



North Carolina Medicaid Bulletin December 2016

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***Providers are responsible for informing their billing agency of information in this bulletin.
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All rights reserved. Applicable FARS/DFARS apply.***

Attention: All Providers**N.C. Medicaid Electronic Health Record (EHR) Incentive Program Announcement****90-day Meaningful Use (MU) Reporting Period in Program Years 2016 and 2017**

Effective Nov. 14, 2016, the Centers for Medicare & Medicaid Services (CMS) [Hospital Outpatient Prospective Payment System \(OPPS\) Final Rule](#) allows all providers to use a **90-day MU reporting period** in Program Years 2016 and 2017. The N.C. Medicaid Incentive Payment System ([NC-MIPS](#)) has been updated to accommodate this change in reporting.

Five Months Remaining to Participate in the EHR program

Since 2011, the N.C. Medicaid EHR Incentive Program has paid more than \$299 million in incentives to providers for adopting, implementing or upgrading to a certified EHR technology and meaningfully using that technology in their practice. Only five months remain to begin participating in the program, so providers who are interested should begin the process now.

In addition to earning \$63,750 over six years, the use of certified EHR technology can help a practice achieve measurable improvements in patient health care.

Providers are eligible for the incentive if they:

1. Have a [CMS-certified EHR](#)
2. Are Medicaid physicians, nurse practitioners, certified nurse midwives or dentists (some physician assistants also qualify), and;
3. Have at least 30 percent Medicaid-enrolled patients

Program Year 2016 is the last year to start participating and earn the first year payment of \$21,250. NC-MIPS is accepting Program Year 2016 Adopt, Implement, Upgrade (AIU) and MU attestations through April 30, 2017 and providers have until then to submit a complete and accurate attestation. **After that, no changes can be made.** Providers are encouraged to attest as soon as possible to give time to address any problems and discrepancies.

Assistance is available through step-by-step attestation guides, an extensive library of answers to Frequently Asked Questions (FAQs), webinars and a dedicated [help desk](#). Providers can receive free onsite support for meeting MU criteria, and guidance in registering and attesting, from our technical assistance partners at the regional [NC AHECs](#).

For more information on how to start participating, visit the [N.C. Medicaid EHR Incentive Program web page](#), or send an email to NCMedicaid.HIT@dhhs.nc.gov.

N.C. Medicaid EHR Incentive Program
NCMedicaid.HIT@dhhs.nc.gov (email preferred)

Attention: All Providers**CCNC/CA Payment Authorization - Clarification**

The N.C. Division of Medical Assistance held trainings on this topic during the month of October, 2016. This article focuses on the questions and concerns raising during those trainings. For more information, read the [September 2016 Special Medicaid Bulletin, CCNC/CA Payment Authorization Update](#).

Providers are encouraged to continue supporting the Community Care of North Carolina / Carolina ACCESS (CCNC/CA) program, which is designed to improve quality and access to care; manage appropriate utilization of services; and achieve cost-effectiveness through care coordination with CCNC/CA Primary Care Providers (PCP).

CCNC/CA “referral” authorizations **are payment authorizations in NCTracks. CCNC/CA payment authorizations are not related to ordering, prescribing or referring (OPR) provider requirements.** A service referral is the process of sending a patient to another practitioner (e.g., specialist) for consultation, or a health care service that the CCNC/CA PCP believes is necessary but is not able to provide.

Service referral requirements are not changing for CCNC/CA providers

CCNC/CA PCP must continue to adhere to care coordination practices as set forth in Section IV of the *NC DHHS Agreement for Participation as a CCNC/CA Provider*. The PCP in the medical home will continue to arrange service referrals for medically necessary health care services and specialty care as required by the agreement. The following CCNC/CA guidelines apply to service referrals:

- Providers must promptly arrange or receive authorization for referrals and document referrals for specialty care in the medical record.
- Referrals may be made by phone or in writing.
- The PCP must define the scope of the referral, including the number of visits and length of time authorized.
- A provider who has received a referral should consult with the PCP before referring to a secondary provider.

