. Therefore, any 17P claim details billed with an NDC from labeler 51552 will be denied. NDCs by labeler 38779 (Medisca) are still covered by N.C. Medicaid.

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

Attention: All Providers**NCFAST Implementation**

NCFAST (North Carolina Families Accessing Services through Technology) is the new computerized eligibility and case management system for economic benefit programs in North Carolina – including N.C. Medicaid, N.C. Health Choice (NCHC), Work First cash assistance, Special Assistance, and Food and Nutrition Services.

N.C. Medicaid and NCHC applications will be taken in NCFAST for individuals who have not previously received assistance. In **late June 2013**, rollout of the new system will begin in three pilot counties: Chatham, Johnston and Orange. All 100 counties are expected to take N.C. Medicaid and NCHC applications through NCFAST by **October 1, 2013**.

Beneficiaries who had eligibility entered into the Eligibility Information System (EIS) prior to the NCFAST rollout will continue to have their information housed in EIS until full conversion. As with applications, conversion of ongoing cases into NCFAST will occur through a phased approach and may continue into the first few months of 2014.

N.C. Medicaid and NCHC eligibility information from both systems – EIS and NCFAST – will be transmitted to Medicaid Management Information Systems (MMIS) to insure current eligibility is recorded for all beneficiaries.

More specific information may be coming in subsequent bulletins.

Medicaid Eligibility
DMA, 919-855-4000

Attention: CCNC/CA Primary Care Providers**E**nrolling Beneficiaries with a CCNC/CA Medical Home at the Provider's Office

Note to Providers: This article was originally published in May 2013

In order to maximize enrollment, providers may enroll beneficiaries at the practice by following these procedures:

- Inform beneficiaries of their right to choose any Community Care of North Carolina/Carolina ACCESS (CCNC/CA) primary care provider who is accepting new beneficiaries, and their right to change primary care providers at any time pursuant to processing deadlines;
- Enrollment is optional for some beneficiaries, including pregnant women and Medicare beneficiaries. Providers must inform optional beneficiaries of their right to disenroll in the program at any time in the future. Optional beneficiaries may discuss enrollment options by contacting their local Department of Social Services (DSS). For a listing of all the county DSS offices, refer to www.ncdhhs.gov/dss/local/;
- Complete the enrollment form and it send to the CCNC/CA contact at the DSS in the county where the beneficiary resides. The form can be found on N.C. Division of Medical Assistance (DMA) Website at www.ncdhhs.gov/dma/ca/ccncproviderinfo.htm; and,
- Provide the Medicaid beneficiary with a CCNC/CA Member handbook. Handbooks may be obtained by contacting the DMA at 919-855-4780. A copy of the handbook is also available on the DMA Website at www.ncdhhs.gov/dma/ca/carehandbook.pdf.

Those with questions regarding enrolling beneficiaries can contact their Regional Consultant. Contact information for your Regional Consultant is available at: www.ncdhhs.gov/dma/ca/MCC_0212.pdf.

**CCNC/CA Managed Care Section
DMA, 919-855-4780**

Attention: CCNC/CA Primary Care Providers

The Process for Referring a CCNC/CA Beneficiary to Another Provider

Coordination of care is a required component of Community Care of North Carolina/Carolina ACCESS (CCNC/CA).

Authorization for payment of services to another provider must be considered for medically necessary or urgent services even when a beneficiary has failed to establish a medical record with a Primary Care Physician (PCP).

[See the main CCNC/CA Web page at www.ncdhhs.gov/dma/ca/ccncproviderinfo.htm for more information about CCNC/CA program.]

- All authorizations and consultations, including services retroactively authorized, must be referred by the PCP.
- Recommendations for referrals to specialists for follow-up care after discharge from urgent care centers must be made to CCNC/CA primary care providers for their assessment and authorization.
- Authorization is not required for services provided in a hospital emergency department or for an admission to a hospital through the emergency department. **The physician component for inpatient services does require authorization.** Referrals for routine follow-up care after discharge from a hospital must be made to the PCP. Referrals to a specialist for follow-up care after discharge from a hospital require PCP authorization and should be coordinated through the PCP's office.
- If surgery is recommended, CCNC/CA primary care providers are required to refer beneficiaries for a second opinion at the request of beneficiaries.
- If beneficiaries disagree with their PCP's decision regarding referrals for specialty services or other care, the beneficiaries should be advised of their option to choose a different CCNC/CA primary care provider.
- All referrals must be documented in the beneficiary's medical record. (If PCPs do not have medical records for the beneficiary, they should document the referral on the referral log. PCPs are encouraged to keep a log of all referrals for ease in management of the Referral Report).

