January 2016 Medicaid Bulletin

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Attention: All Providers*

Update on Enrollment Criteria for Ordering, Prescribing and Referring Providers

Notice to Providers: This article updates the August 2014 Medicaid Bulletin article *Providers Not Enrolled in Medicaid.* This update also appeared in the November 2015 Medicaid Bulletin.

All providers who render services to beneficiaries must be enrolled in N.C. Medicaid or N.C. Health Choice (NCHC). In addition, 42 CFR 455.410 requires that all Ordering, Prescribing and Referring (OPR) physicians – as well as other professionals providing services under the N.C. Medicaid, NCHC or their respective waiver programs – be enrolled as participating providers. This includes anyone who orders, refers, or prescribes services or items (such as pharmaceuticals) to N.C. Medicaid and NCHC beneficiaries, and seeks reimbursement.

Any physician or non-physician practitioners who render services, or write orders, prescriptions or referrals, must be enrolled in N.C. Medicaid or NCHC and their **individual** NPI (**not organizational** NPI) must be included on the claim.

Beginning Feb. 1, 2016, failure of an OPR provider to enroll in N.C. Medicaid or NCHC will result in a 90-day claim suspension. The billing provider will receive a denial with an EOB stating that the OPR provider is not enrolled.

Institutional, clinical and professional claims will suspend for 90 days if **any** of the NPIs on the claim are found to be providers who are not enrolled in N.C. Medicaid or NCHC. Providers should ensure that all rendering, ordering, prescribing and referring providers of the services for which they submit Medicaid or NCHC claims are enrolled in those programs.

As a reminder, effective July 1, 2015, all Institutional (UB-04/837-I) claims for Psychiatric Residential Treatment Facility (PRTF) services must include the name and NPI of the beneficiary's attending psychiatrist and billing provider for reimbursement. If the attending psychiatrist's NPI is not entered on the claim, the claim will deny with EOB Code 03101, "THE TAXONOMY CODE FOR THE ATTENDING PROVIDER IS MISSING OR INVALID." For more information, refer to the April 2015 Medicaid Bulletin.

If services are furnished to beneficiaries in another state, the out-of-state providers are required to enroll with N.C. Medicaid or NCHC. Enrollment in another state's Medicaid program does **not** exempt a rendering or OPR provider from enrolling with N.C. Medicaid or NCHC. More information for OPR professionals can be found in the article *Out-of-State Provider Enrollment* in this bulletin, as well as on the N.C. Division of Medical Assistance (DMA) Provider Enrollment web page.

Providers with questions about the NCTracks online enrollment application can contact the CSC Call Center at 1-**800-688-6696** (phone)**; 919-851-4014 (fax) or** NCTracksprovider@nctracks.com **(email).**

* This also includes providers directly contracted with the LME/MCOs.

Provider Services
DMA, 919-855-4050

Attention: All Providers

Out-of-State Provider Enrollment

Out-of-state providers are required to adhere to all North Carolina rules, regulations, laws and statutes governing healthcare delivery under the N.C. Medicaid and the N.C. Health Choice (NCHC) programs. They are only eligible for time-limited enrollment under the following conditions:

- For the reimbursement of services rendered to N.C. Medicaid or NCHC beneficiaries in response to emergencies or if travel back to North Carolina would endanger the health of the eligible beneficiaries
- For reimbursement of a prior-approved non-emergency service, or,
- For reimbursement of medical equipment and devices that are not available through an enrolled provider located within North Carolina or in the 40-mile border area.

Out-of-state providers must submit a **re-enrollment application** every 365 days in order to continue as N.C. Medicaid or NCHC providers.

Out-of-state providers must wait until the day after their current enrollment period ends – when their provider record is terminated – to begin the re-enrollment process. Many out-of-state providers are attempting to re-enroll using a Managed Change Request (MCR) prior to the end of their current enrollment period. This will not continue provider enrollment. MCRs are used to report changes to the provider record; they do **not** serve as re-enrollment applications.

Providers with questions about the NCTracks online enrollment application can contact the CSC Call Center at 1-800-688-6696 (phone); 919-851-4014 (fax) or NCTracksprovider@nctracks.com (email).