Important changes related to the submission of CCNC/CA payment authorizations are contained in this article.

Effective Nov. 1, 2016, providers are no longer required to:

- Enter a CCNC/CA payment authorization on claims. *The NPI of the CCNC/CA provider was previously used on the claim as payment authorization.*

Note: The field that was used for CCNC/CA payment authorizations was repurposed to meet the requirements for OPR providers. Therefore, CCNC providers should only populate this field to comply with OPR requirements. If you populate this field, the OPR edits will be applied to your claims. The OPR edits can be found in the September 2016 Special Medicaid Bulletin, [Update Federal Regulations: 42 CFR 455.410 Attending, Rendering, Ordering, Prescribing or Referring Providers and 42 CFR 455.440 National Provider Identifier.](#)

- Enter a CCNC/CA payment authorization into the NCTracks provider portal.
- Request CCNC/CA overrides. **Specialists and Urgent Cares will no longer be required to have the CCNC/CA PCP NPI on the claim for their claims to process.**

For dates of service prior to Nov. 1, 2016, claims will continue to require the CCNC/CA payment authorization NPI on the claim or a CCNC/CA override in NCTracks.

Providers are encouraged to routinely review NCTracks Announcements and Medicaid Bulletins for important program updates.

Regional Consultants are available to assist providers with questions on CCNC/CA Payment Authorizations. The DMA website contains a [current list of consultants.](#)

DMA held [webinars](#) regarding these changes throughout the month of October. Additional webinars will be held in November and December.

Tuesday, Nov. 29, 2016, 10:00 – 11:30AM EST

Register at: <https://attendee.gototraining.com/r/7503307420137125889>

Webinar Call in Information:

Toll: +1 (510) 365-3231

Access Code: 363-646-861

Thursday, Dec. 8, 2016, 10:00 – 11:30AM EST

Register at: <https://attendee.gototraining.com/r/3965557289512177153>

Webinar Call in Information:

Toll: +1 (510) 365-3331

Access Code: 123-659-766

Tuesday, Dec. 13, 2016, 10:00 – 11:30AM EST

Register at: <https://attendee.gototraining.com/r/5366252639926788353>

Webinar Call in Information:

Toll: +1 (510) 365-3332

Access Code: 928-827-899

It is important for providers to be aware of the changes beginning with dates of service on or after Nov. 1, 2016, including CCNC/CA payment authorizations, to avoid disruptions in claim reimbursements. Questions about this Medicaid Bulletin article can be directed to the CSRA Call Center at 1-800-688-6696.

Provider Services

DMA, 919-855-4050

Attention: All Providers

OPR and National Provider Identifier - Clarification

The N.C. Division of Medical Assistance held trainings on this topic during the month of October, 2016. This article focuses on the questions and concerns raising during those trainings. For more information, read the [September 2016 Special Medicaid Bulletin, Update: Federal Regulations: 42 CFR 455.410 Attending, Rendering, Ordering, Prescribing or Referring Providers and 42 CFR 455.440 National Provider Identifier](#).

Beginning with date of service Feb. 1, 2016, the N.C. Department of Health and Human Services (DHHS) implemented an interim action for any claim from a provider who had a National Provider Identifier (NPI) but was not enrolled in N.C. Medicaid or N.C. Health Choice (NCHC). This action resulted in a “pay and report edit” appearing on the Remittance Advice (RA). The Explanation of Benefits (EOB) language identified which NPI is not currently enrolled in N.C. Medicaid and/or NCHC. Providers received an EOB warning message on their RA when the attending, rendering, ordering, prescribing or referring provider’s NPI submitted on the billing provider’s claim was not enrolled in the N.C. Medicaid or NCHC program.

According to Federal Regulation 42 CFR 455.410, any physician or other practitioner who orders, prescribes, refers or renders services to N.C. Medicaid or Children’s Health Insurance Program (CHIP) beneficiaries **must be enrolled in those programs**. In North Carolina, the CHIP program is called N.C. Health Choice (NCHC).

