



June 2016 Medicaid Bulletin

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***Providers are responsible for informing their billing agency of information in this bulletin.
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Attention: All Providers**New NCTracks Feature – Enrolled Practitioner Search**

NCTracks has a new feature on the provider portal – the Enrolled Practitioner Search. This feature allows NCTracks providers to inquire about other providers enrolled in N.C. Medicaid and N.C. Health Choice (NCHC). The Enrolled Practitioner Search provides the capability to validate provider information for billing, attending, referring, rendering, ordering, and prescribing providers.

Search criteria include the NPI, license number, and name of the provider. The response includes the NPI, provider name, health plan(s), address, taxonomy code(s), and license number. Multiple rows are returned for providers with more than one health plan, address, or taxonomy code.

Note: The response to the Enrolled Practitioner Search only includes individual providers who are actively enrolled in N.C. Medicaid or NCHC on the date of inquiry. Information contained in the database is maintained by the individual provider and is subject to change daily.

To access this feature, click on the Enrolled Practitioner Search button on the lower left side of the NCTracks [Provider Portal home page](#). There is a Job Aid to assist providers under Quick Links on the Enrolled Practitioner Search page.

CSRA, 1-800-688-6696

Attention: All Providers**NCTracks Updates: Claims Reprocessing Due to PDN Rate Increase**

As previously communicated in the April 2016 Special Medicaid bulletin, [N.C. Session Law 2015-241](#), section 12H.22, required the N.C. Department of Health and Human Services (DHHS) to submit N.C. State Plan Amendment (SPA) 16-001 to the Centers for Medicare & Medicaid Services (CMS) requesting approval for a 10% rate increase for Private Duty Nursing (PDN) with an **effective date of Jan. 1, 2016**.

CMS approved this SPA on April 14, 2016 and the rate was implemented in NC Tracks on April 22, 2016. Beginning April 22, 2016, claims for PDN will be reimbursed at the lessor of this new rate – \$9.90 per 15 minutes – or billed charges. Providers are reminded to bill their usual and customary charges.

Claims with dates of service from Jan. 1, 2016 through April 22, 2016 that were previously paid at the fee schedule rate of \$9.00 will be systematically reprocessed and reflected in the June 14, 2016 checkwrite.

Note: Reprocessing does not guarantee payment for the claim. While some edits may be bypassed as part of the claim reprocessing, changes made to the system since the claims were originally adjudicated may apply to reprocessed claims. Therefore, the reprocessed claim could deny.

**Provider Reimbursement
DMA, 919-814-0060**

Attention: All Providers**C**laim Edit for Rendering Provider Service Location

On March 2, 2015, NCTracks claims processing began searching for any active location on the provider record for which the rendering taxonomy code on the claim is valid. The claim is then processed using that location.

An Informational (pay and report) Edit 04528 RENDERING PROVIDER LOCATION CODE SET BASED ON TAXONOMY has been posted with Explanation of Benefits (EOB) 04528 on the Remittance Advice (RA). This edit alerts providers to take action to update the rendering provider location on the provider record.

EOB 04528 states “UNABLE TO DETERMINE RENDERING PROVIDER LOCATION CODE BASED ON THE SUBMITTED ADDRESS. LOCATION CODE HAS BEEN SET BASED ON THE RENDERING PROVIDER TAXONOMY ONLY. CONTACT THE RENDERING PROVIDER AND ASK THEM TO COMPLETE A MANAGED CHANGE REQUEST ADDING THE SERVICE FACILITY ON THIS CLAIM AS AN ACTIVE SERVICE LOCATION.”

This was intended to be a temporary change to allow providers time to update their provider records with the correct rendering provider location information. The User Guide, *How to Change the Primary Physical Address in NCTracks*, which explains how to update provider location information, can be found under the heading “Provider Record Maintenance” on the [Provider User Guides and Training page](#) of the NCTracks Provider Portal.

Effective Aug. 1, 2016, the claim edit disposition for invalid rendering provider location will change from “pay and report” to “suspend.” Rendering providers must have the addresses of all facilities where they perform services listed as provider service locations under their National Provider Identifiers (NPIs) in NCTracks. The system uses a combination of NPI, taxonomy code, and service location in processing claims. If the address where the service was rendered is not listed in the provider record as a service location for the rendering provider's NPI, the claim will suspend with Edit 04526 and EOB 04526 – RENDERING LOCATOR CODE CANNOT BE DERIVED. This will delay the completion of claim adjudication and payment.

