



# N.C. Medicaid Bulletin

## June 2017

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**Attention: All Providers****NC Medicaid Electronic Health Record Incentive Program  
Announcement****N.C. Medicaid Incentive Payment System (NC-MIPS) is Open for Program Year  
2017**

[NC-MIPS](#) is accepting Program Year 2017 Modified Stage 2 and Stage 3 Meaningful Use (MU) attestations.

As a reminder, in Program Year 2017, the Centers for Medicare & Medicaid Services (CMS) is allowing all Medicaid providers to use a 90-day MU reporting period. Providers are encouraged to use the respective MU attestation guide while attesting. The attestation guides – found on the right-hand side of NC-MIPS – provide detailed instructions for successfully attesting.

For objective and measure requirements, providers should refer to the CMS Specification Sheets. [Click here](#) for CMS' Modified Stage 2 MU Specification Sheets. [Click here](#) for CMS' Stage 3 MU Specification Sheets.

**Note:** The N.C. Medicaid Electronic Health Record (EHR) Incentive Program is no longer accepting year one or Adopt, Implement, Upgrade (AIU) attestations.

For program announcements, resources and information, visit the [N.C. Medicaid EHR Incentive Program web page](#).

**CMS Hardship Exceptions**

If a provider is unable to meet MU in Program Year 2016, they may [file a Hardship Exception Application](#) with CMS to avoid Medicare payment adjustments. The Hardship Exception Application needs to be filed with CMS no later than July 1, 2017.

**N.C. Medicaid EHR Incentive Program**

[NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov)

**Attention: All Providers****H**ome Visit for Postnatal Assessment & Follow-Up Care Exceeds 60-Day Limit

Effective Jan. 6, 2017, NCTracks was updated to allow claims submitted for home visits for postnatal assessment and follow-up care to pend for manual review if attachments are submitted. Providers who have claims denied with Explanation of Benefit (EOB) code 00211 (dates of service not within authorized time period; for date of delivery verification resubmit claim with labor and delivery records) should resubmit claims through NCTracks and attach medical record documentation that verifies the date of delivery.

Claims with supporting documentation submitted through NCTracks will be manually reviewed to ensure that follow up care does not exceed 60 days after the delivery date.

For more information, providers should refer to the Clinical Coverage Policy 1M-5, *Home Visit for Postnatal Assessment and Follow-up Care*, on the Division of Medical Assistance [Maternal Support Services web page](#). Providers with questions can contact the CSRA Call Center at 1-800-688-6696 or [NCTracksprovider@nctracks.com](mailto:NCTracksprovider@nctracks.com).

**Clinical Policy and Programs**  
**DMA, 919-855-4260**

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**Attention: All Providers****C**linical Coverage Policies

The following new or amended combined N.C. Medicaid and N.C. Health Choice clinical coverage policies are available on DMA's [clinical coverage policy web pages](#).

- 1A-13, *Ocular Photodynamic Therapy* (05/01/17)
- 3G-1, *Private Duty Nursing for Beneficiaries Age 21 and Older* (05/12/17)
- 3G-2, *Private Duty Nursing for Beneficiaries Under 21 years of Age* (05/12/17)
- 1E-3, *Sterilization Procedures* (06/01/17)
- 9, *Outpatient Pharmacy Program* (06/01/17)
- 10A, *Outpatient Specialized Therapies* (06/01/2017)
- 10B, *Independent Practitioners* (06/01/2017)

These policies supersede previously published policies and procedures.

**Clinical Policy and Programs**  
**DMA, 919-855-4260**

## Attention: All Providers

# What It Means to be Audited by Centers for Medicare & Medicaid Services

Medicaid providers may receive notice from the Centers of Medicare & Medicaid Services (CMS) that they have been randomly chosen for an audit of services provided Medicaid or N.C. Health Choice beneficiaries. But providers may not understand what that means.

A CMS audit is part of a normal evaluation activity. Providers who are selected will be asked by CMS reviewers to provide documentation describing services provided to designated beneficiaries. This allows the reviewers to assess if errors were committed during the provision of services during that cycle. CMS will contact providers using the information they provided in their credentialing application on NCTracks, including mailing address, phone, fax or email. **Therefore, it is critical for providers to keep their NCTracks information up-to-date.** Being contacted by a CMS representative sets a deadline date to provide requested documentation. Failure to comply with requests may result in an **error** and subsequent repayment of fees paid through the reimbursement process.