42 CFR 455.440 requires the NPI of any ordering or referring physician or other professional to be specified on any claim for payment. **Effective Nov. 1, 2016, DMA will implement new editing in NCTracks to be compliant with the Federal guidelines.** Therefore, for NCTracks to reimburse for services or medical supplies resulting from a practitioner's order, prescription, or referral, the ordering, prescribing or referring provider must be enrolled in N.C. Medicaid or NCHC.

Effective Nov. 1, 2016, the following changes are in effect:

1. When the claim is billed with non-enrolled provider’s NPI, the edit disposition will change from a “pay and report” status to **“pend”** status. This change will have the following claim impact:
 - a. The claim will pend for **90 days** to allow the attending, rendering, ordering, prescribing or referring provider(s) to enroll in the NC Medicaid or NCHC program.
 - b. The EOB language reported on the RA when the claim pends will remain the same for this edit.

- c. If, after 90 days from the date of the claim pending, the attending, rendering, ordering, prescribing, or referring provider **is not enrolled**, the claim **will deny** with the EOB: “the attending, rendering, ordering, prescribing or referring provider is not enrolled.”

Note: A streamlined application for Ordering, Prescribing and Referring (OPR) providers will be available through NCTracks in the early months of 2017. In the interim, OPR providers may enroll using the existing full enrollment application for individual providers.

2. The provider’s NPI will be required as a data element on the claim for claim types listed in the September 2016 Medicaid Special Bulletin, [Update Federal Regulations: 42 CFR 455.410 Attending, Rendering, Ordering, Prescribing or Referring Providers and 42 CFR 455.440 National Provider Identifier](#). All providers should note that any NPI entered on a claim will be validated, even if it is not required for that service/claim type. DMA will accept the Supervising Physician’s NPI on the claim for any Resident or Intern in a Graduate Dental and Medical Education program.
3. In accordance with 42 CFR 415.208, DMA covers the services of moonlighting residents which are defined as “services that licensed residents perform that are outside the scope of an approved GME program.” For example, the physician may work at an Emergency Department that is not part of the approved GME program.

The resident must be fully licensed to practice medicine, osteopathy, dentistry or podiatry by the state in which the services are performed and enrolled with NC DMA. These services are considered to have been furnished by the individual as a physician, dentist or podiatrist and not as a resident.

4. DMA will continue to utilize the NPI Exemption List in NCTracks which allows residents and interns enrolled in Graduate Dental and Medical programs and Area Health Education Centers to be exempt from the provider enrollment requirement through June 2017. The exemption from the provider enrollment requirement does not include an exemption from the DEA registration requirement for controlled substances.
5. **Note:** The information contained in this article does not pertain to the Community Care of North Carolina/Carolina Access (CCNC/CA) referral authorization requirements and processes. A separate article in this bulletin, [CCNC/CA Payment Authorization Update](#), addresses CCNC/CA.

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, ordering, prescribing or referring provider from enrolling with N.C. Medicaid or NCHC.

Billing providers should verify the enrollment of the ordering, prescribing or referring practitioner before services are provided. As of May 1, 2016 the “Enrolled Practitioner Search Function” was made available on NCTracks provider portal. 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.

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](#).

DMA held [webinars](#) regarding these changes throughout the month of October. Additional webinars will be held in November and December:

Tuesday, Nov. 29, 2016, 10:00 – 11:30AM EST

Register at: <https://attendee.gototraining.com/r/7503307420137125889>

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Register at: <https://attendee.gototraining.com/r/5366252639926788353>

Webinar Call in Information:

Toll: +1 (510) 365-3332

Access Code: 928-827-899

Also review DMA’s [Frequently Asked Questions \(FAQs\) regarding OPR Requirements](#).

Provider Services

DMA, 919-855-4050

Attention: All Providers

Re-credentialing Due Dates for Calendar Year 2017

List of Providers due for Re-credentialing

A list of providers scheduled for re-credentialing in calendar year 2017 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/re-validation 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 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 reverification application by the reverification 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 Call Center at 1-800-688-6696 (phone); 919-710-1965 (fax) or NCTracksprovider@nctracks.com (email).