For more information regarding how to correct these pended claims, see the [May 27, 2014 announcement](#) on the NCTracks Provider Portal.

Note: Claims with invalid billing or attending provider locations also will continue to pend.

Rendering providers can add service locations to their provider record by having their Office Administrator (OA) complete a Manage Change Request (MCR) in the *Enrollment Status and Management* section of the secure NCTracks provider portal.

Note: When adding a new service location, the application also will require that taxonomies and applicable accreditations be added to the new service location. The pended claims are recycled

periodically and will recognize changes in the provider record that alleviate Edit 04526. The provider does not need to resubmit the claim.

When updating a provider record in NCTracks, the MCR will assign a default effective date of the current date to most changes. **This is important because the system will edit subsequent transactions against the effective dates in the provider record.** For example, claims are edited against the effective date of the taxonomy codes on the provider record. **The claim will deny if a provider bills for a service rendered prior to the effective date of the relevant taxonomy code on the provider record.**

Some effective dates can be changed from the default date. When providers add or reinstate a health plan, service location, or taxonomy code, the effective dates can be changed from the default date. However, the effective date must be changed **before** the MCR is submitted. (The effective date also cannot precede the enrollment date or the date associated with the relevant credential or license and cannot be older than 365 days.)

Providers with questions can contact the CSRA (formerly CSC) Call Center at 1-800-688-6696 (phone); 1-855-710-1965 (fax) or NCTracksprovider@nctracks.com (email).

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

Attention: All Providers**Affiliation Claim Edit**

One of the requirements associated with NCTracks is that attending/rendering providers must be affiliated with the billing providers who are submitting claims on their behalf. The disposition of Edit 07025 has been set to “pay and report” since NCTracks went live on July 1, 2013. The “pay and report” disposition means that claims where the attending/rendering provider is **not** affiliated with the billing provider will **not** deny, but Edit 07025 and EOB 07025 will post on the provider’s Remittance Advice (RA).

The text of the EOB 07025 reads, “THE RENDERING PROVIDER IS NOT AFFILIATED WITH YOUR PROVIDER GROUP. CONTACT THE RENDERING PROVIDER AND ASK THEM TO COMPLETE A MANAGED CHANGE REQUEST ADDING YOUR PROVIDER GROUP NPI ON THE AFFILIATED PROVIDER PAGE WITHIN THE NEXT FOUR WEEKS TO PREVENT CLAIMS BEING DENIED.”

The intent was to alert providers to situations in which the affiliation relationship does not exist. This allows the attending/rendering provider to initiate a Manage Change Request (MCR) to add the affiliation to the provider record.

Effective Aug. 1, 2016, the claim edit disposition will change from “pay and report” to “suspend.” Once the disposition is changed, a claim failing the edit will suspend for four weeks. If the affiliation relationship is not established within that time period, the claim will be denied. Providers must correct any affiliation issues immediately.

Note: The MCR to establish or change a provider affiliation must be initiated by the Office Administrator (OA) of the individual attending/rendering provider. A group or hospital that acts as a billing provider cannot alter affiliations in NCTracks.

Providers with questions can contact the CSRA (formerly CSC) Call Center at 1-800-688-6696 (phone); 1-855-710-1965 (fax) or NCTracksprovider@nctracks.com (email).

Provider Services
DMA, 919-855-4050

Attention: All Providers**M**edicaid and N.C. Health Choice Provider Fingerprint-based Criminal Background Checks

Note: This article was *originally* published in May 2016

In accordance with [42 CFR 455.434\(b\)](#), Medicaid and Children Health Insurance Program (CHIP) providers designated as a “high” categorical risk by the federal government soon will be required to submit a set of fingerprints to the N.C. Division of Medical Assistance (DMA) through its enrollment vendor, CSRA, as a part of the federally mandated provider screening process.

Note: N.C. Health Choice (NCHC) is the North Carolina’s CHIP.

High-risk providers are listed under [42 CFR 424.518\(c\)](#) and [N.C.G.S. 108C-3\(g\)](#). The requirement for fingerprint-based criminal background checks applies to both:

- High-risk providers, and,
- Any person with a 5 percent or more direct or indirect ownership interest in the organization, as those terms are defined in 42 CFR 455.101.

Providers will be notified of all locations in North Carolina where fingerprinting services will be offered.