Provider Services
DMA, 919-855-4050

Attention: All Providers

NC Medicaid Electronic Health Record (EHR) Incentive Program Announcements

Program Year 2015 Attestation Tail Period

Eligible hospitals (EH) and eligible professionals (EP) have until **April 30, 2016** to submit an attestation for program year 2015. N.C. Medicaid Incentive Payment System (NC-MIPS) will not accept program year 2015 attestations after 11:59 EST on April 30, 2016. EHs and EPs are encouraged to submit their attestation as early as possible so they have time to address any attestation discrepancies. Changes cannot be made to an attestation in NC-MIPS after the attestation tail period has ended. No extensions or exceptions will be made.

Public Health Reporting

In Program Year 2015, all EPs, EHs and Critical Access Hospitals (CAHs) may claim an exclusions for all three measures under Objective No. 10, *Public Health Reporting*. The three measures under this objective are:

1. Immunization Registry Reporting,
2. Syndromic Surveillance Reporting, and,
3. Specialized Registry Reporting.

The N.C. Department of Public Health is **not** currently accepting the electronic submission of:

- Immunization data, or,
- Syndromic surveillance registry data.

Therefore, until further notice, EPs in N.C. **may continue** to claim an exclusion for immunization or syndromic surveillance registry data.

EPs will be required to show active engagement in submitting data to a specialized registry in program year 2016 to meet Objective No. 10, *Public Health Reporting*. More information on meeting the specialized registry measure in Program Year 2016 will be made available on the NC Medicaid EHR Incentive Program web page.

Program Year 2016 Announcements and Reminders

Program year 2016 is the last year an EP may begin participating in the NC Medicaid EHR Incentive Program and the last year an EP may attest to Adopt, Implement, Upgrade (AIU). Program year 2016 is the last year an EH may participate in, and receive payment for, the NC Medicaid EHR Incentive Program.

NC-MIPS will not accept program year 2016 attestations until May 1, 2016. Continue to check the NC Medicaid EHR Incentive Program web page for program announcements and updates as they become available.

NC Medicaid EHR Incentive Program
NCMedicaid.HIT@dhhs.nc.gov (email preferred) or 919-814-0180

Attention All Providers

Cystic Fibrosis Genetic Testing

Clinical Coverage Policy 1S-4, *Genetic Testing Policy,* will enable providers to test symptomatic beneficiaries using CPT codes 81220 and 81221 cystic fibrosis. For additional testing, prior approval (PA) is required for CPT codes 81222 and 81223. Refer to 1S-4, *Genetic Testing Policy,* (formerly 1S-4, *Cytogenetic Studies*), which can be found on the Division of Medical Assistance (DMA) "Laboratory Services" Clinical Coverage Policy Page.

1S-4, *Genetic Testing Policy,* (formerly 1S-4, *Cytogenetic Studies*), will be effective on Jan. 1, 2016.

CPT Code	Conditions for Use of Code
81220	Testing for common variants for a symptomatic beneficiary
81221	Testing for known familial variant for a symptomatic beneficiary for a specific variant
81223	Testing for full gene sequence after obtaining PA, when no mutation is found when no common variants detected
81222	Testing after full gene sequencing and if no mutation found. Testing may be done for duplication/deletion variants after obtaining PA.

CSC, 1-800-688-6696

Attention: All Providers

Clinical Coverage Policies

The following new or amended combined N.C. Medicaid and N.C. Health Choice (NCHC) clinical coverage policies are available on DMA's Clinical Coverage Policy web page:

- 1E-2, Therapeutic and Non-therapeutic Abortions
- 1-O-1, Reconstructive and Cosmetic Surgery
- 1S-4, Genetic Testing
- 3D, Hospice Services
- 8A-2, Facility-Based Crisis Service for Children and Adolescents

These policies supersede previously published policies and procedures.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

Responding to Re-credentialing Invitations

The Centers for Medicare & Medicaid Services requires that all Medicaid providers are revalidated (re-credentialed) at least every five years. This is to ensure that provider enrollment information is accurate and current. The provider's credentials and qualifications will be evaluated to ensure that they meet professional requirements and are in good standing. The re-credentialing process also includes criminal background checks on all owners and managing relationships associated with the provider record.

Every active NCTracks provider must be re-credentialed. However, shortly after NCTracks implementation in 2013, this process was suspended due to the backlog of pended provider Managed Change Requests (MCR). Beginning November 2015, the process was reinstated.

Providers will receive a re-credentialing/reverification letter, or an invitation, through their NCTracks secure portal in-box or e-mail, when they are scheduled to begin the re-credentialing process. This process is completed in the "Status and Management" section of the NCTracks Provider Portal under the section titled "Reverification." A reverification application will only appear when it is time to reverify. Providers are required to pay a $100 application fee for re-credentialing/reverification.