Provider Services
DMA, 919-855-4050

Attention: All Providers**Affiliation Claim Edit**

Note: This is an update of an article from the [November 2016 Medicaid Bulletin](#), including a revised implementation date of Feb 6, 2017.

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. Currently, the disposition of Edit 07025 has been set to “pay and report.” 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).

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.

This is the revised implementation date: Effective Feb. 6, 2017, the claim edit disposition will change from “pay and report” to “pend” and will no longer give the informational message. Once the disposition is changed, a claim failing the edit will suspend for 60 days. Providers will continue to receive EOB 07025:

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.

If the affiliation relationship is not established within 60 days, 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 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 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**C**laim Edit for Rendering Provider Service Location

Note: This is a reposting of an article from the [November 2016 Medicaid Bulletin](#) with a revised implementation date of Feb. 6, 2017.

Rendering providers must list the addresses of all facilities where they perform services as provider service locations under their National Provider Identifiers (NPIs) in NCTracks. This claim edit has been in place since March 2, 2015, but has been set to “pay and report” to alert providers to update the rendering provider location on the provider record.

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

It had previously been announced that as of Nov. 1, 2016, the disposition of the edit would change to “pend” the claim while the provider submits an MCR to update the provider record. However, to help prevent a possible disruption in provider payments due to claims pending for Rendering Provider Service Location, the N.C. Division of Medical Assistance (DMA) has decided to delay the disposition change to **Feb. 6, 2017**. This will allow providers additional time to complete all of the MCRs needed to update the Rendering Provider Service Location(s) on their provider record in NCTracks.

Providers are encouraged to take advantage of this extension to submit any additional MCRs needed to ensure that the Rendering Provider record includes all service locations where the provider renders services billed to NCTracks. Note that this change to the provider record must be made by the Office Administrator or Enrollment Specialist for the Rendering Provider.

Rendering providers who have not already submitted an MCR may also use this opportunity to update their affiliations to groups and hospitals. As of Feb. 5, 2017, rendering providers must be affiliated to the group or hospital that bills for their services or the claims will “pend”. (The rendering provider must establish the affiliation. It cannot

be done by the group or hospital.) A single MCR can be submitted to add service locations and affiliate to a group or hospital.

A new Job Aid, *How to Submit a Manage Change Request adding a Service Location and Affiliate an Individual Provider Record to a Group/Organization in NCTracks*, has been posted under the heading “Provider Record Maintenance” on the [Provider User Guides and Training Page](#) of the NCTracks provider portal.

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.

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 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**D**irect Enrollment of Mid-Level Providers - Update

Effective Nov. 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). Providers must file claims for services provided through 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 and/or NCHC providers. Providers with questions about the NCTracks [online enrollment application](#) can contact the CSRA Call Center at 1-800-688-6696 (phone); 919-710-1965 (fax) or NCTracksProvider@nctracks.com (email).

Provider Services
DMA, 919-855-4050

Attention: All Providers**U**sing NCIDs Properly in NCTracks

NCTracks uses the North Carolina Identity (NCID) Management System to identify providers in the NCTracks Provider Portal. NCID is the standard identity management service provided to state, local, business and individual users by the state of North Carolina. NCID is used by all N.C. Department of Health and Human Services (DHHS) providers accessing the NCTracks system.

If someone uses another person’s NCID when submitting provider enrollment applications to NCTracks, the integrity of the application and provider record may be compromised. This may result in adverse action on the provider’s enrollment application and provider’s record.

More information is available in the [NCID Fact Sheet](#).

CSRA, 1-800-688-6696

Attention: All Providers**NCTracks Provider Training Available in December 2016**

Registration is open for several instructor-led training courses for providers which will be held in December. The courses are instructor led and duration varies depending on the course.

All WebEx courses can be attended remotely from any location with a telephone, computer and internet connection. All WebEx courses are limited to 115 participants.

Note: All courses and the day/time they are offered are subject to change.