Providers required to submit fingerprints will be notified in writing of the requirement. A deadline for compliance will be established. Providers who fail to meet the deadline will be denied participation in the N.C. Medicaid and N.C. Health Choice (NCHC) programs. Providers who have already undergone fingerprint-based criminal background checks for Medicare or another State’s Medicaid or CHIP program are **not** required to submit new fingerprint-based criminal background checks to enroll in N.C. Medicaid and NCHC.

DMA is seeking state legislative approval to fully implement this requirement. Additional information will be provided in future Medicaid bulletins. Questions regarding this new requirement or requests for additional assistance can be directed to the NCTracks Call Center by phone at 800-688-6696, or by email to NCTracksprovider@nctracks.com

Provider Services
DMA, 919-855-4050

Attention: All Providers**Re-credentialing Due Dates for Calendar Year 2016**

Notice: This article was *originally* published as a [Special Medicaid Bulletin in February 2016](#).

List of Providers due for Re-credentialing

A list of providers scheduled for re-credentialing in calendar year 2016 is available on the [provider enrollment page](#) of the DMA website under the “Re-Credentialing” header. Providers can use this resource to determine their re-credentialing/revalidation due date, and determine which month to begin the re-credentialing process. Organizations and systems with multiple providers may download this spreadsheet, which includes NPI numbers and provider names, to compare with their provider list.

Providers will receive a notification letter 45 days before their re-credentialing due date.

Providers are required to pay a \$100 application fee for re-credentialing/ reverification. If the provider does not complete the process **within the allotted 45 days, payment will be suspended** until the process is completed. 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.

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. When it is necessary to submit a full managed change request (MCR), the provider must submit the full MCR prior to the 45th day and the application status must be in one of these status to avoid payment suspension:

- 1) In Review,
- 2) Returned,
- 3) Approved, or,
- 4) Payment Pending.

Providers are required to complete the re-credentialing application after the full MCR is completed. If the provider does not complete the process **within the allotted 45 days, payment will be suspended.** Once payment is suspended, the provider must submit a re-credentialing application or the full MCR before payment suspension will be lifted.

When the provider does **not** submit a re-verification application by the re-verification due date **and** the provider has an MCR application in which the status is In Review, Returned, Approved or Payment Pending, the provider’s due date will be reset to the current date plus 45 calendar days.

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 does not apply to time-limited enrolled providers, such as out-of-state providers. Providers with questions about the re-credentialing process can contact the CSRA (formerly 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**D**irect Enrollment of Mid-Level Providers

Effective Aug. 1, 2016, all mid-level providers, including Physician Assistants (PAs), Nurse Practitioners (NPs), Certified Registered Nurse Anesthetists (CRNAs), and Certified Nurse Midwives (CNM) must enroll with N.C. Medicaid and N.C. Health Choice (NCHC). All services provided must be filed to NCTracks using their National Provider Identifier (NPI) as the rendering (or attending) provider.

Services provided by PAs, NPs, CRNAs and CNMs are no longer billable as “incident to.” The NPI of the mid-level provider must be submitted for all orders, prescriptions, and referrals. For additional information, refer to the May Special Bulletin, [*Federal Regulation 42 CFR 455.410: Attending, Rendering, Ordering, Prescribing or Referring Providers-Update.*](#)

Applicants must meet all program requirements and qualifications for enrollment before they can be enrolled as Medicaid providers. Providers with questions about the NCTracks [online enrollment application](#) can contact the CSRA (formerly 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**P**ayment Error Rate Measurement (PERM)

Note: The article was originally published in May 2016

The Payment Error Rate Measurement (PERM) audit program was developed and implemented by the Centers for Medicare & Medicaid Services (CMS) to comply with the Improper Payments Information Act (IPIA) of 2002. The program examines eligibility determinations and claims payment made by Medicaid and Children's Health Insurance Programs (CHIP) for accuracy and ensure states only pay for appropriate claims. North Carolina's next PERM cycle is federal fiscal year 2016 (October 2015 – September 2016).

Note: N.C. Health Choice (NCHC) is North Carolina's CHIP.

How PERM is implemented

Claims Review – Claims are reviewed to determine if they were processed correctly and the services were provided, medically necessary, coded correctly, and properly paid or denied.

For the PERM cycle, CMS uses two contractors to perform claims reviews:

- **Statistical Contractor** – Collects universe claims data quarterly from states. Uses a stratified random sampling design to draw the sample for review.
- **Review Contractor** – Uses the sample list to request copies of medical records from providers and reviews them for medical necessity, correct coding, correct payment or denial of claims, and services provided.

