



N.C. Medicaid Bulletin

April 2017

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Attention: All Providers

Avoiding Common Pitfalls with Medicaid Claims

An article in the [February 2016 Medicaid Bulletin](#), Payment Error Rate Measurement (PERM) covered aspects of the Centers for Medicare & Medicaid Services (CMS) PERM program. The PERM program evaluation has identified common pitfalls providers face when trying to submit accurate N.C. Medicaid and N.C. Health Choice (NCHC) service claims.

Coding problems that have been identified through PERM include:

- **Describing the problem in terms which are not specific enough to justify the coding or the Diagnostic Related Group (DRG) used.** Providers must be as detailed as possible in describing all diagnoses. Further, providers must provide the most specific qualifiers to illustrate precise problems, rather than codes indicating general diagnoses.
- **Using codes that “unbundle” procedures or activities being charged, rather than using codes which combine activities appropriately.** For example, when submitting a claim for Complete Blood Count (CBC) laboratory charges, providers must bill claims as a “bundled” charge, not as individual charges. Another example would be billing for obstetrical services. The combined charges for prenatal visits and care, delivery, and postnatal obstetric visits should be a bundled service charge, rather than separate charges for each service provided.
- **Submitting a claim for medication units used during a procedure which do not match the documentation of medication units used in the procedural summary.** As an example, a claim was submitted for six units of medication used during a procedure, but in the written procedural summary only four units were documented as being used. The actual medication usage should match the surgical or anesthesia notes for claims to be accurately paid to the provider.

As mentioned in the February 2016 article:

“All provider types delivering services for N.C. Medicaid and NCHC are subject to receiving a request from CNI Advantage for documentation supporting claims paid during this [federal fiscal 2016] year period.”

Recommendations to avoid requests for “additional documentation” include:

- **Provide specific information for all identified diagnoses to validate the services submitted in the claim.** For example, if a child has a fractured femur as a primary diagnosis, and this is submitted on a claim along with charges for respiratory therapy and asthma treatments, the provider will be asked for further documentation for these latter charges. This could be avoided by adding the additional diagnosis “bronchial asthma with severe respiratory distress.”
- **Provide all requested materials earlier than the stated “Due date.”** Sometimes unexpected delays occur or other critical activities divert attention from compliance

requests. Avoid these issues by requesting that medical records be sent out near the request date. That way, if further documents are needed, providers will still meet the deadline and avoid having the cost reimbursement to CMS delayed due to “improper documentation received.”

- **Ensure information in Medicaid provider files are current.** Many times, multiple requests for additional information are made because the provider’s information on file with CMS is **not** current. Because of this oversight, providers may be penalized for non-response or have very little time to complete a CMS request by the due date.

For further information about the PERM program, visit the [CMS PERM Providers website](#). Those with additional questions can contact Sharon Brown (919-814-0146), or Susan Bryan (919-814-0154) at the N.C. Division of Medical Assistance (DMA), Office of Compliance and Program Integrity.

**Office of Compliance and Program Integrity
DMA, 919-814-0122**

Attention: All Providers**NC Medicaid Electronic Health Record Incentive Program
Announcement****Program Year 2016 Attestation Tail Period**

Providers have until the end of the attestation tail period, **April 30, 2017**, to submit a complete and accurate attestation. **After that no changes can be made.** Attestations submitted within 30 days of the close of the tail period are **not** guaranteed to be reviewed prior to April 30, 2017. Providers must carefully review their attestations prior to submission.

Last Month to Begin Participating

April 2017 is the **last** month to begin participating in the N.C. Medicaid Electronic Health Record (EHR) Incentive Program **and earn the first-year payment of \$21,250.** Though the N.C. Medicaid EHR Incentive Program runs through Program Year 2021, providers must successfully attest at least once by April 30, 2017 to participate in future years.

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. For an example, read [the interview](#) with Dr. Karen Smith, 2017 American Academy of Family Physicians' Family Physician of the Year, where she shares her experience with EHRs and the N.C. Medicaid EHR Incentive Program.

Providers are eligible for the incentive if they:

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

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 Meaningful Use (MU) criteria, and guidance in registering and attesting, from the program's technical assistance partners at the regional [NC Area Health Education Centers \(AHECs\)](#).