Submitting a Professional Claim/Recipient Eligibility Verification Infant Toddler Program (ITD) (Division of Public Health) (Webex)

- Monday, Dec. 5 - 9:30 a.m. to noon (WebEx)

This course will cover how to submit a professional (1500/837P) claim in the NCTracks system, with an emphasis on claim level adjustments. This course also will show how to use the Eligibility Verification System (EVS), which provides information on a recipient's eligibility for services in real time. The provider and recipient must be enrolled in the same health plan or benefit plan for eligibility information to be returned. At the end of training, providers will be able to:

- Submit a professional and an institutional claim via NCTracks web portal
- Create a claim
- Save a claim draft
- Use claims draft search
- View results of a claim submission
- Submit an individual recipient eligibility inquiry
- Submit a batch eligibility inquiry
- View an eligibility response.
-

Prior Approval Inquiry - Division of Public Health (DPH) Infant Toddler Program (DPH) (Webex)

- Monday, Dec. 5 – 1 to 2 p.m. (WebEx)

This course will cover how to inquire about previously submitted prior approval (PA) requests for Division of Public Health (DPH) Infant Toddler Program (ITP) recipients. At the end of training, users will be able to inquire about PAs on NCTracks.

Submitting a Professional Claim – Non-Emergency Medical Transportation (NEMT) (Webex)

- Tuesday, Dec. 6 - 1 to 4 p.m.
- Thursday, Dec. 8 - 9 a.m. to noon
- Wednesday, Dec. 14 - 9 a.m. to noon
- Wednesday, Dec. 21 - 9 a.m. to noon

This course will review the process of submitting Non-Emergency Medical Transportation (NEMT) claims through NCTracks. At the end of training, users will be able to:

- Understand claims terminology
- Understand the Prior Approval (PA) process
- Create a professional claim via NCTracks
- Save a draft
- Use claims draft search
- Submit a claim
- View results of a claim submission
- Claim status and claim copy
- Resubmit a claim
- Void prior claim or replacement prior claims
- Understand how to read a remittance advice
- Prior authorization inquiry.

Prior Approval - Dental and Orthodontic (WebEx)

- Friday, Dec. 9 – 9:30 a.m. to noon

This course will cover submitting Prior Approval (PA) Requests for dental and orthodontic procedures to help ensure compliance with Medicaid clinical coverage policy and medical necessity. It will also cover the PA inquiry process to check on the status of a PA request.

Submitting Dental and Orthodontic Claims (WebEx)

- Friday, Dec. 9 – 1 to 4 p.m.

This course will focus on how to submit Dental and Orthodontic Claims via the NCTracks Provider Portal. At the end of training, providers will be able to enter Dental and Orthodontic claims, save a Draft claim, use the Claims Draft Search tool, submit a claim and view the results of a claim submission. This course is taught via WebEx and can be attended remotely from any location with a telephone, computer and internet connection.

Prior Approval - Medical (Professional) (On-site)

- Friday, Dec. 16 - 9:30 a.m. to noon

This course will cover submitting prior approval (PA) requests to help ensure compliance with Medicaid clinical coverage policy and medical necessity. It also will cover PA inquiry to check on the status of a PA Request. The course is being offered in-person at the CSRA facility at 2610 Wycliff Road in Raleigh. It includes hands-on training and will be limited to 45 participants.

Submitting a Professional Claim (On-site)

- Friday, Dec. 16 - 1 to 4 p.m.

This course will focus on how to submit a professional claim via the NCTracks provider portal. At the end of training, providers will be able to enter a professional claim, save a draft claim, use the claims draft search tool, submit a claim and view the results of a claim submission. The course is being offered in-person at the CSRA facility at 2610 Wycliff Road in Raleigh. It includes hands-on training and will be limited to 45 participants.

Enrollment Instructions for All Trainings

Providers can register these courses in SkillPort, the NCTracks Learning Management System. Logon to the secure NCTracks provider portal and click “Provider Training” to access SkillPort. Open the folder labeled **Provider Computer-Based Training (CBT) and Instructor Led Training (ILT)**. The courses can be found in the sub-folders labeled **ILTs: On-site** or **ILTs: Remote via WebEx**, depending on the format of the course.

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.