The purpose of an audit is to find inappropriate provision of services, billing or payment. As an example, a provider prescribed Synagis without first obtaining prior approval. However, sometimes providers bill appropriately, but do not accurately respond to the audit request. Those types of mistakes can also result in a repayment demand, as the following examples illustrate:

- A provider was asked to submit a complete patient file for a nursing home stay of two weeks. The CMS reviewer asked specifically for 18 sections of the client's chart for certain dates of service to be securely sent to CMS. After 30 days, the provider sent 17 items to the reviewer, omitting only one item – the signed physician orders for the plan of care for the beneficiary. After 45 days, the missing document resulted in an **error** and subsequent demand for repayment of fees already paid– approximately \$1,500.
- Two providers were sent separate requests regarding behavioral health services provided to their respective clients at independent facilities. Each provider was requested to send client file sections for 18 sections of the client's chart – and each complied. However, both providers were found in **error** for not following secure transition standards indicated in the HIPAA regulations of 1996 [amended on Jan. 16, 2009, and adopted as ASC X12 Version 5010 as the HIPAA Electronic Transaction standard]. Final Rule, 45 CFR 162, adopted the transaction standard (effective July 1, 2012) which required the attending physician's NPI. Neither provider included the attending physician's NPI in their submissions. In both situations, the claims were found to be in **error** and repayment of funds was required of the facilities -approximately \$1,400 and \$2,700.

**Office of Compliance and Program Integrity  
DMA, 919-814-0146**

**Attention: All Providers****The Final 2017 Regional NCTracks Seminar is June 6**

The final 2017 Regional NCTracks Seminar will be on Tuesday, June 6 at the Forsyth County Center, 1450 Fairchild Road., Winston-Salem, N.C., 27105.

Regional NCTracks Seminars teach new providers and new billing staff of existing providers how to use NCTracks. They also offer a refresher for current and experienced provider staff. These seminars are offered on various dates and locations across the state. Each seminar runs from 9 a.m. to 4 p.m. and includes a Provider Help Center.

For more information – including registration information, dates, and locations of other regional seminars – see the [March 10 announcement](#) on the NCTracks Provider Portal.

**CSRA, 1-800-688-6696**

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

Registration is open for two instructor-led training courses for providers that will be held in June 2017. The duration varies depending on the course. Both courses will be taught via WebEx and can be attended remotely from any location with a telephone, computer and internet connection. The WebEx will be limited to 115 participants.

Following are details on the courses, including dates, times and how to enroll.

**Dental Helpful Hints (WebEx)**

- Thursday, June 8 – 1 to 3 p.m.

This course will provide users with tips for requesting Dental Prior Approval (PA) and dental claim submission within NCTracks.

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

- Identify the three methods for submitting a PA request
- Identify how to upload documents when submitting a new PA request or supplementing an existing PA request
- Avoid common errors when completing the American Dental Association form
- Avoid common errors that trigger requests for PA additional information
- Avoid common errors when submitting claims

**Submitting A Time Limit Override Request (WebEx)**

- Friday, June 9 – 1 to 4 p.m.

This course will guide authorized users through the Time Limit Override Request process using the Delay Reason Code (DRC), which is available to providers who submit claim transactions using the NCTracks Provider Portal.

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

- Indicate a “Time Limit Override” request using the “Delay Reason” field on a claim.
- Explain the Delay Reason Code
- Attach an Explanation of Benefits (EOB) document to a claim
- Submit a claim

## Training Enrollment Instructions

Providers can register for 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-folder labeled **ILTs: Remote via WebEx**.

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****Affiliation Claim Edit and Edit Capability – Clarification**

**Note: This article is being republished. It combines two articles which were published in the [April 2017 Medicaid Bulletin](#) – *Affiliation Claim Edit and Affiliation Edit Capabilities*.**

NCTracks requires rendering providers to be affiliated with billing providers who submit professional claims on their behalf. Previously, the disposition of the edit was set to “pay and report.” The claim did not deny, but an informational Explanation of Benefit (EOB) 07025 was posted on the provider’s Remittance Advice (RA).