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

Attention: All Providers**New Coverage and Prior Approval Requirements for Spinal Surgeries**

[Session Law 2011-145](#) HB 200 Section 10.37(a)(11)(g)(4) requires the N.C. Division of Medical Assistance (DMA) to implement Prior Approval (PA) for spinal surgery for selective diagnoses, and requires that all other therapies have been exhausted prior to granting approval. Currently, only cervical laminoplasty (CPT codes 63050 and 63051) require PA.

A Clinical Coverage policy has been finalized to add coverage for single-level cervical artificial disc replacement, and adding a PA requirement for 87 spinal surgery CPT codes. **July 1, 2017**, is the effective date for the new coverage and PA requirement.

The newly covered artificial disc codes are as follows:

- **22856** - Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophyctomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical, and,
- **22861** – Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace, cervical.

In addition to cervical laminoplasty CPT codes 63050 and 63051, the following procedure codes will require PA for both N.C. Medicaid and N.C. Health Choice (NCHC) beneficiaries:

22532	22533	22534	22548	22551	22552	22554	22556	22558	22585
22586	22590	22595	22600	22610	22612	22614	22630	22632	22633
22634	22800	22802	22804	22808	22810	22812	22818	22819	22830
22856	22861	63001	63003	63005	63012	63015	63016	63017	63020
63030	63035	63040	63042	63043	63044	63045	63046	63047	63048
63055	63056	63057	63064	63066	63075	63076	63077	63078	63081
63082	63085	63086	63087	63088	63090	63091	63101	63102	63103
63170	63172	63173	63180	63182	63185	63190	63191	63194	63195
63196	63197	63198	63199	63200					

PA for spinal surgery must be submitted electronically by the rendering physician through the NCTracks Provider Portal. The following information must be submitted with the request for surgery:

1. A signed letter of medical necessity clearly documenting diagnosis and date of symptom onset, the specific procedure(s) requested with CPT code(s) and disc level(s) indicated
2. Office notes, including a current history and physical exam within the past 30 days
3. Detailed documentation of extent and response to conservative medical management, including length of treatment, outcomes of any procedural interventions, medication use

(including dose and frequency), participation in physical therapy or a home exercise program, and beneficiary acceptance of recommended lifestyle modifications,

4. All radiology reports relevant to the surgical request, read by an independent radiologist
5. Documentation of pre-operative psychological or psychiatric evaluation conducted within the past six months by a licensed psychiatrist or psychologist (if diagnosed with a psychiatric comorbidity or taking a prescribed psychotropic medication),
6. Post-operative plan of care, and,
7. Medical clearance reports (as appropriate)

N.C. Medicaid and NCHC do not require PA for spinal surgeries when the procedure is **emergent** in nature. As such, the following diagnoses do not require PA:

1. Acute, traumatic cervical spine fracture or dislocation
2. Acute, traumatic thoracic or lumbar spinal fracture with neural compression or radiologic evidence of instability
3. Tumor or infection-related nerve, spinal cord, vertebral, or epidural compression, vertebral destruction, or pathologic fracture
4. Spinal tuberculosis
5. Acute cauda equina syndrome
6. Atlantoaxial subluxation (C1-C2 vertebrae) with odontoid migration or cord compression related to **one of the following**:
 - a. Congenital abnormality at C1-C2
 - b. Os odontoideum
 - c. Rheumatoid arthritis
 - d. Trauma
7. Spinal biopsy or lesion removal

Additional information related to spinal surgery PA will be made as needed through future bulletin articles and other provider notifications.

Practitioner, Facility Service and Policy Development
DMA, 919-855-4320

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

Note: This article is being republished monthly until the July implementation. It was previously published in the *March 2017 Medicaid Bulletin*.

In accordance with [42 CFR 455.410\(a\)](#), the Centers for Medicare & Medicaid Services (CMS) requires state Medicaid agencies to screen enrolled providers for “categorical risk” according to the provisions of Part 455 subpart E.

Under 42 CFR 455.450, state Medicaid agencies are required to screen all applications for “categorical risk,” including initial applications, applications for a new practice location and applications for re-enrollment or revalidation.

According to [42 CFR 455.434\(b\)](#), providers who meet the following criteria must submit a set of fingerprints to the N.C. Division of Medical Assistance (DMA) through its enrollment vendor, CSRA:

- N.C. Medicaid and Children Health Insurance Program (CHIP) providers designated as “high categorical risk” under [42 CFR 424.518\(c\)](#) and [N.C.G.S. 108C-3\(g\)](#), and,
- Any person with a 5 percent or more direct or indirect ownership interest in the organization - those terms are defined in [42 CFR 455.101](#).