CSRA, 1-800-688-6696

Attention: Adult Care Homes and Skilled Nursing Facilities

Pre-Admission Screening and Resident Review (PASRR) and N.C. Medicaid Uniform Screening Tool (NCMust) - Update Article

Information about the N.C. Medicaid Uniform Screening Tool (NCMust) can be found at www.ncmust.com. Visitors to NCMust.com will note some minor changes that reflect current practice and provide clarifications of existing policy.

Skilled Nursing Facilities (SNF)

References to “Annual Resident Review,” which was previously required under the Preadmission Screening and Resident Review (PASRR) regulations, have been removed as they are no longer required.

SNF PASRR Codes: At the end of every PASRR number there is an alpha character that indicates the characteristics of the authorization provided. Those codes can now be found on the NCMust.com website as indicated below.

SNF: PASRR – Authorization Codes, Timeframes, Restrictions

- A: Lifetime, no Level of Care (LOC) restrictions
- H: Lifetime, no LOC restrictions. (Dementia primary, or does not meet Level II target population criteria)
- B: No limitation unless change in condition. Must stay in SNF or Hospital LOC. **No** specialized services required
- C: No limitation unless change in condition. Must stay at SNF or Hospital LOC. These individuals receive specialized services
- E: 30-day rehabilitation services only
- D: Seven-day respite or emergency only
- J: Locked state psychiatric hospital or state-operated nursing facility only
- F: 30-, 60- or 90-day time limited stays – Level II reviews only
- Z: Denial – nursing facility placement is not appropriate

Adult Care Homes/Assisted Living Facilities (ACH/ALF)

PASRR screenings are required for Medicaid beneficiaries **prior to admission** to adult care homes.

PASRR and Personal Care Services (PCS): In order to acquire prior authorization for PCS services delivered in adult care homes, the beneficiaries must have valid PASRR screenings. The associated numbers for screenings must reflect the adult care home level of care. Do not mistake SNF PASRR numbers with adult care home PASRR numbers.

Private Pay Admissions to Adult Care Homes: PASRR screenings are not required for persons being admitted to adult care homes who are not Medicaid beneficiaries.

However, a PASRR screening is required when those residents become Medicaid-eligible.

Dementia as Primary Diagnosis: A signed medical doctor's diagnostic statement is required in those cases where a beneficiary has a primary diagnosis of dementia.

End of Life: A certification of terminal illness signed by a medical doctor is required for those beneficiaries who need a time-limited PASRR number for six months or less due to terminal illness.

Related Conditions: "Related Conditions" are not a form of intellectual disability, but produce similar functional impairments and require similar treatment or services. Related conditions must:

- a) Emerge before age 22
- b) Be expected to continue indefinitely, and
- c) Result in substantial functional limitations of three or more life activities (self-care, understanding and use of language, learning, mobility, self-direction and capacity for independent living).

ACH/ALF PASRR Codes: At the end of every PASRR number there is an alpha character that indicates the characteristics of the authorization provided. Those codes can now be found on the NCMust.com website as indicated below.

ACH/ALF PASRR Codes

- G: Dementia primary (requires MD certification)
- O: Level I: No evidence of Severe Mental Illness/Severe and Persistent Mental Illness (SMI/SPMI)
Level II: Referral Notification
- K: Level II: Evidence of SMI/SPMI
- U: Level II: Medically unstable – medical needs cannot be met in adult care home
- R: Level II: Psychiatrically unstable – behavioral health needs cannot be met in adult care home
- T: Time Limited: Six months (Terminal Illness Certification)
- P: Cancelled – private pay
- X: Cancelled (No longer seeking placement / Consent not granted)

More information can be found in an [NCACT Webinar on N.C. PASRR](#). The webinar also can be found on the [DMA Seminars and Trainings web page](#) under the headings "Adult Care Homes" and "Nursing Facilities."