The Lewin Group is the Statistical Contractor and A+ Government Solutions/CNI Advantage, LLC, is the Review Contractor for the FY 2016 PERM cycle. A+ served as the Review Contractor for the FY 2010 through FY 2013 PERM cycles so many of the processes states are accustomed to will continue into FY 2016.

Throughout the cycle, A+ 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. The website allows state representatives to track medical records requests, view review findings, request different resolution/appeals on identified errors, etc.

Where providers can find out more information

- [CMS website](#)
- [CMS PERM "Providers" web page](#)
- [Central PERM email for providers](#)

- [“Provider Education Calls” to learn more about the PERM process and provider responsibility](#)

Provider Education Webinar/Conference Calls

To access all of the meetings call 1-877-267-1577 and enter the WebEx Meeting Number.

- **June 21, 3 p.m. to 4 p.m.**
 - WebEx Meeting Number: 996 196 415
 - [Click here](#) to view the presentation online
- **June 29, 3 p.m. – 4 p.m.**
 - WebEx Meeting Number: 994 831 426
 - [Click here](#) to view the presentation online
- **July 19, 3 p.m. – 4 p.m.**
 - WebEx Meeting Number: 997 909 667
 - [Click here](#) to view the presentation online
- **July 27, 3 p.m. – 4 p.m.**
 - WebEx Meeting Number: 999 454 534
 - [Click here](#) to view the presentation online.

Presentation materials will be posted as downloads on the [Providers Tab of the PERM Website](#).

**Program Integrity
DMA, 919-814-0000**

Attention: Behavioral Health Providers, LME-MCO**R**ecoupment of Funds with Retroactive Change in LME-MCO Enrollment

On May 1, 2016, NCTracks began a new process of handling retroactive enrollment in a Local Management Entity-Managed Care Organization (LME-MCO). When new or updated eligibility and enrollment records are received from NC FAST, NCTracks creates new capitation claims or voids and recoups previously paid capitation claims, based on the retroactive change in LME-MCO enrollment. There is no time limit for how far back the NCTracks records will be updated. However, the newly created or voided/recouped capitation claims are allowed to go back no more than 24 months prior to the payment-processing month from when the updates are received.

Fee for service claims are impacted by this change when a beneficiary is retroactively enrolled in an LME-MCO. In this situation, the fee for service claims for behavioral health services that are covered by the LME-MCO – which paid during the time the recipient was retroactively enrolled in the LME-MCO – are systematically voided and the payment recouped.

Voided claims are reported on the providers' Remittance Advice (RA) with Explanation of Benefits (EOB) 06038 – CLAIM RECOUPED BASED ON RECENT ELIGIBILITY UPDATE. SERVICE IS COVERED BY BEHAVIORAL HEALTH MANAGED CARE PLAN. SUBMIT CHARGES TO RECIPIENT'S LME MCO.

If a provider has fee for service claims systematically voided and recouped due to retroactive enrollment in an LME-MCO, the provider can submit claims to the recipient's LME-MCO for reimbursement.

For more information about the impact to capitation claims when new or updated eligibility and enrollment records are received from NC FAST, refer to the [LME-MCO Communication Bulletin #J196](#).

CSRA, 1-800-688-6696

Attention: Chiropractors**C**hiropractic Crosswalk from ICD-9 to ICD-10 Complete

On Oct. 1, 2015 providers were required to transition from the use of ICD-9 codes to ICD-10 codes due to a federal mandate. The crosswalk from ICD-9 to ICD-10 for chiropractic editing was incomplete.

DMA has identified and resolved these issues in NCTracks. Providers who had claims deny can resubmit these claims for processing.

Clinical Coverage Policy 1F, *Chiropractic Services*, will be updated to include the complete list of ICD-10 codes. Refer to future Medicaid Bulletin articles for the correction of ICD-10 codes in this policy.

Practitioners and Facilities

DMA, 919-855-4320

Attention: Chiropractors and Podiatrists

Instructions for MPW Chiropractic and Podiatry Prior Approval

Chiropractors and Podiatrists must use the following procedure when submitting a prior approval (PA) request for a Medicaid for Pregnant Women (MPW) beneficiary.