This will be implemented on July 30, 2017, and is retroactively effective for providers enrolled or revalidated on or after Aug. 1, 2015.

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

Providers required to submit fingerprints will be notified via the NCTracks provider portal. Locations in North Carolina where fingerprinting services are offered will be posted on the NCTracks website.

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 ones. 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 at 800-688-6696 or NCTracksprovider@nctracks.com.

Provider Services
DMA, 919-855-4050

Attention: All Providers**Affiliation Claim Edit – Clarification**

Note: This article repeals the previously published article in the *March 2017 Medicaid Bulletin*.

One of the requirements associated with NCTracks is the rendering provider must be affiliated with the billing provider who are submitting professional claims on their behalf. Currently, the disposition of the edit is set to “pay and report.” The “pay and report” disposition means that for professional claims where the rendering provider is not affiliated with the billing provider, the claim will not deny, but an informational Explanation of Benefit (EOB) 07025 will post on the provider’s Remittance Advice (RA).

EOB 07025 informs providers:

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 rendering provider to initiate an abbreviated Manage Change Request (MCR) to add the affiliation to the provider record.

It was previously announced that, as of Feb. 5, 2017, the disposition of the edit would change to “pend” the claim while the provider submits an MCR to update the provider record. However, the N.C. Division of Medical Assistance (DMA) has decided to delay the disposition change. **Effective May 1, 2017, the claim edit disposition will change from “pay and report” to “pend.”** Once the disposition is changed, a professional claim failing the edit will pend for 60 days. Providers will continue to receive EOB 07025.

If the affiliation relationship is not established within 60 days, the claim will be denied.

Providers must correct any affiliation issues immediately to continue to bill claims to NCTracks.

Note: Providers are encouraged to take advantage of this extension to submit MCRs that are needed to ensure the rendering provider is affiliated to the billing provider. The MCR to establish or change a provider affiliation must be initiated by the Office Administrator (OA) of the individual rendering provider. A group or organization 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**Affiliation Edit Capability**

Provider affiliation is required for individuals who provide services as attending or rendering providers to organizations or groups. Provider affiliation permits those groups to bill on behalf of individuals.

Starting May 1, 2017, the following changes will be made to the Affiliated Provider Information web page on NCTracks, which will allow individual providers to:

- Affiliate to active, suspended, and terminated organizations in enrollment, re-enrollment and Manage Change Request (MCR) applications
- Edit the “begin date” when adding new affiliations in MCR and re-enrollment applications
- Edit the “begin date” of existing affiliations in an MCR application
- Back-date the “begin date” of the affiliation in an MCR application

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

Provider Services
DMA, 919-855-4050

Attention: All Providers**Re-credentialing Due Dates for Calendar Year 2017**

Note: This article is being republished monthly. It was originally published in the [December 2016 Medicaid Bulletin](#).

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 Division of Medical Assistance 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 National Provider Identifier (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 MCR application status must be in one of these statuses to avoid payment suspension:

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

Providers are required to complete the re-credentialing application after the full MCR is completed. Payment will be suspended if the provider does not complete the process **by the due date.** To lift payment suspension, the provider must submit a re-credentialing application or the full MCR (if required).

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 resets 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

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

Attention: All Providers

Using the N.C. Identity Management System Properly in NCTracks

Note: This article is being republished. It was originally published in the [December 2016 Medicaid Bulletin](#).

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 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**U**pload Documents in NCTracks Provider Portal

Note: This article is being republished. It was previously published in the [February 2017 Medicaid Bulletin](#).

Effective April 1, 2017, providers must submit all attachments to the following applications electronically through the NCTracks Secure Provider Portal Status and Management web page:

- Enrollment
- Re-enrollment
- Manage Change Request (MCR)
- Change Office Administrator (OA)
- Maintain eligibility
- Re-verification

CSRA will not process any mailed, faxed or emailed documents received on or after April 1, 2017.

The NCTracks “Upload Documents” option allows an authorized user to submit attachments electronically after an application has been submitted. If CSRA requests additional information, providers will be required to upload the requested additional documentation.

The Office Administrator (OA) can access the “Upload Documents” button from the Final Steps page of the application or from the Upload Documents hyperlink on the Status and Management web page. The Enrollment Specialist (ES) can access the Upload Documents hyperlink from the Status and Management page. Providers with additional questions can contact the NCTracks Operations Contact Center at 1-800-688-6696.