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.

The intent was to alert providers to situations in which affiliation relationships do not exist. This allows rendering providers to initiate an abbreviated Manage Change Request (MCR) to add the affiliation to the provider record.

**Effective May 1, 2017, providers will notice two changes:**

1. **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.
  - a. 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.
  - b. **If the affiliation relationship is updated in NCTracks within 60 days, the claim will auto-recycle for payment.** No action is required on the provider’s part.
  - c. **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.
2. The Affiliated Provider Information web page on NCTracks will be updated to allow individual providers to:
  - a. Affiliate to active, suspended, and terminated organizations in enrollment, re-enrollment and MCR applications



- b. Edit the “begin date” when adding new affiliations in MCR and re-enrollment applications
- c. Edit the “begin date” of existing affiliations in an MCR application
- d. 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](mailto:NCTracksprovider@nctracks.com).

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

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## **Attention: All Providers**

### **P**rovider Qualifications and Requirements Checklist

**Note: This article is being republished until August 2017. It was originally published in the [May 2017 Medicaid Bulletin](#).**

Beginning July 30, 2017, the Provider Qualifications and Requirements Checklist located on the NCTracks Provider Enrollment page will be replaced with an Excel spreadsheet. Providers will be able to apply filters to the spreadsheet to locate information on program requirements and qualifications specific to taxonomy codes. An instruction sheet for applying the Excel filters also will be available.

Providers with questions can contact the CSRA Call Center at 1-800-688-6696 (phone) or [NCTracksprovider@nctracks.com](mailto:NCTracksprovider@nctracks.com).

**CSRA, 1-800-688-6696**

## 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 N.C. 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 the following statuses to avoid payment suspension:

- In Review
- Returned
- Approved
- 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](mailto:NCTracksprovider@nctracks.com).

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

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## **Attention: All Providers**

### **Nash County Transition**

In December 2016, the Secretary of the N.C. Department of Health and Human Services (N.C. DHHS) approved the disengagement of Nash County from the Eastpointe Local Management Entity (LME-MCO) and its realignment with Trillium Health Resources LME-MCO.

**Effective July 1, 2017**, Trillium Health Resources will be the responsible LME-MCO for enrollees who are residents of Nash County. Any provider delivering Medicaid behavioral health services to a Nash County enrollee after July 1, 2017, must be contracted with Trillium Health Resources. This only applies to mental health, substance abuse and intellectual/developmental disability services.

For more information, contact Deb Goda, DMA Behavioral Health, at 919-855-4290. Providers can reach Trillium Health Resources at its administrative and business line at 1-866-998-2597.

**Community Based Services**  
**DMA, 919-855-4290**

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

**Note:** This article is being republished until August 2017. **It repeals all previously published articles.**

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 North Carolina’s CHIP.

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

Per [42 CFR 455.416\(e\)](#), providers subject to the fingerprinting requirement who fail to submit sets of fingerprints as required within the 30-day timeframe will be terminated from, or denied enrollment in, the N.C. Medicaid and NCHC programs.

Providers who fail to comply with the fingerprinting requirement are subject to a “for cause” denial or termination. A “for cause” action is one related to program compliance, fraud, integrity, or quality. DMA is required to report providers terminated or denied for cause to CMS.

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.

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](mailto:NCTracksprovider@nctracks.com).

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

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### **Attention: All Providers**

## **R** **Request for Disproportionate Share Hospital Data for MEDICARE:** **Change in Process**

Effective July 1, 2017, Medicaid and N.C. Health Choice Providers (NCHC) will be able to obtain batch Medicare Disproportionate Share Hospital (DSH) Recipient Eligibility Verifications and Provider Statistical and Reimbursement (PS&R) reports through NCTracks.

Hospitals or their designated representative will no longer need to manually submit Medicare DSH eligibility verification and claims data requests to the N.C. Division of Medical Assistance (DMA).

