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Attention: All Providers

NCTracks Updates

Guidance in Viewing and Requesting Provider Statistical and Reimbursement Reports

Provider Statistical and Reimbursement (PS&R) reports are used to help complete the annual cost reporting submitted by hospital providers participating in the Medicaid Program. As noted in the Aug. 6, 2015, announcement, NCTracks now provides electronic delivery of PS&R Summary Reports. The PS&R Summary Report is automatically generated 90 days following the end of the fiscal year listed in the NCTracks provider record.

When the PS&R Report is generated, a message will be posted to the provider's Message Center Inbox on the secure NCTracks Provider Portal. The message will contain a link to the PS&R Summary report, which can be viewed online, printed, or downloaded. This approach is similar in nature to accessing the provider's paper Remittance Advice (RA).

The message containing a link to the PS&R Summary report is published to all of the NCIDs associated with the provider number. The Office Administrator can add users (staff) to view, print, and download the PS&R Summary report from the provider's Message Center Inbox.

For Office Administrators wanting more information regarding how to add users, see the Computer Based Training (CBT) course "PRV501_Office Admin Functions" in SkillPort. For users who are new to NCTracks, the CBT course "GEN111_NCTracks Overview Provider Portal for Providers" is recommended. 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 regarding Java, which is required for the use of SkillPort.

Important Note: Production of the PS&R Reports is linked to the Fiscal Year End month (e.g. September), which is on the NCTracks provider record. If a provider has been involved in a Change of Ownership or merger that alters their Fiscal Year End month, the Office Administrator must update the NCTracks provider record with the correct month using an MCR.

Also, remember that NCTracks can now produce Detailed PS&R Reports for hospital providers. The reports can be requested for any 12-month time period. For more information, including instructions on how to order the Detailed PS&R Reports, see the March 13, 2015, announcement.

Prior Approval for Chiropractic and Podiatry Services for Medicaid for Pregnant Women

Recipients with eligibility through Medicaid for Pregnant Women (MPW) only can receive services that are related to pregnancy such as prenatal care, delivery, childbirth classes, postpartum care and family planning. Medicaid also provides coverage of services that are medically necessary to treat conditions that may complicate a pregnancy. Some of these services require PA to validate the medical necessity for the service requested.

Effective Dec. 14, 2015, NCTracks began accepting PA requests for the authorization of chiropractic and podiatry services for medically necessary pregnancy-related services for recipients with MPW coverage.

Effective with date of service March 1, 2016, claims submitted for chiropractic or podiatry services for recipients with MPW coverage will deny if PA is not on file for the recipient.

Note: Other services that may be necessary to treat a pregnancy-related complication already have processes in place to evaluate the medical necessity of the requested service. These services include:

- Durable Medical Equipment,
- Home Health Services,
- Home Infusion Therapy,
- Hospice,
- Personal Care Services,
- Private Duty Nursing, and
- Optical Services.

Providers also are reminded that dental services are covered only through the day of delivery for recipients with MPW coverage.

All PA requests for chiropractic and podiatry services must submitted via the provider portal. Paper versions of the request submitted by mail or fax will not be accepted. Providers may access NCTracks communications for information related to upcoming training events about this process.

A referral is required from whomever is providing the recipient's obstetric care (e.g., family practice physician, OB/GYN, nurse midwife, nurse practitioner, health department, etc.). The referral must document the condition that makes it medically necessary for the recipient to see a chiropractor or podiatrist. It must be specific as to how the condition is complicating the pregnancy and include the number of requested visits. The referral may or may not be to a particular chiropractor or podiatrist.

PA is **not** required for the initial visit. Providers may bill for an evaluation using the appropriate procedure codes. PA is required for subsequent visits/treatment. The referral may be submitted as an attachment to the PA request or it may be mailed or faxed to CSRA (formerly CSC). No medical records, plans of care or other documentation are required to be submitted with the request.

The chiropractic (or podiatry) provider is responsible for entering and submitting the PA request through the NCTracks Provider portal. The provider must indicate the service requested (chiropractic or podiatry) and the request begin and end dates. For chiropractic services, a primary diagnosis must be selected from a drop-down list of diagnosis codes **and** a secondary diagnosis must be manually entered. For podiatry services, a valid diagnosis code per policy must be entered on the PA request.