Provider Services
DMA, 919-855-4050

Attention: All Providers**NCTracks Provider Training Available in April 2017**

Registration for several instructor-led training courses hosted in April 2017 has opened for providers. The duration varies depending on the course.

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

Following are details on the courses, their dates and times, and instructions for how to enroll.

Provider Web Portal Applications (WebEx)

- Tuesday, April 4 – 1 to 4 p.m.

This course will guide providers through the process of submitting all types of provider applications found on the NCTracks Provider Portal.

At the end of this training, providers will be able to:

- Understand the Provider Enrollment Application processes
- Navigate to the NCTracks Provider Portal
- Complete applications for Provider Enrollment, Manage Change Request (MCR), Re-Enrollment and Re-verification, and Maintain Eligibility
- Track and submit applications using the NCTracks Status and Management page.

This course is taught via WebEx. Providers can attend remotely from any location with a telephone, computer and internet connection. The WebEx will be limited to 115 participants.

Provider Re-Credentialing/Re-Verification Refresher (WebEx)

- Thursday, April 6 – 1 p.m. to 2:30 p.m.

This is a refresher course on completing the re-verification process through NCTracks. It also covers the steps to enter information and submit a Manage Change Request (MCR) in the event the user is prompted to complete an MCR during re-verification/re-credentialing. (The terms re-credentialing and re-verification are used interchangeably in NCTracks.)

At the end of training, providers will be able to:

- Explain what provider re-verification is and why it is required
- Explain each phase of re-verification
- Complete the re-verification process in NCTracks
- Complete an MCR for invalid or missing provider data

This course is taught via WebEx. Providers can attend remotely from any location with a telephone, computer and internet connection. The WebEx will be limited to 115 participants.

Submitting a Professional Claim (On-site)

- Friday, April 7 - 1 to 4 p.m.

This course will focus on how to submit a professional claim through 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
- 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.

Submitting Institutional Prior Approvals (On-site)

- Tuesday, April 11 – 9:30 a.m. to noon

This course will cover submitting Prior Approval (PA) requests with a focus on nursing facilities, 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.

Enrollment Specialist User Roles, Abbreviated Manage Change Request's and Upload Documents (WebEx)

- Friday, April 14 – 9 a.m. to noon

This course will guide providers through the following enhancements to the provider enrollment application processes:

- Enrollment Specialist user role
- Upload supporting documents
- Abbreviated Manage Change Request (MCR) applications

This course is taught via WebEx. Providers can attend remotely from any location with a telephone, computer and internet connection. The WebEx will be limited to 115 participants.

Submitting Institutional Claims (On-site)

- Wednesday, April 19 – 1 to 4 p.m.

This course will focus on how to submit an institutional claim through the NCTracks Provider Portal with emphasis on long term care and secondary claims. At the end of training, providers will be able to:

- Enter an institutional claim
- Save a draft claim
- Use the Claims Draft Search tool
- Submit a claim
- 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.

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

- Friday, April 21 - 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.

How to Add/Update Credentials (WebEx)

- Tuesday, April 25 – 1 to 3 p.m.

Some taxonomy codes require specialized providers to be licensed, accredited or certified according to specific laws and regulations. This course will provide instructions for adding and updating licensing or certifications to the provider's record in NCTracks.

This course is taught via WebEx. Providers can attend remotely from any location with a telephone, computer and internet connection. The WebEx will be limited to 115 participants. The WebEx will be limited to 115 participants.

Training Enrollment Instructions

Providers can register for these courses in SkillPort, the NCTracks Learning Management System. Log on 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: All Providers**2017 Annual NCTracks Regional Seminars**

NCTracks will conduct four **Regional NCTracks Seminars** to educate new providers, new billing staff of existing providers and serve as a refresher for current and experienced provider staff. Regional seminars allow for participation by more providers, particularly those who cannot travel to attend single Instructor-Led Training (ILT) classes. They will also allow providers an opportunity to meet their NCTracks Regional Provider Relations Representatives.

The seminars will be held 9 a.m. to 4 p.m. on:

- **Thursday, April 13** - 65 East Chatham St., Pittsboro, N.C. 27312
- **Thursday, May 18** – 359 Ferrell Lane, Halifax, N.C.
- **Tuesday, June 6** - 1450 Fairchild Rd., Winston-Salem, N.C.