Those with questions regarding referring beneficiaries can contact their Regional Consultant. Contact information for Regional Consultants is available at www.ncdhhs.gov/dma/ca/MCC_0212.pdf.

**CCNC/CA Managed Care Section
DMA, 919-855-4780**

Attention: Federally Qualified Health Center/Rural Health Clinic Providers**FQHC/RHC Clinic Providers Rebilling T1015 modifiers HI or SC**

Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) that have submitted T1015 modifier HI or T1015 modifier SC for billing to HP Enterprise Services (HPES) and received denial code EOB 6647 - "This service is covered by the MCO for the recipient's county and this recipient's claims must be submitted directly to the MCO/LME for payment" – should resubmit the claim to HPES for appropriate adjudication.

Behavioral Health Policy
DMA, 919-855-4290

Attention: All Behavioral Health, N.C. Innovations Providers and LME-MCOs**Enrollment in N.C. Medicaid and N.C. Health Choice**

Providers enrolled in N.C. Medicaid and N.C. Health Choice (NCHC) who provide services to beneficiaries with mental health, substance abuse or developmental disability issues – including providers working under the N.C. Innovations Program – must maintain their enrollment with N.C. Medicaid and NCHC along with their Local Management Entity-Managed Care Organization (LME-MCO).

If you are providing services with an LME-MCO and received a request to renew your enrollment with N.C. Medicaid, complete the forms and return them to N.C. Medicaid.

Behavioral Health Policy
DMA, 919-855-4290

Attention: ICF/IID Providers and LME-MCOs**P**rior Approval for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) for ages 0-3

The N.C. Division of Medical Assistance (DMA) issues prior approval for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) services for children **0-3 years of age**.

The Local Management Entity-Managed Care Organization (LME-MCO) issues prior approval for children **3 years of age and older**.

For prior approval for ICF/IID level of care for children **under the age of 3**, submit an MR2 to the Behavioral Health Section of DMA at the following address:

N.C. Department of Health and Human Services
DMA
2501 Mail Service Center
Raleigh, NC 27669-2501

Behavioral Health Services
DMA, 919-855-4290

Attention: Personal Care Services (PCS) Providers

Personal Care Services (PCS) Program Highlights

Note: This article does not apply to Personal Care Services (PCS) billed under Community Alternative Programs (CAP).

Updated PCS Forms

PCS New Referral Request Forms and Change of Status Request Forms (Home Care and Licensed Residential Facilities) have been updated, which is reflected in the forms (revised date of March 8, 2013). The N.C. Division of Medical Assistance (DMA) has approved a time period for providers to transition to the updated forms without being penalized. New Referral Request Forms and Change of Status Request Forms dated December 19, 2012 can be submitted without penalty to The Carolina's Center for Medical Excellence (CCME) until June 15, 2013. After June 15, 2013, those forms must have the revision date of March 8, 2013 or they will receive a technical denial and won't be processed.

Retroactive Prior Approval for PCS

DMA has authorized retroactive prior approval for Personal Care Services (PCS) that were approved on or after January 1, 2013. Retroactive prior approval will only be applied to initial requests for PCS services, and will authorize prior approval for requests dating back to January 1, 2013. The retroactive effective date for authorization will be the request date on the referral form, providing the date is not more than 10 calendar days from the date that CCME received the request form.

If the referral is received by CCME more than 10 calendar days from the request date on the referral form, the authorization will be effective the date CCME received the form. Providers will receive new authorization letters for beneficiaries who were approved for initial requests of PCS from January 1, 2013 to the current time. The new authorization letter will not affect the beneficiaries approved service level or reassessment date.

For more information, read the Medicaid Special Bulletin *Retroactive Prior Approval for Personal Care Services*, located at www.ncdhhs.gov/dma/bulletin/pdfbulletin/0413_Special_Bulletin_PCS_PA.pdf.

House Bill 5 Session Law 2013-4 – Special Funding for Group Homes and Special Care Units

The General Assembly of North Carolina approved House Bill 5 Session Law 2013-4 as an act requiring the N.C. Department of Health and Human Services to provide temporary, short-term financial assistance to:

1. Group Homes serving residents determined not to be eligible for Medicaid-covered PCS as a result of changes to eligibility criteria that became effective on January 1, 2013; and,
2. Special Care Units serving residents who qualify for Medicaid-covered PCS on or after January 1, 2013.

To learn how to access these funds, read the Special Medicaid bulletin *House Bill 5 Temporary Funding for Group Homes and Special Care Units*, located at www.ncdhhs.gov/dma/bulletin/pdfbulletin/0413_Special_Bulletin_HB5.pdf.