PA cannot exceed 60 calendar days. Requests cannot be submitted retroactively (unless the recipient is approved for Medicaid retroactively).

If services are needed after the initial approved limits or time period, providers must submit a new PA request. A new referral from the recipient's primary obstetric caregiver also must be submitted indicating the medical need for the new time period being requested.

NCTracks ICD-10 Web Page Remains Available

As previously announced, the NCTracks ICD-10 Crosswalk and NCTracks ICD-10 Inbox for providers were discontinued on Dec. 31, 2015.

However, the NCTracks ICD-10 web page on the Provider Portal will remain updated with information and links to resources, including Frequently Asked Questions and the NCTracks ICD-10 Help Kit.

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. IntelliCorp informed CSRA (formerly CSC) of changes for 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 be included for each Agent, Managing Employee, and Owner.

Note: Providers are encouraged to submit the residential address for each Agent, Managing Employee and Owner.

NCTracks currently captures the physical address of Owners who 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 an MCR for any reason will be required to complete this information if it is missing from their 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 their provider record.

  Note: For more information on re-credentialing, refer to the October 28 announcement and the new Provider Re-credentialing/Re-verification web page on the NCTracks Provider Portal.

- All new provider enrollments or re-enrollments that list an Owner, Agent, or Managing Employee must provide this information.

NCTracks provider enrollment, verification and credentialing activities cannot be completed without a background check on Owners, Agents, and Managing Employees.

CSRA (formerly CSC), 1-800-688-6696

Attention: All Providers

NCTracks Updates on Durable Medical Equipment Codes

PA and Claim Information for DME codes E0450, E0463 and E0465

The following Durable Medical Equipment (DME) HCPCS codes were end dated Dec. 31, 2015, per Centers for Medicare & Medicaid Services (CMS) mandate:

- E0450 - Volume control ventilator, without pressure support mode, may include pressure control mode, used with invasive interface (e.g. tracheostomy tube)

- E0463 – Pressure support ventilator with volume control mode, may include pressure support mode, used with invasive interface (e.g. tracheostomy tube)

The code that replaced these end dated codes is E0465 – Home ventilator, any type, used with invasive interface (e.g. tracheostomy tube) with an effective date of Jan. 1, 2016. This change was implemented in NCTracks on Dec. 22, 2015 and affects prior approval (PA) and claims for these codes.

Prior Approval

DME PA requests for Home Ventilators submitted to NCTracks with the end-dated codes for 2016 dates of service cannot be processed.

To obtain PA for Home Ventilator beginning in 2015 and continuing into 2016, the DME provider needs to submit two separate PA requests:

- One PA request using the old HCPCS codes for dates up to and including Dec. 31, 2015, and

- One PA request using the new HCPCS code for dates of service beginning Jan. 1, 2016, and forward.

The old and new HCPCS codes for Home Ventilators cannot be submitted on the same PA or the request will deny.

DME Home Ventilator PA requests already in the system for dates that span from 2015 into 2016 are being researched and more information will be forthcoming.

PA requests submitted for an effective date of Jan. 1, 2016, or forward, should use code E0465.

Claims

Claims that span dates of service from 2015 to 2016 will need to be split when filed. A split claim is actually two claims: one with codes for services provided prior to Dec. 31,

2015 (E0450 and E0463) and another claim with E0465 for services provided on or after Jan. 1, 2016. There must be a corresponding PA for each claim.

CSRA (formerly CSC), 1-800-688-6696

Attention All Providers

Clinical Coverage Policy 1S-4 *Genetic Testing Policy*

NCTracks system changes for CPT codes in Clinical Coverage Policy 1S-4, *Genetic Testing*, are not completed. NCTracks is in the process of completing system updates to ensure claims billed with the new codes will process and pay correctly.

Providers should file claims timely. The N.C. Division of Medical Assistance (DMA) will notify providers when this process is completed through NCTracks Announcements and Medicaid Bulletins at which time providers may resubmit denied claims.

Providers should continue to request prior approval for cystic fibrosis codes 81222 and 81223 as outlined in the policy and in the January 2016 bulletin article.