- All chiropractic and podiatric PA requests must be entered through the NCTracks Provider Portal. Faxed or mailed requests will **not** be accepted.
- A signed and dated referral from the OB/GYN is required (a medical assistant's signature is not accepted).
- The MPW PA form ([DMA-0002](#)) on the NCTracks website can be used as the referral, or the referral can be written on the provider's letterhead. The OB/GYN must complete, sign and date the referral. The referral must be uploaded and attached to the PA request.
- If a provider is unable to upload the referral, the provider should print the PA cover sheet with the bar code, attach the referral, and mail or fax them to CSRA.

Note: This method of submission will delay PA processing.

- The referral must be dated on or before the effective begin date of the PA request.
- The referral **must** state the reason the treatment is medically necessary and how it is related to pregnancy. The referral **cannot** just say the patient needs treatment for "pain".
- The referral must state the specific number of visits being requested for the beneficiary. Only listing the number of visits on the detail line will result in the PA being sent back for additional information.
- PA requests are approved for up to a 60 calendar day duration. If the beneficiary requires a longer period of time for treatment, a new PA request with a newly signed and dated referral must be entered into NCTracks.

For more information on MPW chiropractic and podiatric PA, see the [Feb. 12, 2016, announcement](#) on the NCTracks Provider Portal.

CSRA, 1-800-688-6696

Attention: Community Alternatives Program for Children (CAP/C) Stakeholders

Announcement of the Expiration of Two CAP/C HCPCS Codes

The single G-code of G0154 for skilled nursing services expired effective **Dec. 31, 2015**. Claims for G0154 submitted with a date of service on or after Jan.1, 2016 will deny. The Community Alternatives Program for Children (CAP/C) Unit is in the process of establishing replacement HCPCS codes for G0154 and G0156 specific to the CAP/C waiver.

Claims that were denied due to expired G-codes should be resubmitted for payment when the replacement codes are available. The replacements codes for G0154 and G0156 should be available to use by June 2016 and will be retroactive to Jan. 1, 2016.

The following chart provides instructions on how to use the replacement HCPCS codes:

Expired HCPCS Codes	Replacement Codes
G0154TD	S9123
G0154TE	S9124
G0156TG	S9122TG
G0156TF	S9122TF

**Long-Term Services and Supports Section, CAP/C
DMA, 919-855-4360**

Attention: Community Care of North Carolina/Carolina ACCESS (CCNC/CA) Providers

Managed Care Referrals in NCTracks

Prior to rendering treatment, providers must obtain a managed care referral from the beneficiary's assigned Community Care of North Carolina/Carolina ACCESS (CCNC/CA) Primary Care Provider, **unless** the specific service is exempt from managed care referral requirements.

For a listing of exempt services, see Section 6.4.4.3.2 "Services Exempt from CCNC/CA Authorization" in the *Provider Claims and Billing Assistance Guide*, located on the [NCTracks Provider Policies, Manuals, Guidelines and Forms web page](#).

Currently, providers may use the National Provider Identifier (NPI) of the beneficiaries' CCNC/CA provider on the claim. However, CCNC/CA providers have the option to enter managed care referrals directly into NCTracks, and are encouraged to become familiar with this process. Providers should begin provisioning their staff that may use this function in NCTracks.

For more information on entering managed care referrals in NCTracks, see Section 6.4.2.1 "Managed Care Referrals: Submission" in the *Provider Claims and Billing Assistance Guide* or Section 5.0 the *NCOMMIS Prior Approvals: Medical (Providers) Participant User Guide* in SkillPort.

[Regional consultants](#) also are available to answer questions regarding Carolina ACCESS.

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

Attention: Hospital Providers

Billing Requirements for 340B Drugs

On Jan. 21, 2016, the Centers for Medicare & Medicaid Services (CMS) issued the final Outpatient Pharmacy Drugs Policy. The N.C. Division of Medical Assistance (DMA) is clarifying that the definition of “outpatient pharmacy” with respect to outpatient hospital pharmacy services.

In defining retail community pharmacy and covered outpatient drugs, CMS excluded pharmacies that dispense medications to patients primarily through hospital pharmacies and outpatient hospital services.

CMS defines a retail community pharmacy as an independent pharmacy, a chain pharmacy, a supermarket pharmacy, or a mass merchandiser pharmacy that is licensed as a pharmacy by the state and that dispenses medications to the general public at retail prices. Such term does not include a pharmacy that dispenses prescription medications to patients primarily through the mail, nursing home pharmacies, long-term care facility pharmacies, hospital pharmacies, clinics, charitable or not-for-profit pharmacies, government pharmacies, or pharmacy benefit managers.