Re-credentialing is not optional. It is crucial that all providers who receive a notice promptly respond and begin the process. Providers will receive a notification letter 45 days before their re-credentialing due date. If the provider does not complete the process **within the allotted 45 days, payment will be suspended** until the process is completed. The provider will also receive a termination notice.

If the provider does not complete the re-credentialing process within 30 days from payment suspension and termination notice, **participation in the N.C. Medicaid and Health Choice programs will be terminated**. Providers must submit a re-enrollment application to be reinstated.

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.

Re-credentialing applies to providers who are enrolled for an indefinite period of time. It does not apply to any time-limited enrolled providers such as Out-of-State (OOS) providers. OOS providers must continue to complete the enrollment process every 365 days.

Provider Services
DMA, 919-855-4050

Attention: All Providers

NCTrack Updates

Community Care of NC/Carolina ACCESS Overrides

This is an update to an article that was published on May 13, 2015. It contains additional information on requesting a Community Care of NC/Carolina ACCESS (CCNC/CA) override and the features available on the form.

Medical providers must obtain a CCNC/CA Referral Authorization from the member's CCNC/CA Primary Care Physician (PCP) of record prior to rendering treatment, unless the specific service is exempt from CCNC/CA Referral Authorization. For a listing of exempt services, see "Section 6.4.4.3.2 Services Exempt from CCNC/CA Authorization" of the *Provider Claims and Billing Assistance Guide* located on the NCTracks Provider Policies, Manuals, Guidelines and Forms page.

When services are rendered to a CCNC/CA member (recipient) without first obtaining a CCNC/CA Referral Authorization from the CCNC/CA PCP of record and the PCP refuses to authorize retroactively, medical providers may request an override. CCNC/CA overrides are authorizations issued by the NCTracks Customer Support Center for CCNC/CA members. CCNC/CA override confirmation numbers are not placed on the claim.

- Override requests will only be considered if extenuating circumstances – beyond the control of the parties involved on the claim – affect the member's access to medical care.
- Overrides will not be considered for current, future, or past dates of service unless the CCNC/CA PCP of record has been contacted and refused to authorize treatment.
- Medical providers needing a CCNA/CA override must submit N.C. Division of Medical Assistance (DMA) CA Override Request to the NCTracks Customer Support Center.
- All information needs to be legible and valid such as the National Provider Identifier (NPI) and Recipient ID being used.
- Whether the request is by fax or phone, providers must provide a valid diagnosis or symptoms indicating why a CCNC/CA Override is being requested.
- Providers should only include the date of service within the current month on each type of request.
    - Phone requests cannot be processed with a past date of service whether in the current month or not.
    - Inpatient admission/therapy services are an exception, they can be date spanned month to month.

- Providers should include the requestor's name and number, which is useful if there is a need for clarification.

The following are two preferred methods for submitting an Override Request:

- Telephone - The provider can call NCTracks at 1-800-688-6696 to request an override for future dates of service, or if the member is in the provider's office waiting for treatment.

- Fax - The provider can fax the Override Request Form to NCTracks at 1-855-710-1964. Providers may fax the override request form for past dates of service.

The form on NCTracks website has fillable form fields. This feature allows providers to print the completed form and save it to their device. A copy of the DMA CA Override Request Form can be found on the NCTracks NCTracks Provider Policies, Manuals, Guidelines and Forms page. Be sure that the form is completely filled in since missing information can cause a delay in making a determination.

Providers may contact NCTracks at 1-800-688-6696 to check on the status of a pending override request.

Regional consultants also are available to assist providers with outstanding override requests. A current list of consultants is on DMA's CCNC/CA web page.

Reminder About Manage Change Request/Re-Enrollment Application in Progress when "N/A" Displayed

When providers are on the Status and Management page of the secure NCTracks Provider Portal to complete a "Manage Change Request (MCR)" or "Re-Enrollment Application," they may see an "N/A" under the "Select" column of the Record Result. This indicates that there is a saved **draft** MCR or application for the NPI. This happens when an Enrollment Specialist or a former Office Administrator (OA) started a MCR or application, but has not completed it.

In order to continue with submission of the new MCR/Re-Enrollment Application, the draft must be completed or deleted. OAs need to check with each Enrollment Specialist who has access to that NPI to see if they have saved a draft. **Left unattended, the draft will automatically delete after 90 days.**

NCTracks Updates from NPPES

National Plan and Provider Enumeration System (NPPES) creates and sends a weekly update file to NCTracks containing NPI additions and updates. This file is loaded into NCTracks weekly.