From 9 a.m. to noon, the seminars will give providers an overview of:

- NCTracks
- Claim Submission
- Provider Enrollment
- Credentialing
- Re-Verification
- Provider Record Maintenance, and,
- Recent system updates.

Registration is for all sessions, but participants can review the [agenda](#) and choose to attend as many topics as they wish. Printed materials will not be distributed at the seminar, but providers can download or print their own Participant User Guides from the **ILT Guides** folder in SkillPort prior to the seminar.

There will be a **Provider Help Center** at each location from 1 to 4 p.m. NCTracks staff from Claims, Provider Enrollment and Provider Relations will be available on site to assist registered N.C. providers with their questions, and concerns. Providers will get the most out of these sessions if they bring specific examples of issues.

Registration is required, separate from the morning seminar, for a 30-minute block of time, limited to a total of 30 providers. If time permits, NCTracks staff will see other session participants on a first-come, first-served basis after all registered providers have been assisted.

Providers can register for the NCTracks Regional Seminars and the Provider Help Centers in SkillPort, the NCTracks Learning Management System. Log on 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 sessions for the 2017 Annual Regional Seminar and the Provider Help Center can be found in the sub-folder labeled **ILTs: On-site**. 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: All Providers

Claims that Contain National Drug Codes Related to Vaccine CPT Codes

Currently, providers are required to submit National Drug Codes (NDC) with vaccine CPT codes by some private insurers. However, if a non-rebatable NDC, such as those for vaccines, is submitted on N.C. Medicaid or North Carolina Health Choice (NCHC) claims, NCTracks has denied the service in the past.

Rather than requiring Medicaid and NCHC providers to bill differently for Medicaid and NCHC than they do for private insurers, **effective Jan. 1, 2017**, NCTracks has bypassed Edit 00996 - SUB NDC IS NON-REBATABLE. Providers can now add NDCs for vaccines onto Medicaid and NCHC claims for better uniformity among processing requirements by the various insurers. Providers are required to use appropriate NDCs that correspond to the vaccine used for administration and corresponding CPT code.

Below are the claim types and vaccine procedure (CPT) codes impacted by this implementation:

- Medicare Part B, Outpatient, Professional, and Health department claims
- 90585, 90620, 90621, 90632, 90636, 90644, 90645, 90647, 90648, 90649, 90651, 90656, 90658, 90670, 90675, 90680, 90681, 90685, 90686, 90687, 90688, 90696, 90698, 90700, 90703, 90704, 90706, 90707, 90710, 90713, 90714, 90715, 90716, 90723, 90732, 90733, 90734, 90736, 90744, 90746

CSRA 1-866-846-8505

Attention: All Providers**Clinical Coverage Policies**

The following new or amended combined N.C. Medicaid and N.C. Health Choice clinical coverage policies are available on DMA's website at <http://dma.ncdhhs.gov/>:

- 1A-41, *Office-Based Opioid Treatment: Use of Buprenorphine and Buprenorphine-Naloxone* (3/1/17)
- 1A-2, *Preventive Medicine Annual Health Assessment* (4/1/17)
- 1E-2, *Therapeutic and Non-Therapeutic Abortions* (4/1/17)
- 1S-3, *Laboratory Services* (3/1/17)
- 3K-1, *Community Alternatives Program for Children (CAP/C)* (3/1/17)
- 3K-2, *Community Alternatives Program for Disabled Adults (CAP/DA)* (2/22/17)
- 5B, *Orthotics & Prosthetics* (3/1/17)
- 8A, *Enhanced Mental Health and Substance Abuse Services* (4/1/17)
- 11A-1, *Hematopoietic Stem-Cell or Bone Marrow Transplantation for Acute Lymphoblastic Leukemia (ALL)* (3/15/17)
- 11A-2, *Hematopoietic Stem-Cell and Bone Marrow Transplant for Acute Myeloid Leukemia* (3/15/17)
- 11A-3, *Hematopoietic Stem-Cell & Bone Marrow Transplantation for Chronic Myelogenous Leukemia* (3/15/17)
- 11A-5, *Allogeneic Hematopoietic & Bone Marrow Transplant for Genetic Diseases and Acquired Anemias* (3/15/17)
- 11A-6, *Hematopoietic Stem-Cell & Bone Marrow Transplantation in the Treatment of Germ Cell Tumors* (3/15/17)
- 11A-7, *Hematopoietic Stem-Cell & Bone Marrow Transplantation for Hodgkin Lymphoma* (3/15/17)
- 11A-8, *Hematopoietic Stem-Cell Transplantation For Multiple Myeloma and Primary Amyloidosis* (3/15/17)
- 11A-9, *Allogeneic Stem-Cell & Bone Marrow Transplantation for Myelodysplastic Syndromes & Myeloproliferative Neoplasms* (3/15/17)
- 11A-10, *Hematopoietic Stem-Cell & Bone Marrow Transplantation for Central Nervous System (CNS) Embryonal Tumors & Ependymoma* (3/15/17)
- 11A-11, *Hematopoietic Stem-Cell & Bone Marrow Transplant for Non-Hodgkin's Lymphoma* (3/15/17)
- 11A-14, *Placental and Umbilical Cord Blood as a Source of Stem Cells* (3/15/17)
- 11A-15, *Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood* (3/15/17)
- 11A-16, *Hematopoietic Stem-Cell Transplantation for Chronic lymphocytic leukemia (CLL) and Small lymphocytic lymphoma (SLL)* (3/15/17)