Clinical Policy and Programs
919-855-4320

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 DMA's website at http://dma.ncdhhs.gov/:

- 1E-4, *Fetal Surveillance*
- 1E-6, *Pregnancy Medical Home*
- 1E-7, *Family Planning Services*
- 1K-7, *Prior Approval for Imaging Services*
- 15, *Ambulance Services*

These policies supersede previously published policies and procedures.

Clinical Policy and Programs
DMA, 919-855-4260

Attention All Providers:

HCPCS Code Changes for the Physician's Drug Program

The following HCPCS code changes were made in NCTracks to comply with Centers for Medicare & Medicaid Services (CMS) HCPCS code changes for Jan. 1, 2016.

End-Dated Codes with Replacement Codes

The following HCPCS codes were end-dated effective with date of service Dec. 31, 2015 and replaced with new codes effective with date of service Jan. 1, 2016. Claims submitted for dates of service on or after Jan. 1, 2016, using the end-dated codes will be denied.

Old Code	New Code and Description	Unit
Q9979	**J0202 (**Injection, alemtuzumab, 1 mg), **Lemtrada**	1 mg
J1446	**J1447 (**Injection, tbo-filgrastim, 1 microgram), **Granix**	1 mcg
J7302	**J7297** (Levonorgestrel-releasing intrauterine contraceptive system, 52mg, 3 year duration**), Liletta**	52mg
J7302	**J7298** (Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 5 year duration**), Mirena**	52mg

New HCPCS Procedure Codes

The following HCPCS codes were added to the list of covered codes for the Physician's Drug Program (PDP) effective with date of service Jan. 1, 2016. These codes do not replace other codes.

New HCPCS Code	Description	Unit
J1443	Injection, ferric pyrophosphate citrate solution, 0.1 mg of iron	0.1 mg
J7121	5% dextrose in lactated ringers infusion, up to 1000 cc	1000 cc
J7328	Hyaluronan or derivative, gel-syn, for intra-articular injection, 0.1 mg	0.1 mg

New Codes That Were Previously Billed with the Miscellaneous Drug Codes J3490, J3590, J7199 and J9999

Effective with date of service Jan. 1, 2016, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover specific HCPCS codes for the drugs listed in the following table. Claims submitted for dates of service on or after Jan. 1, 2016, using the unlisted drug codes J3490, J3590, J7199 or J9999 will be denied.

Old HCPCS Code	New Code and Description	Unit
J3590	**J0596** (Injection, c1 esterase inhibitor (recombinant), ruconest, 10 units), **Ruconest**	10 units
J3490	**J0695** (Injection, ceftolozane 50 mg and tazobactam 25 mg), **Zerbaxa**	75 mg
J3490	**J0714** (Injection, ceftazidime and avibactam, 0.5 g/0.125 g), **Avycaz**	0.625g
J3490	**J0875** (Injection, dalbavancin, 5mg), **Dalvance**	5 mg
J3590	**J1575** (Injection, immune globulin/hyaluronidase, (hyqvia), 100 mg immunoglobulin), **Hyqvia**	100 mg
J3490	**J1833** (Injection, isavuconazonium, 1 mg), **Cresemba**	1 mg
J3490	**J2407** (Injection, oritavancin, 10 mg), **Orbactiv**	10 mg
J3490	**J2502** (Injection, pasireotide long acting, 1 mg), **Signifor**	1 mg
J3490	**J2547** (Injection, peramivir, 1 mg), **Rapivab**	1 mg
J3590	**J2860** (Injection, siltuximab, 10 mg), **Sylvant**	10 mg
J3490	**J3090** (Injection, tedizolid phosphate, 1 mg), **Sivextro**	1 mg
J3590	**J3380 (**Injection, vedolizumab, 1 mg), **Entyvio**	1 mg
J7199	**J7188** (Injection, factor viii (antihemophilic factor, recombinant), (obizur), per i.u.), **Obizur**	1 IU
J7199	**J7205** (Injection, factor viii fc fusion (recombinant), per iu), **Eloctate**	1 IU
J3490	**J7313** (Injection, fluocinolone acetonide, intravitreal implant, 0.01 mg), Iluvien	0.01 mg

