July 2016 Medicaid Bulletin

Attention: All Providers

Consolidation of NCTracks Fax Numbers

In some cases, it may be appropriate or necessary to fax information to NCTracks. To simplify this process, fax submissions to NCTracks should use the appropriate number listed below:

Subject	Fax Number
Non-Pharmacy Prior Approval (and Carolina ACCESS Overrides)	855-710-1964
Pharmacy Prior Approval	855-710-1969
Call Center (and all other correspondence)	855-710-1965

These fax numbers have been in use since NCTracks went live on July 1, 2013. **As of July 1, 2016, they are the only valid fax numbers for NCTracks. All other fax numbers have been discontinued.**

Consolidation of the fax numbers enables requests from providers to be routed quicker to the appropriate team. The Contact Information document under Quick Links on the NCTracks Provider Portal has been updated to reflect this change.

Note: When possible, it is faster to submit information to NCTracks through the secure Provider Portal than by faxing it.

CSRA, 1-800-688-6696

Attention: All Providers

Manage Change Request and Reverification Application Process

Most providers are required to submit a full Managed Change Request (MCR) before submitting a re-verification application. The due date for the re-verification application is extended an additional 45 calendar days if a MCR is still in process. MCR's and reverification applications are processed in the order in which they are received.

Authorized users are able to check the status of MCRs/Reverification applications by viewing the Status and Management page within the secure NCTracks Provider Portal.

CSRA, 1-800-688-6696

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/re-verification. 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 statuses 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. Out-of-state providers must complete the enrollment process every 365 days. 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

Affiliation Claim Edit

Note: This is a reposting of an article from the June 2016 Medicaid Bulletin with a revised implementation date.

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 Nov. 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

Claim Edit for Rendering Provider Service Location

Note: This is a reposting of an article from the June 2016 Medicaid Bulletin with a revised implementation date.

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 Nov. 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

Clinical Coverage Policies

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

- 1F, Chiropractic Services Policy (7/1/16)
- 10A, Outpatient Specialized Therapies (6/1/16)

These policies supersede previously published policies and procedures.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

NCTracks Call Center Closed for Independence Day

The NCTracks Call Center will be closed Monday, July 4, in observance of Independence Day. (The Pharmacy Prior Approval Unit will be open holiday hours from 7:00 a.m. to 6:00 p.m.)

In keeping with the published 2016 checkwrite schedule, that week's checkwrite date will be Wednesday, July 6. The posting and availability of funds to provider bank accounts will depend on the provider's financial institution. Bank of America customers should see payments posted to their accounts the same day the EFT is processed – Thursday, July 7. Providers who bank at other financial institutions should see payments posted the afternoon of the following day – Friday, July 8. (Some may post sooner.)

The 2016 checkwrite schedules can be found under Quick Links on the NCTracks [Provider Portal home page](#).

CSRA, 1-800-688-6696

Attention: All Providers

Update to NCTracks System Requirements

The NCTracks System Requirements web page has been updated to list current versions of internet browsers that are compatible with NCTracks. Providers are encouraged to review this information which can be found by clicking the [System Requirements link](#) in the footer of any NCTracks web page.

CSRA, 1-800-688-6696

Attention: Chiropractors

Updated Clinical Coverage Policy 1F Chiropractic Services

As of July 1, 2016, Clinical Coverage Policy (CCP) 1F, *Chiropractic Services*, has been updated to include the complete list of primary and secondary ICD-10 codes that can be reported by chiropractors on claims. Refer to Attachment A, Section B of CCP 1F, *Chiropractic Services,* for the Updated ICD-10 codes.

Practitioners and Facilities
DMA, 919-855-4320

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 (PCP), **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. As announced in a June 2016 Medicaid Special Bulletin, effective Nov. 1, 2016 NCTracks will deny a claim when an NPI is not submitted for the ordering provider, referring provider, operating provider, or service facility.

Editing must also be implemented to ensure that the ordering provider or the referring provider is an individual; claims should not be paid if the ordering provider or the referring provider is identified in the system as an organization. Beginning with dates of service Nov. 1, 2016, CCNC/CA referrals must be entered directly into NCTracks. Providers will no longer submit the beneficiary's PCP organization NPI on the claim for CCNC/CA referrals.

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 *NCMMIS Prior Approvals: Medical (Providers) Participant User Guide* in SkillPort. **Training is scheduled for July and will be announced on NCTracks.**

Regional consultants also are available to answer questions regarding Carolina ACCESS.