Long Term Services and Supports
DMA, 919-855-4364

Attention: Nurse Practitioners, Physicians Assistants and Physicians

Buprenorphine Implant for Subdermal Administration (Probuphine®) HCPCS code J3490: Billing Guidelines

Effective June 15, 2016, the N.C. Medicaid and N.C. Health Choice (NCHC) Program covers buprenorphine implant for subdermal administration (Probuphine®) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3490 - Unclassified drugs. Probuphine is currently commercially available as an ethylene vinyl acetate (EVA) implant, 26 mm in length and 2.5 mm in diameter, containing 74.2 mg of buprenorphine (equivalent to 80 mg of buprenorphine hydrochloride). Probuphine is a schedule three controlled substance (CIII).

Probuphine is indicated for the maintenance treatment of opioid dependence in patients who have achieved and sustained prolonged clinical stability on low-to-moderate doses of a transmucosal buprenorphine-containing product (i.e., **doses of 8 mg or less per day of Subutex® or Suboxone® sublingual tablet or generic equivalent**). Probuphine should be used as part of a complete treatment program to include counseling and psychosocial support. Probuphine is not appropriate for new entrants to treatment.

Prescription use of Probuphine is limited under the Drug Addiction Treatment Act. Four Probuphine implants are inserted subdermally in the upper arm for six months of treatment and are removed by the end of the sixth month. Probuphine implants should not be used for additional treatment cycles after one insertion in each upper arm. Probuphine implants must only be inserted and removed by trained healthcare providers. Probuphine implants should be administered in patients who have achieved and sustained prolonged clinical stability on transmucosal buprenorphine. Examine the insertion site one week following insertion of Probuphine implants for signs of infection or other problems. Providers will need to complete a certification process in order to prescribe Probuphine.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis codes required for billing Probuphine are:
 - F11.10 - Opioid abuse, uncomplicated
 - F11.20 - Opioid dependence, uncomplicated
 - F11.21 - Opioid dependence, in remission
- Providers must bill Probuphine with HCPCS code J3490 - Unclassified drugs.
- One Medicaid unit of coverage for Probuphine is 1 implant. NCHC bills according to Medicaid units. The maximum reimbursement rate per unit is \$1,336.50.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Probuphine is: 58284-0100-14.

- The NDC units for Probuphine 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 web page](#).

CSRA 1-800-688-6696

Attention: Nurse Practitioners, Physicians Assistants and Physicians**Clevidipine Injectable Emulsion, For Intravenous Use (Cleviprex®) HCPCS Code J3490: Billing Guidelines**

Effective Nov. 1, 2016, the N.C. Medicaid program covers clevidipine injectable emulsion (Cleviprex®) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3490 – Unclassified drugs. Cleviprex is currently commercially available as single-use vials: 50 mL or 100 mL with a concentration of 0.5 mg/mL.

Cleviprex is indicated for the reduction of blood pressure when oral therapy is not feasible or not desirable.

Cleviprex is intended for intravenous use. Initiate intravenous infusion of Cleviprex at 1-2 mg/hour.

Double the dose at short (90 second) intervals initially. As the blood pressure approaches goal, increase the dose by less than doubling and lengthen the time between dose adjustments to every 5-10 minutes. An approximately 1-2 mg/hour increase will generally produce an additional 2-4 mmHg decrease in systolic pressure. Titrate Cleviprex to achieve the desired blood pressure reduction. Individualize dosage depending on the blood pressure response of the patient and the goal blood pressure.

Most patients will achieve the desired therapeutic response at approximately 4-6 mg/hour. Severe hypertension is likely to require higher doses. Most patients have received maximum doses of 16 mg/hour or less. There is limited experience with short-term dosing as high as 32 mg/hour. Because of lipid load restrictions, no more than 1000 mL or an average of 21 mg/hour of Cleviprex infusion is recommended per 24 hour period. There is little experience beyond 72 hours at any dose.

For Medicaid Billing

- The ICD-10-CM diagnosis codes required for billing Cleviprex are:
 - I10 - Essential (primary) hypertension,
 - I11.0 - Hypertensive heart disease with heart failure,
 - I11.9 - Hypertensive heart disease without heart failure,
 - I15.0 - Renovascular hypertension,
 - I15.1 - Hypertension secondary to other renal disorders,
 - I15.2 - Hypertension secondary to endocrine disorders,
 - I15.8 - Other secondary hypertension,
 - I15.9 - Secondary hypertension, unspecified,
 - I97.3 - Postprocedural hypertension.
- Providers must bill Cleviprex with HCPCS code J3490 - Unclassified drugs.