Old HCPCS Code	New Code and Description	Unit
J9999	**J9032** (Injection, belinostat, 10 mg), **Beleodaq**	10 mg
J9999	**J9039** (Injection, blinatumomab, 1 microgram), **Blincyto**	1 mcg
J9999	**J9271** (Injection, pembrolizumab, 1 mg), **Keytruda**	1 mg
J9999	**J9299** (Injection, nivolumab, 1 mg), **Opdivo**	1 mg
J9999	**J9308** (Injection, ramucirumab, 5 mg), **Cyramza**	5 mg

Refer to the fee schedule for the PDP on the N.C. Division of Medical Assistance (DMA) Fee Schedule web page for the current reimbursement rates. Providers must bill their usual and customary charges.

Outpatient Pharmacy
DMA, 919-855-4300

Attention: All Providers|

2016 CPT Code Update: Correction

CPT Code 90620 and 90621 were inadvertently listed as non-covered by N.C. Medicaid and N.C. Health Choice in the *January 2016 Medicaid Bulletin*. These codes are covered effective April 1, 2015.

HCPCS Code E0466 is **non-covered** by N.C. Medicaid and NCHC.

HCPCS G0431 and G0434 were end-dated effective Dec. 31, 2015. Providers should select the most appropriate code from the lab section of the 2016 CPT manual that describes the service performed.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

HIPAA Data Sharing Protections /DMA Addresses

Notice to Providers: This is an update of an article published in the *January 2016 Medicaid Bulletin*. The section titled "For items sent via FedEx, UPS or Other Courier Service" has been corrected.

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, UPS or Other Courier Service

DMA operates out of five office buildings.

- Adams Building, 101 Blair Drive, Raleigh, NC 27603
- Kirby Building: 1985 Umstead Drive, Raleigh, NC 27603
- Six Forks Building: 333 E Six Forks Road, Second Floor, Raleigh, NC 27609
- Hoey Building: 801 Ruggles Drive, Raleigh, NC 27603
- Dobbins Building: 815 Palmer Drive, Raleigh, NC 27603

Before sending a package via FedEx or UPS contact the person to whom the package is addressed for their **exact street address**. Packages sent to the main Mail Service Center (1985 Umstead Drive) may not reach the intended recipient for two or three additional days.

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

Responding to Re-credentialing Invitations

Notice to Providers: This article was previously published in the *January 2016 Medicaid Bulletin*.

The Centers for Medicare & Medicaid Services (CMS) 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

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 CSRA Call Center at 1-800-688-6696 (phone); 919-851-4014 (fax) or NCTracksprovider@nctracks.com (email).

Provider Services
DMA, 919-855-4050

Attention: Ambulance Providers

Ambulance Policy Update

Clinical Coverage Policy 15, *Ambulance Services,* is available on the Division of Medical Assistance (DMA) Clinical Coverage Policy web page effective Feb. 1, 2016. This policy supersedes the previously published *Ambulance Manual*.

Institution–based ambulance providers file claims using the UB-04/8371, an institutional claim format. Independent/private ambulance providers file claims using the CMS 1500/837P professional claim format.

Independent/private ambulance providers file one of the following HCPCS codes for each ambulance trip and for mileage, when applicable, on separate details on the claim: A0425, A0426, A0427, A0428, A0429, A0430, A0431, A0433, A0435, A0436 and T2003.

Institution-based providers file RC 540, ambulance general class, with one of the above HCPCS codes for each ambulance trip, when applicable, on separate details on the claim.

All ambulance providers must report an origin and destination modifier for each ambulance trip provided. Origin and destination modifiers for ambulance services are created by combining two alpha characters. Each alpha character, except for "X," represents an origin or destination code and together they create one modifier. The first position character equals origin, the second position character equals destination.

The origin and destination modifiers include D, E, G, H, I, J, N, P, R, S and X. The origin and destination modifier descriptions are listed in the *HCPCS Level II* book. Providers shall refer to the applicable edition for the code description as it is no longer documented in the policy.

Ambulance providers may see a slight increase in denials if another ambulance claim was submitted with the same date of service. Ambulance providers should submit documentation electronically instead of paper for more efficient and quicker claim resolution and possibly expedited payment.