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

Attention: Nurse Practitioners, Physician Assistants and Physicians

Coagulation Factor IX (Recombinant), Albumin Fusion Protein] for intravenous injection (Idelvion®) HCPCS code J7199: Billing Guidelines

Effective with date of service March 15, 2016, the N.C. Medicaid and North Carolina Health Choice (NCHC) programs cover Coagulation Factor IX (Recombinant), Albumin Fusion Protein (Idelvion) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J7199 – Hemophilia clotting factor, not otherwise classified. Idelvion is currently commercially available as single-use vials in nominal strengths of 250 IU, 500 IU, 1,000 IU and 2,000 IU of Factor IX activity.

Idelvion is indicated in children and adults with hemophilia B (congenital Factor IX deficiency) for on-demand control and prevention of bleeding episodes, perioperative management of bleeding, and routine prophylaxis to prevent or reduce the frequency of bleeding episodes. Idelvion is not indicated for immune tolerance induction in patients with hemophilia B.

The dose and duration of therapy depend on the severity of the Factor IX deficiency, the location and extent of the bleeding and the patient's clinical condition, age and recovery of Factor IX.

The required dose of IDELVION for **treatment of bleeding episodes** is determined using the following formula:

>   Required Units (IU) = Body Weight (kg) x Desired Factor IX rise (% of normal or IU/dL) x (reciprocal of recovery (IU/dL per IU/kg))

>   **OR**

>   Increase in Factor IX IU/dL (or % of normal) = Dose (IU) x Recovery (IU/dL per IU/kg)/ body weight (kg)

Adjust the dose based on the individual patient's clinical condition and response

Dosing for routine prophylaxis

For patients age 12 and over: 25-40 IU/kg every 7 days. Patients who are well-controlled on this regimen may be switched to a 14-day interval at 50-75 IU/kg.

For patients less than 12 years of age: 40-55 IU/kg every 7 days. Adjust the dosing regimen based on individual response.

See package insert for full prescribing information.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis code required for billing Idelvion is D67 - Hereditary Factor IX deficiency.

- Providers must bill Idelvion with HCPCS code J7199 – Hemophilia clotting factor, not otherwise classified.

- One Medicaid unit of coverage for Idelvion is one IU. NCHC bills according to Medicaid units. The maximum reimbursement rate per unit is $5.10000.

- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Idelvion are 69911-0864-02, 69911-0865-02, 69911-0866-02, and 69911-0867-02.

- The NDC units for Idelvion should be reported as "UN1".

- For additional information, refer to the January 2012, Special Bulletin, *National Drug Code Implementation Update*.

- For additional information regarding NDC claim requirements related to the PDP, refer to the PDP Clinical Coverage Policy No. 1B, Attachment A, H.7 on DMA's website.

- Providers shall bill their usual and customary charge for non-340B drugs.

- PDP reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340-B participating providers who have registered with the Office of Pharmacy Affairs (OPA). Providers billing for 340-B drugs shall bill the cost that is reflective of their acquisition cost. Providers shall indicate that a drug was purchased under a 340-B purchasing agreement by appending the "UD" modifier on the drug detail.

- The fee schedule for the PDP is available on DMA's PDP fee schedule web page.

CSRA, 1-800-688-6696

Attention: Outpatient Specialized Therapy Providers

Outpatient Specialized Therapy Claim Denials for Prior Authorization

Some Outpatient Specialized Therapy providers are receiving claim denials with EOB 01807-OUTPATIENT SPECIALIZED THERAPY SERVICES REQUIRE PRIOR AUTHORIZATION.

In most of these cases, the benefit health plan on the prior authorization for the recipient is incorrect. The benefit health plan is different than the NCTracks eligibility information. Providers need to submit a new prior authorization request to The Carolinas Center for Medical Excellence (CCME) and request prior authorization under the correct benefit health plan.

(This is a follow-up to the April 29 announcement.)

Outpatient Specialized Therapies
DMA, 919-855-4260

Attention: Pharmacy Providers and Prescribers

Nucala (mepolizumab) Now Covered

Nucala is now covered by N.C. Medicaid and N.C. Health Choice (NCHC) with prior approval (PA). The PA criteria can be found on the NCTracks Prior Approval Drugs and Criteria page. Providers may request Nucala using the temporary PA forms. Providers must mail or fax the PA request using the Standard Drug Request Form as the first (top) page and add the Nucala PA Attachment behind it.

The CSRA Pharmacy PA fax number is 855-710-1969. This information also is available on the NCTracks Pharmacy Services web page.

CSRA, 1-800-688-6696

Attention: Pharmacy Providers

Pharmacy Reimbursement Methodology Changes

Note: This is an update to the May 2016 Medicaid Pharmacy Newsletter.