Based on the enumeration date, it may take up to four weeks for the NPI to be linked to NCTracks. NPI's will not be visible or searchable by NCTracks staff if the provider has not used NCTracks to enroll in the N.C. Medicaid or N.C. Health Choice (NCHC) programs. The only way to know if the NPI is available is to have the provider attempt the enrollment process.

During the provider enrollment process on the NCTracks website, the provider may receive an error message that the NPI is invalid. If an error has occurred, wait a week to see if the NPI is linked to NCTracks.

New Features for DME and Home Health Prior Approval-Updated

Note: This is an update to the article *NCTracks Update* in the December 2015 Medicaid Bulletin. For home health, these features only apply to miscellaneous supply providers.

For Prior Approval (PA) requests for Durable Medical Equipment (DME) and home health miscellaneous supply services, a signed and completed Certificate of Medical Necessity (CMN) is required. Currently in NCTracks, CMNs can only be submitted using the paper *Request for Prior Approval CMN/PA Form (DMA 372-131)* available on the NCTracks website, or by having the prescribing provider sign the system generated document when a PA request is submitted through the secure Provider Portal.

As of Nov. 1, 2015, providers requesting DME and Home Health miscellaneous supply services can route through NCTracks a PA request to the recipient's (beneficiary's) prescribing provider for review. The prescribing provider can approve and electronically sign the request using their PIN, then submit to NCTracks for review. If the prescribing provider does not agree with the service request, the record can be returned back to the requesting provider to review and correct as applicable.

Per DMA policy, a prescribing provider is defined as a physician, physician assistant or nurse practitioner. A new NCTracks user role has been developed for this group to access the routed records – Prescribing Provider. The Office Administrator (OA) for the NPI must assign the appropriate authorized users this new user role in NCTracks to access records routed for review. The paper CMN is still available after Nov. 1, 2015, but the online routing of the request can help expedite the submission of PA requests for providers.

Note: Home health miscellaneous supply providers can only submit the form via NCTracks. They cannot mail or fax copies. For home health providers, the CMN form is submitted as an attachment to the T1999 request submitted in the portal only if the provider does not intend to route the request for electronic signature in the system.

Note: Until a signed PA request is successfully submitted to NCTracks, it is not visible to the Call Center or DMA staff. Call Center Agents and DMA have no information about records being routed between the requesting and prescribing providers. The two provider groups (prescribing provider and service provider) must communicate with each other if there are any questions about the status of one of these PA records.

Additional Options

Providers also have the new option of ‘N/A’ for describing the recipient's living arrangement/support system and skin condition. This addition was made to the *Request for Prior Approval CMN/PA Form (DMA 372-131)* and the PA entry pages in the secure Provider Portal. This information is required as part of the PA request process. An attestation statement also was

added below the signature section on the form. The updated form has been posted to the NCTracks Prior Approval web page.

Training Available

Training for OAs regarding the assignment of user roles in NCTracks is available in Skillport, the NCTracks Learning Management System. In addition, there is an instructor-led training (ILT) course and two Job Aids developed to assist providers with taking advantage of this new functionality. For more information on the ILT course, see the Skillport course schedule. Job aids (one for DME and one for Home Health) can be found in the Reference Documents folder under User Guides in the SkillPort Catalog.

New Job Aid - How to Determine Your Re-credentialing Due Date

A new NCTracks Job Aid, *How to Determine Your Re-credentialing Due Date*, has been posted to the Re-Credentialing web page on the NCTracks provider portal. As noted in the Job Aid, the re-credentialing due date can be found in the Status and Management section of the secure provider portal 45 days before re-credentialing is due. The Job Aid includes screen shots showing a provider's due date.

This Job Aid is a subset of the more comprehensive *Re-Credentialing Job Aid PRV573*, which is available to providers in SkillPort, the NCTracks Learning Management System. More information can also be found on the Re-credentialing web page.

Update on Lab Codes Denying for Edit 00180

Lab codes are denying for Edit 00180-INVALID DIAGNOSIS FOR LAB CODE when diagnosis Z00.00 is the only diagnosis on the claim. These are valid denials. A diagnosis code supporting the medical necessity of this service must be submitted on the claim. Providers should refile the claim and include a diagnosis code supporting medical necessity.