These policies supersede previously published policies and procedures.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: Community Care of North Carolina/Carolina ACCESS Providers**Reminder about Community Care of NC/Carolina ACCESS Payment Authorization**

Effective with dates of service Nov. 1, 2016, Community Care of North Carolina/Carolina ACCESS (CCNC/CA) providers shall **not**:

- Enter a National Provider Identifier (NPI) as the CCNC/CA payment authorization number for claims processing
- Use the NCTracks Provider Portal to make referrals for CCNC/CA enrollees; This functionality this functionality will not be available effective May 1, 2017
- Make requests to NCTracks for CCNC/CA overrides for services provided after Oct. 31, 2016
 - Provider have up to six months from the date of service to make request for CCNC/CA overrides
- After Oct. 31, 2016, providers should not receive claims denials due to CCNC/CA payment authorization.

Provider must still adhere to the CCNC/CA coordination of care protocols.

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

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

Attention: Dental Providers

Billing for Partial and Complete Dentures

Note: This article was previously published in the June 2014 and the November 2015 Medicaid Bulletins.

Providers must use the date of delivery as the date of service when requesting payment for a partial or complete denture. Submission of a claim for payment indicates that all services on the claim have been completed and delivered. N.C. Medicaid or N.C. Health Choice (NCHC) payments may be recouped for claims filed using a date other than the delivery date.

Note: If the beneficiary's Medicaid or NCHC eligibility expires **between** the final impression date and delivery date, the provider shall use the final impression date as the date of service. This exception is allowed **only** when the dentist has completed the final impression on a date for which the beneficiary is eligible **and** has delivered the denture(s). The delivery date **must** be recorded in the beneficiary's chart.

Billing for Non-Deliverable Partial and Complete Dentures

Dentists shall make every effort to schedule partial and complete denture delivery **before** requesting payment for a non-deliverable denture. This must include contact with the beneficiary's county social worker, who must be allowed at least two weeks to assist in scheduling an appointment for denture delivery. If a reasonable time has elapsed and circumstances beyond the dentist's control prevent denture delivery, then a claim for payment of non-deliverable dentures may be filed. The dentist shall submit the following:

1. A completed claim form clearly marked "Non-deliverable dentures"
2. Any supporting material documenting the reason for non-delivery
3. A copy of the lab bill indicating a charge for the dentures
4. A copy of the dental record indicating dates and methods by which the beneficiary was notified and dates of any appointments for impressions or try-ins.

These claims must be sent to:

**N.C. Division of Medical Assistance (DMA) Dental Program - 20
2501 Mail Service Center
Raleigh, N.C. 27699-2501**

Reimbursement is determined on a case-by-case basis. The dentist shall retain the dentures, lab work orders, lab bills, and record documentation for six years as proof that dentures were constructed. Dentures **must not** be mailed to the Division of Medical Assistance.

**Dental Program
DMA, 919-855-4280**

Attention: Hospitals**O**utpatient CroFab Claims

CroFab is a single source anti-venom product with no rebate. However, it is covered by N.C. Medicaid and N.C. Health Choice for claims with dates of service of Nov. 6, 2016 or later. Providers will no longer have to fax CroFab payment requests to the Division of Medical Assistance for claims with the dates of service Nov. 6, 2016 and later.