This update will allow the following:

- The eligibility and claims information will be in the correct transaction format.
- Hospitals will receive eligibility verifications and PS&R data from NCTracks.
- The Recipient Eligibility Verification is a free service to hospital providers.

For more information on how to submit **batch** requests of eligibility verifications in NCTracks, refer to Recipient Eligibility Verification Participant User Guide found on the [NCTracks Provider User Guides and Training Web Page](#).

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

**Attention: All Providers****C**hange of Ownership for Medicaid and Health Choice Providers Enrolled in Medicare

N.C. Medicaid and N.C. Health Choice (NCHC) providers enrolled in Medicare and undergoing a change of ownership (CHOW) must complete the CHOW process with Medicare **before** submitting a CHOW application to Medicaid. CHOW reporting requirements are outlined in [NCGS 108C-10\(b\)](#) which states:

A provider must notify the Department at least 30 calendar days prior to the effective date of any change of ownership.

Therefore, the selling provider must submit notification of the upcoming CHOW via written correspondence on company letterhead to NCTracks

These providers must submit a CHOW application to Medicare and receive approval (tie-in notice) **before** submitting a CHOW application to N.C. Medicaid/NCTracks. Providers have 30 calendar days from receiving the tie-in notice to submit a CHOW application for Medicaid through NCTracks. The tie-in notice will come from the Centers for Medicare and Medicaid Services (CMS)

If the NPI is “sold” from seller to buyer for Medicaid billing purposes, it must be specifically stated in the sales transaction/agreement. In this case, following Medicare enrollment rules, the buyer and seller must be fully aware that payments shall continue to the seller until the CHOW process is complete and approved. During this process, the seller does assume some risk.

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

**Attention: All Providers****M**edicaid Behavioral Health Provider Enrollment

Effective July 1, 2017, Local Management Entities-Managed Care Organizations (LME-MCOs) will **no longer enroll new Medicaid providers**. These providers will be new to the LME-MCO network and do not have an active enrollment record in NCTracks.

Medicaid providers requesting an initial enrollment with the LME-MCO **must** be instructed to submit an enrollment application for processing through NCTracks. Providers interested in rendering behavioral health services must contact an LME-MCO prior to enrolling via NCTracks. Being approved as a Medicaid provider does **not** guarantee a contract with a LME-MCO.

This provider enrollment change is prompted by [42 CFR 438.602 \(b\) \(1\)](#), *Screening and Enrollment and Revalidation of Providers*. The regulation requires states to screen and enroll, and periodically revalidate, all network providers of MCOs (Managed Care Organizations), PIHPs (Prepaid Inpatient Health Plans), and PAHPs (Prepaid Ambulatory Health Plans). Therefore, PIHPs will no longer use the Provider Upload process to enroll new Medicaid providers in North Carolina. The current Provider Upload process for newly enrolling Medicaid providers will **end on June 30, 2017**.

Enrollment in NCTracks will generate three changes for new providers:

- 1) A state-mandated application fee of \$100 will be charged to Medicaid providers for all initial enrollments and reverifications. Additionally, the Affordable Care Act (ACA) application fee may be charged to providers who meet Center for Medicare and Medicaid Services (CMS) definition of institutional provider and the definition of a moderate- or high-risk provider as defined in [N.C. General Statute 108C-3](#). The fee for calendar year 2017 is \$560.
- 2) State-Mandated training is required for all initially enrolling Medicaid providers. This training is online and provided through the N.C. Department of Health and Human Services (DHHS) contracted vendor, Public Consulting Group (PCG).
- 3) Medicaid providers in moderate- and high-risk categories as defined by [N.C. General Statute 108C-3](#) are subject to site visits as required by [42 CFR 455 Subpart B](#), which are also conducted by PCG.
- 4) Federal Regulation [42 CFR 455.434](#) and [42 CFR 455.450 \(c\)](#), requires fingerprint-based background checks for all high categorical risk providers and their owners who have a 5 percent or greater direct or indirect ownership interest as a condition of enrollment in the N.C. Medicaid Program.

Providers with questions about this article can submit them to [Medicaid.BehavioralHealth@dhhs.nc.gov](mailto:Medicaid.BehavioralHealth@dhhs.nc.gov).