Ambulance Providers should reference the updated Fact Sheet, as well as *Job Aid – Submit an Ambulance Claim,* located in SkillPort, the Learning Management System for NC Tracks. Refer to the Provider Training page of the public Provider Portal for specific instructions on how to use SkillPort.

Practitioner, Clinical and Facility Services
DMA, 919-855-4320

Attention: 'Be Smart' Family Planning Program Providers

Annual Exam Requirement for Transition to the 'Be Smart' Family Planning Program

The "Be Smart" Family Planning Medicaid ("Be Smart") program covers an annual exam and six additional inter-periodic visits every 365 days. The annual exam is required prior to a beneficiary receiving other services under the program.

In an effort to ease the transition to the "Be Smart" program, prevent duplication of services and minimize the burden for Medicaid beneficiaries, the N.C. Division of Medical Assistance (DMA) is now allowing beneficiaries transitioning to the "Be Smart" program from other Medicaid programs to use the comprehensive annual, physical or postpartum exams received under these programs to meet the "Be Smart" annual exam requirement.

The annual exam requirement is as follows:

1. **Transition of Regular Medicaid Beneficiaries to the "Be Smart" Family Planning Medicaid Program**

   Beneficiaries who have received a comprehensive annual or physical exam under regular Medicaid within 365 days prior to transitioning to the "Be Smart" program will be considered to have met the annual exam requirement for the "Be Smart" program and therefore, **will not** be required to receive another comprehensive annual or physical exam.

2. **Transition of Medicaid for Pregnant Women Beneficiaries to the "Be Smart" Family Planning Medicaid Program**

   It is the expectation that beneficiaries with Medicaid for Pregnant Women (MPW) coverage will receive a postpartum exam by the last day of the month in which the 60th postpartum day occurs. MPW beneficiaries who received their postpartum exam within the 365 days prior to enrolling in the "Be Smart" program **will not** be required to receive another comprehensive annual or physical exam in order to begin receiving services under the "Be Smart" program.

In summary, to meet the comprehensive annual or physical exam requirement, the beneficiary is allowed one of the three options below:

1. Receive the MPW postpartum exam in the 365 days prior to enrollment as the required comprehensive annual or physical exam; or,

2. Receive the regular Medicaid comprehensive annual or physical exam in the 365 days prior to enrollment; or,

3. Receive the comprehensive annual or physical exam under the "Be Smart" program prior to receiving other "Be Smart" services.

The list of procedure codes that meet the comprehensive annual or physical exam requirement under the "Be Smart" Family Planning Medicaid program now contains procedure codes that include the postpartum exam – 59400, 59410, 59430, 59510, and 59515 – in addition to the comprehensive annual or physical exam codes: 99383, 99384, 99385, 99386, 99387, 99393, 99394, 99395, 99396, and 99397.

Providers will be allowed to submit all claims for "Be Smart" services provided on or after Oct. 1, 2015 for beneficiaries who meet one of the three criteria above to NCTracks. Questions should be directed to CSRA at 1-800-688-6696.

Practitioner, Clinical and Facility Services
DMA, 919-855-4320

Attention: Local Health Departments

Home Visit for Newborn Care and Assessment Missing Diagnosis Code Implementation

With the transition from ICD-9 to ICD-10, two diagnosis codes were missing from the required diagnosis code list for Home Visit for Newborn Care and Assessment (CPT 99502):

- Z00.110 (health examination for newborn under 8 days old) and
- Z00.111 (health examination for newborn 8 to 28 days old)

Claims that were billed with these codes were denied.

System changes were made on Dec. 14, 2015 with an effective date of Oct. 1, 2015 to add ICD-10-CM diagnosis codes Z00.110 and Z00.111 to the diagnosis code list for CPT 99502 to ensure appropriate reimbursement for Home Visit for Newborn Care and Assessment services.

Claims denied for dates of service Oct. 1, 2015 and after may be resubmitted as new claims.

Practitioner, Clinical and Facility Services
DMA, 919-855-4320

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
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
March 2016	03/03/16	03/08/16	03/09/16
	03/10/16	03/15/16	03/16/16
	03/17/16	03/22/16	03/23/16
	03/24/16	03/29/16	03/30/16
	03/31/16	04/05/16	04/06/16

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