Special Transition Funds for Adult Care Homes Licensed Under 131D

In Session Law (SL) 2012-142 Section 10.23A (f), the N.C. General Assembly appropriated \$39.7 million to the Community Living Fund for the implementation of the State's plan to provide temporary, short-term assistance to Adult Care Home (ACH) providers. This assistance is available **from January 1, 2013 until June 30, 2013** to providers who:

- Continue to provide PCS to residents living in ACH who received ACH-PCS on or before December 31, 2012;
- Are denied State Plan PCS effective January 1, 2013; and,
- Are certified by the appropriate Lead Agency not to have a safe and timely placement available for these residents.

Beneficiaries must be residing in the ACH and receiving ACH-PCS on or before December 31, 2012 for the ACH provider to access these funds. The funds will be paid by dates of service through the biweekly checkwrite process.

To access the funds, an ACH provider will refer a resident for whom they have issued a discharge notice to the local Department of Social Services (DSS). The local DSS will determine whether the Lead Agency is the local Department of Social Services (DSS) or Local Management Entity (LME). The Lead Agency will conduct a mini-assessment and certify to the N.C. DHHS that a community placement has not yet been arranged and the beneficiary cannot be safely and timely discharged in to the community. Once the beneficiary has been certified, prior approval will be issued to allow the ACH provider to submit claims and receive reimbursement for short-term assistance. Funds available to ACH providers are not to exceed \$694.00 for days 1 to 90; funds are not to exceed \$520.50 for days 91 to 180.

Claims for dates of service from January 1, 2012 to June 30, 2013 will be submitted utilizing the electronic billing tool using HCPCS Code S 5126 and the following modifiers:

- SE modifier for dates of service up to the 90th day, but no later than June 30, 2013; the per diem rate is \$23.13.

- TS modifier for dates of service from days 91 to 180, but no later than June 30, 2013; the per diem rate is \$17.35.

DMA asks for 10 business days from the beneficiary certification date before submitting claims to allow for verification and transmission of the prior approval. To view the December 31, 2012 Webinar presented by DMA regarding special payment to ACH, visit www.ncdhhs.gov/dma/pcs/Forms/ACH_transition20130104p-12-31-12.pdf. Providers can also view the special payment for ACH flowchart at: www.ncdhhs.gov/dma/pcs/Forms/provider-flow-chart-20130103.pdf.

Upcoming Training

Training dates, locations, and registration information will be available on the DMA PCS Website at www.ncdhhs.gov/dma/pcs/pas.html and the CCME Website at www.thecarolinascenter.org for all upcoming trainings and Webinars. Check the PCS Web page frequently for updates.

PCS Program Contacts

To contact the PCS program, call 919-855-4340 or send an email to PCS_Program_Questions@dhhs.nc.gov. For PCS updates and important links, visit the PCS Website at www.ncdhhs.gov/dma/pcs/pas.html.

Home and Community Care
DMA, 919-855-4340

Employment Opportunities with the N.C. Division of Medical Assistance (DMA)

Employment opportunities with DMA are advertised on the Office of State Personnel’s Website at www.osp.state.nc.us/jobs/. To view the vacancy postings for DMA, click on “Agency,” then click on “Department of Health and Human Services.” If you identify a position for which you are both interested and qualified, complete a state application form online and submit it. If you need additional information regarding a posted vacancy, call the contact person at the telephone number given in the vacancy posting. General information about employment with North Carolina State Government is also available online at www.osp.state.nc.us/jobs/general.htm

Proposed Clinical Coverage Policies

In accordance with NCGS §108A-54.2, proposed new or amended Medicaid clinical coverage policies are available for review and comment on DMA's Website. To submit a comment related to a policy, refer to the instructions on the Proposed Clinical Coverage Policies Web page at www.ncdhhs.gov/dma/mpproposed/. Providers without Internet access can submit written comments to the address listed below.

Richard K. Davis
 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.

2013 Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
June	06/06/13	06/11/13	06/12/13
	06/13/13	06/18/13	06/19/13
	06/20/13	06/27/13	06/28/13
July	07/05/13 (POS Only. See checkwrite article)	07/09/13	07/10/13
	07/12/13	07/16/13	07/17/13
	07/19/13	07/23/13	07/24/13
	07/26/13	07/30/13	07/31/13

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.

Carol H. Steckel, MPH
Director
Division of Medical Assistance
Department of Health and Human Services

Melissa Robinson
Executive Director
HP Enterprise Services