Professional claims should be submitted as normal to NCTracks, using the National Drug Code 50633-0110-12 and the HCPCS code J0840.

Providers still waiting on reimbursement for CroFab when the date of service on the claim is after Nov. 6, 2016, can resubmit their claims to NCTracks for payment.

CSRA 1-866-246-8505

Attention: Nurse Practitioners, Physician Assistants and Certified Nurse Midwives

Billing Code Updates

Updates for Nurse Practitioners and Physician Assistants

DMA continues to provide instructions to NCTracks on updating the claims processing system based on calls received concerning claim denials for some services provided by nurse practitioners (NPs) and physician assistants (PAs). The following procedure code list has been updated recently to include additional NP and PA taxonomies. The newly added codes are:

15271	15734 (A)	15734 (C)	15852	19361 (A)	19361 (C)	27602 (A)
27602 (C)	31624	33534 (A)	33535 (A)	33542 (A)	33983 (A)	35372 (A)
35621 (A)	49905 (A)	51720	64483	64633	64635	65222
76536	76536 (B)	76705 (E)	76770 (E)	76819	76819 (B)	76820
76870 (E)	77077	93880	93990	94620 (E)	94621 (E)	

Note: CPT codes 94260 and 94261 should not be billed with modifier 26 by NPs and PAs.

Update for Certified Nurse Midwives

The following procedure code list has been updated recently to include the Certified Nurse Midwife (also called “Advanced Practice Midwife”) taxonomy. The newly added codes are:

11982	19020	19020 (B)	19020 (C)	76825	93325
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- * Codes marked with an (A) were updated for modifiers 80 and 82 only
- * Codes marked with a (B) were updated for modifier 59 only
- * Codes marked with a (C) were updated for modifier 55 only
- * Codes marked with a (E) were updated for modifier TC only

[Click here for a complete list of accepted codes for the NP, PA and Certified Nurse Midwives.](#)

Note: Codes currently in process for system updates will be published once system modifications are complete. New coding issues will be addressed as they are identified.

CSRA, 1-800-688-6696

Attention: Pharmacists and Prescribers

Clinical Pharmacist Practitioner

Authorized by 21 N.C.A.C. 46.3101, a Clinical Pharmacist Practitioner (CPP) is an N.C. licensed pharmacist approved to provide drug therapy management - including controlled substances - under the direction or supervision of a licensed physician. Only a pharmacist approved by the N.C. Board of Pharmacy may legally be identified as a CPP.

Beginning May 1, 2017, CPP individual providers shall directly enroll in the N.C. Medicaid Program through NCTracks, using the taxonomy code 183500000X. The N.C. Medicaid application fee is \$100 and covers costs associated with processing the enrollment application. The \$100 application fee is required for initial enrollments and during each five-year re-credentialing process.

To enroll, CPPs must have full and unrestricted:

- Licenses to practice as pharmacists in North Carolina
- Certificates to practice as CPPs in North Carolina at the N.C. Board of Pharmacy.

A variety of Job Aids can be found on the [NCTracks Provider User Guides and Training web page](#). For more information on reenrolling in NCTracks, refer to the Job Aid, *How to Enroll in North Carolina Medicaid as an Individual*.

Provider Services
DMA, 919-855-4050

Attention: Pharmacists and Prescribers**Proposed Pharmacy Clotting Factor Reimbursement Methodology Changes**

Effective April 1, 2017, DMA will be making changes to the reimbursement methodology for clotting factor. This reimbursement model IS NOT programmed in NCTracks at this time. The current State Plan Amendment follows, but is subject to change depending on CMS approval:

Payment for Clotting Factor from Specialty Pharmacies, Hemophilia Treatment Centers (HTC), Centers of Excellence or any other pharmacy provider:

Reimbursement for clotting factor purchased through the 340B program and dispensed by specialty pharmacies, hemophilia treatment centers (HTC), Centers of Excellence or any other pharmacy provider will be reimbursed at the lesser of the following:

1. The 340B state maximum allowable cost (SMAC) plus a per unit professional dispensing fee; or
2. The provider's usual and customary charge to the general public or their submitted charge.

Reimbursement for clotting factor purchased outside of the 340B program and dispensed by specialty pharmacies, hemophilia treatment centers (HTC), Centers of Excellence or any other pharmacy provider will be reimbursed at the lesser of the following:

1. The state maximum allowable cost (SMAC) plus a per unit professional dispensing fee; or
2. The provider's usual and customary charge to the general public or their submitted charge.