As published the article *340b Purchased Drugs* in the [August 2012 Medicaid Bulletin](#), drugs dispensed by a hospital to its patients during an outpatient visit are not considered “retail” pharmacy transactions. Since the patient is registered as a hospital outpatient for services and procedures – and the drugs are incidental to the outpatient services – the cost of the drugs is included in the outpatient settlement.

As such, the drugs must be billed to DMA at their usual and customary charge, including those drugs used from the 340b inventory. To do otherwise would be in conflict with Medicare cost reporting guidelines. Transactions of outpatient hospital services are billed to DMA on a UB-04 or 837i transaction. Those drugs from the 340b inventory are billed with a UD modifier to indicate a 340b claim and will not be included in the rebate calculation.

Hospital “retail” pharmacy claims can be submitted as either a Point-Of-Sale or as 837p transactions. 837p transactions must contain a UD modifier added to the claim when a drug is administered from 340b inventory. Point-Of-Sale transactions must contain a claims submission code (either an 8 in the basis of cost field or a 20 in the submission clarification field) when a drug is dispensed from 340B inventory. 340b drug claims identified with either a UD modifier or a claims submission code will not be included in the rebate collection. Since these transactions are not cost settled, the pharmacy is required to bill DMA at the acquisition cost of the 340b drug when 340b drug is administered or dispensed.

**Pharmacy Services
DMA, 919-855-4300**

Attention: Outpatient Specialized Therapy Providers

Update on Outpatient Specialized Therapy Claims and Prior Authorization

As of May 1, 2016, Outpatient Specialized Therapy claims deny when the required prior authorization (PA) has been denied, has expired, or the number of authorized units has been exhausted. This applies to all N.C. Medicaid and N.C. Health Choice (NCHC) claims adjudicated on or after May 1, 2016.

During claim adjudication, claims are matched with prior authorizations. Explanation of Benefit (EOB) 01807 (PRIOR AUTHORIZATION FOR OUTPATIENT SPECIALIZED THERAPY SERVICES IS MISSING OR EXHAUSTED) is posted on institutional (837I/UB-04) and professional claims (837P/CMS-1500 format) when no PA is found during that matching process. If the units on the claim exceed the number of available units on the PA, the claim also denies for this EOB; no cutbacks are applied. This EOB also is applied when no valid PA is on file.

Note: Inpatient services and services provided by Local Education Agencies (billing taxonomy 251300000X) are not required to obtain PA for specialized therapies and do not bill with a rendering provider.

The NCTracks system searches, compares and confirms that the information on the PA and claim are valid, accurate and matching. During this process, NCTracks also compares the provider taxonomy code to the procedure code to ensure that the procedure code/revenue code is a valid service for the provider type.

Outpatient Specialized Therapy providers can only bill for therapy services. These providers are identified by taxonomy codes. (See list below.) These providers are the rendering provider on professional claims and the attending provider on outpatient institutional claims.

- 231H00000X-Audiologist
- 225X00000X-Occupational Therapist
- 225100000X-Physical Therapist
- 227900000X-Respiratory Therapist, Registered
- 235Z00000X-Speech-Language Pathologist

Institutional Claims

Two EOBs for claim adjudication were created that are applicable only to institutional claims when the attending provider taxonomy is a specialized therapy provider based on the taxonomy codes above.

- EOB 1790 (MAX SUBMITTED UNITS FOR REVENUE CODES FOR OUTPATIENT SPECIALIZED THERAPY IS ONE) is applied when revenue codes 0420, 0424, 0430, 0434, 0440 and 0444 are billed with units greater than one.
- EOB 01827 (SPECIALIZED THERAPY PROVIDERS MAY ONLY RENDER PROVIDER TYPE SPECIFIC THERAPY SERVICES) is applied when the provider has billed a service that is not a specialized therapy service.

For more information regarding guidelines and requirements, refer to [clinical coverage policies for specialized therapies](#) on the N.C. Division of Medical Assistance (DMA) website.

CSRA, 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 the DMA 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
June 2016	06/02/16	06/07/16	06/08/16
	06/09/16	06/14/16	06/15/16
	06/16/16	06/21/16	06/22/16
	06/30/16	07/06/16	07/07/16
July 2016	07/07/16	07/12/16	07/13/16
	07/14/16	07/19/16	07/20/16
	07/21/16	07/26/16	07/27/16
	07/28/16	08/02/16	08/03/16

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