Reminder - New Information Required on Provider Record for Agents, Managing Employees and Owners

IntelliCorp Records, Inc. serves as the state-approved vendor for the criminal background searches performed during NCTracks provider enrollment, verification and credentialing activities. IntelliCorp informed CSC of changes required to perform any future background checks on individuals named in the NCTracks provider records.

As of Nov. 1, 2015, the NCTracks provider application process requires that the physical address, email address, and phone number is included for each agent, managing employee and owner.

Note: Providers are encouraged to make every effort possible to submit the residential address for each agent, managing employee and owner.

NCTracks currently captures the physical address of owners that are listed on the application; this modification requires the email address and phone numbers of owners as well.

How to add this information:

- Providers can add this information by completing a full **Manage Change Request** (MCR) at any time.

  Note: Those who submit a MCR for **any** reason you will be required to complete this information, if it is missing from the provider record.

- Those providers who are required to complete **re-credentialing** will be prompted to complete an MCR prior to completing the re-credentialing application, if the information is missing from the provider record.

  Note: For more information on re-credentialing, refer to the article *Responding to Re-credentialing Invitations* in this bulletin, the October 28 NCTracks announcement and the new NCTracks Provider Re-credentialing/Re-verification web page.

- All new provider **enrollments or re-enrollments** that list an owner, agent, or managing Employee will be required to provide this information.

NCTracks provider enrollment, verification and credentialing activities cannot be completed without a background check on owners, agents, and managing employees.

Come Back to NCTracks Emails

In the months leading up to the implementation of ICD-10, several emails were sent to help providers prepare for the changes ahead. During that time period, a number of providers unsubscribed from the email distribution list. Now that ICD-10 is up and running, the amount of emails has lessened; we invite providers who unsubscribed to come back.

Email is a key means of communicating with the provider community about important topics regarding NCTracks, such as outstanding issues, claims reprocessing, upcoming system changes, etc. Once a provider unsubscribes, NCTracks can no longer send that provider any email communication from our distribution list.

Those who unsubscribed from NCTracks email communication and would like to re-subscribe can go to the Provider Communications page on the portal, click on the link in the upper right corner to "Sign Up for NCTracks Communications" and re-enter the email address.

CSC, 1-800-688-6696

Attention: All Providers

HIPAA Data Sharing Protections /DMA Addresses

HIPAA Safeguards

Providers must use reasonable safeguards when sharing items containing Protected Health Information (PHI) as defined under HIPAA.

Addressing DMA Mail

For items sent via US Postal System

Staff member name
Division of Medical Assistance
Section Name
2501 Mail Service Center
Raleigh, NC 27699-2501

For items sent via FedEx or UPS

Packages sent via FedEx or UPS should be sent directly the physical address below. Include the staff and section information indicated:

Staff member name and phone number
Division of Medical Assistance
Section
1985 Umstead Drive
Raleigh, NC 27603

Providers with questions should contact the DMA mailroom or DMA's HIPAA section.

For items sent via email (Encryption)

To avoid breach notification under HIPAA, covered entities and business associates can only send emails in which the PHI is secure from unauthorized persons. Secure PHI is protected health information that has been rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology. More information can be found in the Centers for Medicare & Medicaid Services (CMS) *HIPAA Security Series Newsletter – March 2007*. **PHI should never be placed in the subject line of an email.**

Additional Information

- U.S. Department of Health and Human Services (US DHHS) General HIPAA web page
- US DHHS HIPAA Breach Notifications web page

DMA HIPAA Privacy, 919-814-0170
DMA Mailroom, 919-855-4160

Attention: All Providers

Change in Prior Approval Requirements for High Tech Imaging

Effective Jan. 1, 2016, beneficiaries who have Medicaid for Pregnant Women (MPW) coverage will no longer require prior authorization for high tech imaging through eviCore.

Effective Jan. 1, 2016, Pregnancy Medical Home (PMH) providers are no longer required to register the ultrasounds listed below through eviCore.

CPT CODES		
76801	76814	76821
76802	76815	76825
76805	76816	76826
76810	76817	76827
76811	76818	76828
76812	76819	
76813	76820	

Refer to Clinical Coverage Policy 1K-7, *Prior Approval for Imagining* for the list of high tech imaging codes which require prior approval. The updated policy will be posted on DMA's CCP web page in mid-January. Contact eviCore at 800-575-4517 option 3 with questions.