On Jan. 11, 2016, the Centers for Medicare & Medicaid Services (CMS) notified the Division of Medical Assistance (DMA) that State Plan Amendment (SPA 14-047) had been reviewed, was consistent with 42 CFR 430.20 and was **approved effective Jan. 1, 2016**.

The approved SPA proposes that the state will use an average acquisition cost (AAC) reimbursement methodology to reimburse brand and generic drug ingredient costs. The National Average Drug Acquisition Cost (NADAC) will be used to determine the AAC when NADAC is available. If NADAC pricing is not available, the state will calculate the AAC as the Wholesale Acquisition Cost (WAC) + 0 percent. Reimbursement methodology will continue to include the lesser of NADAC, or WAC in absence of NADAC, and the State Maximum Allowable Cost (SMAC) rate on file. The amendment also proposed that the state pay pharmacies a tiered dispensing fee as follows:

- $13.00 when 85 percent or more claims per quarter are for generic or preferred brand drugs,
- $7.88 when less than 85 percent of claims per quarter are for generic or preferred brand drugs, and,
- $3.98 for non-preferred brand drugs

A NADAC FAQ has been posted on the DMA website.

These changes are being implemented in NCTracks on Aug. 1, 2016. Pharmacy claims paid between January 1 and July 31, 2016, will be reversed and rebilled according to the updated reimbursement methodology. An announcement will be posted in the Medicaid Bulletin and Pharmacy Newsletter when the date for the claim reprocessing has been finalized.

Until then, pharmacies will continue to be paid according to the current reimbursement methodology. Pharmacies are advised that this may result in an overpayment once the reverse and rebilling process is completed. Any difference will be recouped from future payments.

CSRA, 1-800-688-6696

Attention: Therapeutic Foster Care and Day Treatment Providers

Direct Enrollment for Therapeutic Foster Care and Day Treatment Providers for Services Provided to Medicaid Beneficiaries Ages 0 – 3 and Legal Aliens and for N.C. Health Choice Beneficiaries

Therapeutic Foster Care (TFC) and Children and Adolescent Day Treatment providers must be directly enrolled in N.C. Medicaid and N.C. Health Choice (NCHC) via NCTracks by **Oct. 1, 2016** in order to be reimbursed for services provided to:

1. Children age 0 – 3
2. Legal Aliens of any age
3. NCHC Beneficiaries

NCTracks is currently processing these enrollment applications.

Pass-through billing for TFC by Local Management Entities-Managed Care Organizations (LME-MCOs) will no longer be allowed after a provider's direct enrollment date or after Oct. 1, 2016, whichever is earliest. **Claims for services which are provided <u>before</u> the provider's direct enrollment date cannot be billed to the provider's NPI.**

Some providers are already approved to provide services to beneficiaries via a pass-through NPI authorization. If the dates of the pass-through NPI encompass the provider's enrollment date, providers must request a Provider NPI Change for the authorization through Beacon Health Options. This NPI change will ensure direct payment of claims to providers.

Specific enrollment application requirements for each of these provider types are presented below.

Therapeutic Foster Care Providers:

- To submit an application, go to the [NCTracks Provider Enrollment web page](#) and follow directions.

- Provider agencies that are not already enrolled in NCTracks will be required to pay a $100.00 enrollment fee and $554 ACA fee upon submission of their applications.

- Agencies that are already enrolled to provide other services and will be adding the TFC taxonomy for these services to their enrollment file will not be subject to this charge.

- As a behavioral health service provider, this provider type is considered High Risk and will be subject to a site visit by Public Consulting Group.

- Ownership will be subject to background checks.

- Use Taxonomy: 253J00000X

- Submit an active license from the Department of Social Services.

Day Treatment for Children and Adolescents Providers

- To submit an application, go to [NCTracks provider enrollment web page](#) and follow directions.

- Provider agencies that are not enrolled in NCTracks will be required to pay a $100.00 enrollment fee and $554 ACA fee upon submission of their applications.

- Agencies that are already enrolled to provide other community mental health services with a taxonomy of 251S00000X and will be adding Day Treatment to their enrollment file will not be subject to this charge.

- Agencies providing this service must be currently certified as a Critical Access Behavioral Health Agency (CABHA).

- As a behavioral health services provider, this provider type is considered high risk and will be subject to a site visit by Public Consulting Group.

- Ownership will be subject to background checks.

- Use Taxonomy: 251S00000X and submit proof of being credentialed to provide this service from your Prepaid Inpatient Health Plan.

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
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
August 2016	08/04/16	08/09/16	08/10/16
	08/11/16	08/16/16	08/17/16
	08/18/16	08/23/16	08/24/16
	08/25/16	08/30/16	08/31/16

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