This reimbursement is applicable to both pharmacy and procedure coded professional claims.

The per unit professional dispensing fee will be 4 cents per unit for HTC pharmacies and 2.5 cents per unit for all other pharmacies.

Clotting factor per unit professional dispensing fees shall be established by a clotting factor dispensing fee survey conducted no less than every three years.

The calculated actual acquisition costs and 340B ceiling prices will serve as the basis for establishing the SMAC reimbursement rates. There will be one rate listing for specialty pharmacies and one rate listing for HTC pharmacies. The SMAC rate listings will incorporate an additional 5.5 cents per unit for specialty pharmacies and an additional 7.5 cents per unit for HTC pharmacies, as well as a 0.015 cents per unit for Medication Therapy Management (MTM) for both type pharmacies.

Outpatient Pharmacy Services
DMA, 919-855-4300

Attention: Physicians**Session Law 2013-360, Reprocessing of Claims and Medicare Crossover Claims subject to 3 Percent Rate Reduction**

N.C. Session Law [2013-360](#), subsequently modified by N.C. Session Law [2014-100](#), required a 3 percent rate reduction in physician services. The 3 percent rate reduction for physician services was implemented March 1, 2015, for current claims and going forward. The rate reduction was applied to majority of previously paid claims over multiple checkwrites earlier this year. For more information, see the [April 2015 Special Medicaid Bulletin, Session Law 2013-360 3% Physician Services Rate Reduction Claims Reprocessing Update](#).

However, some claims and the Physician Medicare Crossover claims reprocessed during this time did not result in the repayment of the rate reduction. Therefore, a reprocessing of claims to apply the 3 percent rate reduction will occur and will be reflected between April 25, 2017 and July 5, 2017, checkwrites.

The affected claims reprocessed between April 25, 2017 and July 5, 2017, checkwrite will appear in a separate section of the paper Remittance Advice (RA) with a unique Explanation of Benefits (EOB) code:

- EOB 06017-REPROCESSED FOR 3% REDUCED PHYSICIAN RATE or,
- EOB 10301-REPROCESSED FOR 3% REDUCED PHYSICIAN RATE-MEDICARE CROSSOVER ONLY.

The 835 electronic transactions will include the reprocessed claims along with other claims submitted for the checkwrite. (There is no separate 835.)

If there are not sufficient funds from claims paid between April 25, 2017 and July 5, 2017, checkwrite to satisfy the recoupment of an overpayment, an Accounts Receivable (AR) will be created. Recoupment of the AR will begin with the subsequent NCTracks checkwrite and the recoupment process will continue with each checkwrite until the full amount due is recouped.

If funds are insufficient to collect the full amount due from the NPI for which the AR was generated, NCTracks will automatically seek to recoup the AR from other NPIs with the same Internal Revenue Service Taxpayer Identification Number. For more information about the AR process, see the [February 29, 2016, NCTracks announcement, Change in Processing of Accounts Receivable](#).

Additional Information:

- [January 2014 Medicaid Bulletin](#) (3 Percent Rate Reduction, page 3)
- Medicaid Special Bulletins - [Feb. 20, 2015](#) and [April 2015](#)
- N.C. Session Laws [2013-360](#) and [2014-100](#)

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

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 periods will instead be 30- and 10-day periods.

As of April 1, 2017, the following policies are open for public comment:

Proposed Policy	Date Posted	Comment Period End Date
<i>1G-2, Skin Substitutes</i>	03/13/17	04/27/17
<i>Prior Approval Criteria; Antiemetic Agents</i>	03/10/17	04/24/17
<i>Prior Approval Criteria: Exondys 51</i>	03/10/17	04/24/17
<i>10-B, Independent Practitioners</i>	03/08/17	04/22/17
<i>10-A, Outpatient Specialized Therapies</i>	03/08/17	04/22/17
<i>1-F, Chiropractic Services</i>	03/08/17	04/22/17

Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date*	Checkwrite Date	EFT Effective Date
April 2017	04/06/17	04/11/17	04/12/17
	04/13/17	04/18/17	04/19/17
	04/20/17	04/25/17	04/26/17
	04/27/17	05/02/17	05/03/17
May 2017	05/11/17	05/16/17	05/17/17
	05/18/17	05/23/17	05/24/17
	05/25/17	05/31/17	06/01/17

* 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