Clinical Section
DMA, 919-855-4320

Attention: All Providers

CPT Code Update: 2016

Effective with date of service Jan. 1, 2016, the American Medical Association (AMA) has added new CPT codes, deleted others, and changed the descriptions of some existing codes. (For complete information regarding all CPT codes and descriptions, refer to the 2016 edition of *Current Procedural Terminology*, published by the AMA.) **Providers should note the full descriptions and all associated parenthetical information published in this edition when selecting a code for billing services to the N.C. Division of Medical Assistance (DMA).**

New CPT codes that are covered by the N.C. Medicaid program are effective with date of service Jan. 1, 2016. Claims submitted with deleted codes will be denied for dates of service on or after Jan. 1, 2016. Previous policy restrictions continue in effect unless otherwise noted. This includes restrictions that may be on a deleted code that are continued with the replacement code(s).

New CPT Codes Covered by Medicaid and NCHC (effective Jan. 1, 2016)									
10035	10036	31652	31653	31654	33477	37252	37253	39401	39402
43210	47531	47532	47533	47534	47535	47536	47537	47538	47539
47540	47541	47542	47543	47544	49185	50430	50431	50432	50433
50434	50435	50606	50693	50694	50695	50705	50706	54437	54438
61645	61650	61651	72081	72082	72083	72084	73501	73502	73503
73521	73522	73523	73551	73552	77767	77768	77770	77771	77772
78265	78266	88350	92537	92538					

Note: **CPT Code 33477 will require prior authorization for Medicaid and N.C. Health Choice (NCHC) beneficiaries. Medicaid will pay for procedure code 33477 for children and adults who have the following conditions:**

- **Existence of a full circumferential dysfunctional Right Ventricular Outflow Tract (RVOT) conduit that was equal to or greater than 16 mm in diameter when originally implanted, and,**
- **Dysfunctional RVOT conduit with one of the following clinical indications for intervention:**
  - **moderate or greater pulmonary regurgitation, or,**
  - **pulmonary stenosis with a mean RVOT gradient equal to or greater than 35 mm of mercury.**

The device has to be FDA approved for the intended use.

New HCPCS Codes Covered by Medicaid and NCHC (effective Jan. 1, 2016)									
E0465	E0466	D1354	D9223	D9243	J0202	J0596	J0695	J0714	J0875
J1443	J1447	J1575	J1833	J2407	J2502	J2547	J2860	J3090	J3380
J7121	J7188	J7205	J7297	J7298	J7313	J7328	J9032	J9039	J9271
J9299	J9308								

New CPT Codes Not Covered by Medicaid and NCHC									
99415	99416	64461	64462	64463	65785	69209	74712	74713	80081
81170	81162	81218	81219	81272	81273	81276	81311	81314	81412
81432	81433	81434	81437	81438	81442	81490	81493	81525	81528
81535	81536	81538	81540	81545	81595	90620	90621	90625	90697
93050	96931	96932	96933	96934	96935	96936	99177		

End-Dated CPT Codes (effective Dec. 31, 2015)									
21805	31620	37202	37250	37251	39400	47136	47500	47505	47510
47511	47525	47530	47560	47561	47630	50392	50393	50394	50398
64412	67112	70373	72010	72069	72090	73500	73510	73520	73530
73540	73550	74305	74320	74327	74475	74480	75896	75945	75946
75980	75982	77776	77777	77785	77786	77787	82486	82487	82488
82489	82491	82492	82541	82543	82544	83788	88347	92543	95973

All Category II and III Codes are not covered.

Claims submitted with the new 2016 Codes will pend.

The state and CSC are in the process of completing system updates to align our policies with CPT code changes (new codes, covered and non-covered, as well as the end-dated codes), to ensure that claims billed with the new codes will process and pay correctly.

Until this process is completed, claims submitted with new codes will pend for "no fee on file." These pended claims will recycle and pay when the system work is completed. No additional action will be required by providers to ensure that claims process and pay correctly after the system work is completed. This process will also be applicable to the Medicare crossover claims.

To maintain cash flow, providers may wish to split claims and bill new codes on a separate claim. This will ensure that only claims billed with the new procedure codes are pended for processing.