- One Medicaid unit of coverage for Cleviprex is 1 mg. The maximum reimbursement rate per unit is \$2.87.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Cleviprex are:

65293-0005-00,
65293-0005-11
65293-0005-50
65293-0005-55.

- The NDC units for Cleviprex 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-340-B 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 web page](#).

CSRA 1-800-688-6696

Attention: Nurse Practitioners, Physician Assistants and Physicians**Methylene Blue Injection, for Intravenous Use (Provayblue™)
HCPCS Code J3490: Billing Guidelines**

Effective Sept. 1, 2016, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover methylene blue injection (Provayblue™) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3490 – Unclassified drugs. Provayblue is currently commercially available as 50 mg/10 mL (5 mg/mL) single-dose ampules.

Provayblue is indicated for the treatment of pediatric and adult patients with acquired methemoglobinemia. This indication is approved under accelerated approval. Continued approval for this indication may be contingent upon verification of clinical benefit in subsequent trials.

The recommended dosage of Provayblue is 1 mg/kg intravenously over 5-30 minutes. If methemoglobin level remains above 30 percent or if clinical symptoms persist, give a repeat dose of 1 mg/kg one hour after the first dose. If methemoglobinemia does not resolve after two doses, consider initiating alternative interventions for treatment of methemoglobinemia.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis code required for billing Provayblue is: D74.8 - Other methemoglobinemias.
- Providers must bill Provayblue with HCPCS code J3490 - Unclassified drugs.
- One Medicaid unit of coverage for Provayblue is one milliliter. NCHC bills according to Medicaid units. The maximum reimbursement rate per unit is \$20.14.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Provayblue are: 00517-0374-01 and 00517-0374-05.
- The NDC units for Provayblue 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-340-B 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 web page](#).

CSRA 1-800-688-6696

Attention: Nurse Practitioners, Physician Assistants and Physicians

Eteplirsen injection, for intravenous use (Exondys 51™) HCPCS code J3490: Billing Guidelines

Effective Sept. 19, 2016, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover eteplirsen injection (Exondys 51™) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3490 – Unclassified drugs. Exondys 51 is supplied as 100 mg/2 mL (50 mg/mL) and 500 mg/10 mL (50 mg/mL) single-use vials.

Exondys 51 is indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients who have a confirmed mutation of the DMD gene that is amenable to exon 51 skipping. This indication is approved under accelerated approval based on an increase in dystrophin in skeletal muscle observed in some patients treated with Exondys 51. A clinical benefit of Exondys 51 has not been established. Continued approval for this indication may be contingent upon verification of a clinical benefit in confirmatory trials.

The recommended dose of Exondys 51 is 30 milligrams per kilogram administered once weekly as a 35 to 60 minute intravenous infusion.

See package insert for complete prescribing and preparation instructions.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis codes required for billing Exondys 51 is G71.0 – Muscular dystrophy.
- Providers must bill Exondys 51 with HCPCS code J3490 - Unclassified drugs.
- One Medicaid unit of coverage for Exondys 51 is one milliliter. NCHC bills according to Medicaid units. The maximum reimbursement rate per unit is \$864.00.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Exondys 51 are: 60923-0284-10 and 60923-0363-02.
- The NDC units for Exondys 51 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-340-B 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 web page](#).

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 Division of Medical Assistance'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
December 2016	12/01/16	12/06/16	12/07/16
	12/08/16	12/13/16	12/14/16
	12/15/16	12/20/16	12/21/16
	12/30/16	01/04/17	01/05/17
January 2017	01/06/17	01/10/17	01/11/17
	01/13/17	01/18/17	01/19/17
	01/20/17	01/24/17	01/25/17
	01/27/17	01/31/17	02/01/17

* Batch cutoff date is previous day

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

Paul Guthery
Executive Account Director
CSRA