Note: Several new codes for 2016 contain parenthetical rules from the AMA prohibiting billing for services within the same family of codes if they are in the same anatomical area. Providers will receive a denial requesting documentation if a claim is submitted without documentation that a separate procedure was performed on a different lesion, urinary collecting system, vascular territory, etc. Providers may submit replacement or new claims through the provider portal with supporting documentation (history and physical, operative notes, discharge summary, etc.) demonstrating a distinct procedure was performed for reimbursement review.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: Dental Providers

American Dental Association Code Updates

Effective with date of service January 1, 2016, the following dental procedure codes have been added for the N.C. Medicaid and N.C. Health Choice (NCHC) dental programs. These additions are a result of the Current Dental Terminology (CDT) 2016 American Dental Association (ADA) code updates. Clinical Coverage Policy 4A, *Dental Services,* will be updated to reflect these changes.

CDT 2016 Code	Description and Limitations	PA Indicator
D9223	Deep sedation/general anesthesia – each 15 minute increment • Allowed only in an office setting • Allowed up to a total of six (6) hours of anesthesia time • Deep sedation/general anesthesia performed in the dental office must include documentation in the record of pharmacologic agents, monitoring of vital signs, and complete anesthesia time • Reimbursement includes all drugs and/or medicaments necessary for adequate anesthesia • Reimbursement includes monitoring and management	N
D9243	Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment • Allowed only in an office setting • Allowed up to a total of six (6) hours of anesthesia time • Intravenous conscious sedation performed in the dental office must include documentation in the record of pharmacologic agents, IV site, monitoring of vital signs, and complete anesthesia time • Reimbursement includes all drugs or medicaments necessary for adequate anesthesia • Reimbursement includes monitoring and management	N

Note: Rates for these new codes are currently under review.

The following procedure codes were end-dated effective with date of service Dec. 31, 2015.

End-Dated CDT Code	Description
D0260	Extraoral – each additional radiographic image
D2970	Temporary crown (fractured tooth)
D9220	Deep sedation/general anesthesia – first 30 minutes
D9221	Deep sedation/general anesthesia – each additional 15 minutes
D9241	Intravenous moderate conscious sedation/analgesia – first 30 minutes
D9242	Intravenous moderate conscious sedation/analgesia – each additional 15 minutes

The following procedure code descriptions were revised effective with date of service **Jan. 1, 2016**.

Revised CDT Code	Description
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis

Providers are reminded to bill their usual and customary charges rather than the Medicaid rate. For coverage criteria and additional billing guidelines, refer to Clinical Coverage Policy 4A, *Dental Services*, on the DMA's Clinical Coverage Policy web page.

Dental Program,
DMA, 919-855-4280

Attention: Home Health Providers

Updated Bill Type for Home Health Providers

Notice to Providers: This was originally published as a Special Bulletin in October 2015.

Effective Nov. 1, 2015, providers should no longer submit original claims for home health services using Bill Type 33X. Providers should use Bill Type 32X or 34X instead. Bill Type 33X will be discontinued per the Centers for Medicare & Medicaid Services (CMS) and the National Uniform Billing Committee.

Service Limit Information Accessible via NCTracks and AVRS

Effective with date of service **Nov. 1, 2015,** home health providers are able to obtain service limit information via the NCTracks Provider Portal or the Automated Voice Response System (AVRS).

To access service limit information via the Provider Portal, go to the "Eligibility" tab, input the required information and review the Medicaid Service Limits section of the screen.
The AVRS allows enrolled providers to access detailed information pertaining to the N.C. Medicaid program. Providers may access service limit information by calling 1-800-723-4337.

Implementation of Prior Approval Requirement for the Miscellaneous Supply Procedure Code (T1999)

Effective with date of service **Nov. 1, 2015,** home health providers must submit prior approval requests for use of the T1999 procedure code through the NCTracks Provider Portal. Limits and prior approval of requirements for use of the T1999 code include the following:

- Total maximum miscellaneous billing limit of $250 per patient per year without prior approval required.
- Prior approval is required for total miscellaneous billing greater than $250.
- Total maximum miscellaneous billing limit of $1,500 per patient per year.

Verification of limits are made available through the AVRS and via NCTracks in the Provider Portal.

Home Health Services
DMA, 919-855-4380

Attention: Hospice Providers

Concurrent Hospice and Personal Care Services for Adults

Clinical Coverage Policy 3D, *Hospice Services* has been amended to allow concurrent hospice and personal care services (PCS) to be provided to Medicaid-only and dually eligible adults residing in their primary private residence. **On Jan. 1, 2016**, the revised policy will be posted to the DMA website and will become effective.

DMA conducted a series of webinars in December 2015 to educate providers on this policy change and the process to coordinate hospice and PCS. Providers may access the live session recordings on the DMA's Hospice Services web page.

For more information, contact Regina Harrell at 919-855-4342.

Home Health, Home Infusion and Hospice Services
DMA, 919-855-4380

Attention: Hospitals, LME-MCOs

Medical Detoxification Billing

This article provides clarification on the process for review of medical detoxification claims. Claims for hospital admission due to medical detoxification are currently being denied at the Local Management Entity–Managed Care Organization (LME-MCO) level. These denied claims are being sent to the N.C. Division of Medical Assistance (DMA) for fee-for-service payments.

"Medical detoxification" is encompassed in a psychiatric Diagnosis-Related Group (DRG) that was included in LME-MCO capitation rate development. Therefore, "medical detoxification" must be part of the benefit plan offered by LME-MCOs. **Effective with dates of service Dec. 1, 2014,** all claims included in a psychiatric DRG – including "medical detoxification" – must be paid by the LME-MCO.

Requests for claim overrides must include:

- LME-MCO rationale for denial,
- Original UB-04 claim form,
- Remittance Advice, and,
- Admit/discharge summary notes.

All information must be scanned and sent through secure email, with the exception of the UB-04 claim form which must be mailed to the address below.

Note: LME-MCOs also are responsible for follow-up and aftercare of these beneficiaries, which is more effectively done if LMEs-MCOs follow beneficiaries throughout their course of treatment.

Email: monica.hamlin@dhhs.nc.gov

Mail
Attention: Monica Hamlin
Division of Medical Assistance
Behavioral Health Section
2501 Mail Service Center
Raleigh, NC 27699-2501

Phone: Monica Hamlin, 919-855-4336

Behavioral Health
DMA, 919-855-4290

Attention: Nurse Practitioners and Physicians Assistants

Billing Code Update for Nurse Practitioners and Physician Assistants

Since the transition to NCTracks, the N.C. Division of Medical Assistance (DMA) has received calls concerning claim denials for some services provided by nurse practitioners (NPs) and physician assistants (PAs).

DMA has provided instruction to NCTracks on updating the claims processing system. The following procedure code list has been updated recently to include additional NP and PA taxonomies. The newly added codes are:

27822*	27822***	27827*	27827***	90935	96111	96921

***Codes marked with an asterisk (*) were updated for modifiers 80 and 82 only**
***Codes marked with asterisks (***) were updated for modifier 55 only**

A complete list of accepted codes **can be found on the Claims and Billing Section of the DMA web site.**

Note: Codes currently in process for system updates will be published once system modifications are completed. New code problems will be addressed as DMA Clinical Policy becomes aware of them.

CSC, 1-800-688-6696

Attention: Nursing Facility Providers

Change in Delivery of Nursing Facility Rate Letter and Patient Roster

Notice to Providers: This article was originally published in the November 2015 Medicaid Bulletin.

Effective Jan. 1, 2016, nursing facility providers will receive their nursing facility rate letters and Final Point in Time Reports (patient rosters) from CSC via the secure NCTracks provider portal. Previously this information was mailed to providers from the N.C. Division of Medical Assistance (DMA).

The nursing facility rate letter and patient roster will be posted to the provider's Message Center Inbox each quarter. This approach provides quick accessibility to review, download, and print letters and patient rosters. This is the same method used to retrieve the paper Remittance Advice (RA). The letters and rosters will remain available for up to eight quarters.

Nursing facility providers may see a slight difference in the format of the facility rate letter and patient roster, but the content will be the same. Access is restricted to those people who have permission to view the corresponding NPI on the secure NCTracks provider portal. To obtain permission, contact the Office Administrator for the NPI.

Training information will be made available for nursing facility providers shortly.

CSC, 1-800-688-6696

Proposed Clinical Coverage Policies

According to 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. Providers without Internet access can submit written comments to:

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 substantively revised as a result of the initial comment period. If the adoption of a new or amended medical coverage policy is necessitated by an act of the N.C. General Assembly or a change in federal law, then the 45- and 15-day time periods will instead be 30- and 10-day time periods.

Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
January 2016	01/07/16	01/12/16	01/13/16
	01/14/16	01/20/16	01/21/16
	01/21/16	01/26/16	01/27/16
February 2016	02/04/16	02/09/16	02/10/16
	02/11/16	02/17/16	02/18/16
	02/18/16	02/23/16	02/24/16
	02/25/16	03/01/16	03/02/16

Sandra Terrell, MS, RN
Director of Clinical
Division of Medical Assistance
Department of Health and Human Services

Paul Guthery
Executive Account Director
CSC