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

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## **Attention: All Providers**

### **Maintain Eligibility Process**

Effective Oct. 29, 2017, NCTracks will implement a quarterly Maintain Eligibility Process which identifies providers with no claim activity within the past 12 months. NCTracks will notify the provider via the secure provider portal mailbox. The provider must attest electronically to remain active.

When a provider is identified with having no claims activity in 12 months, a Maintain Eligibility Due Date will be set. Providers will be notified 30 days before the due date that they must submit a Maintain Eligibility Application. Upon submission of the Maintain Eligibility Application, the provider's enrollment record will be updated with the current date.

If the provider does not submit the application by the due date, the provider's participation in the N.C. Medicaid and N.C. Health Choice (NCHC) programs **will be end dated**. This will prevent fraud, waste and abuse in the N.C. Medicaid and NCHC programs,

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



**Attention: All Providers****Non-Emergency Medical Transportation – Clarification**

**Note:** This article was originally published in the [September 2016 Medicaid Bulletin](#). It is being republished with updates. **It repeals all previously published articles.**

Non-emergency Medical Transportation (NEMT) providers **must** have a contract with the local county Department of Social Services (DSS). The determination to grant a contract is at the discretion of the county DSS. The county DSS will submit payment authorization to NCTracks for the NEMT providers for approved NEMT transports. This authorization allows processing of the provider's NEMT claims.

**If the provider enrolls in the N.C. Medicaid program prior to contracting with the local county DSS, the provider will not be authorized for any NEMT services through NCTracks. In addition, the provider will not be entitled to a refund of application fees.**

Once NEMT providers have a contract in place with the local county DSS, the NEMT provider can obtain a National Provider Identifier (NPI) or an atypical identifier (ID) will be assigned via the enrollment process. An online Medicaid enrollment application is available through NCTracks. Requirements for NEMT providers include:

- State-mandated application fee of \$100 and Affordable Care Act (ACA) application fee of \$560 will be charged for all initial enrollments and reverifications.
- State-mandated training for all initially enrolling Medicaid providers. This training is online and provided through the N.C. Department of Health and Human Services (DHHS) contracted vendor, Public Consulting Group (PCG).
- Site visits as required by 42 CFR 455 Subpart B, which are also conducted by PCG.

For NEMT providers, the available taxonomy code is **343900000X-Non-Emergency Medical Transport**. Providers are not required to submit certification, accreditation, or license when completing the enrollment application. NEMT providers can only enroll in the N.C. Medicaid health plan.

Providers with questions about the NCTracks online enrollment application for NEMT providers can contact the CSRA call center at 1-800-688-6696 (phone); 1-855-710-1965 (fax) or [NCTracksprovider@nctracks.com](mailto:NCTracksprovider@nctracks.com).

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

**Attention: All Providers****Abbreviated Application for Ordering, Prescribing and Referring Practitioners**

Effective Oct. 29, 2017, an abbreviated enrollment application will be available for **ordering, prescribing, and/or referring** (OPR) practitioners. As required by [42 CFR 455.410](#), physicians and non-physician practitioners **must** enroll in the Medicaid program for the sole purpose of ordering, referring, or prescribing items or services for N.C. Medicaid or N.C. Health Choice (NCHC) beneficiaries.

**Physician and non-physician practitioners may elect to enroll as OPR-only providers (OPR lite). Billing providers will use the NPI (National Provider Identifier) of the OPR-only provider on their claims when these providers order or refer items or services. NCTracks will not reimburse OPR-only providers when their NPI is used as rendering or attending on a claim.**

The following requirements will apply to OPR lite enrollment providers:

- Revalidate every five years
- \$100 application fee
- Credentialing and Background Checks including fingerprinting, if applicable
- Manage Change Request (MCR) submission to update or end date the provider record
- MCR to change from an OPR lite enrollment provider to a fully enrolled provider if they are to be reimbursed for claims.

**Note:** OPR providers can request a retroactive effective date up to 365 days preceding the date of application.

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

**Attention: All Providers****O**ut of State Provider Enrollment

Effective Oct. 29, 2017, Out of State (OOS) providers who are seeking to enroll with N.C. Medicaid or the Children's Health Insurance Program (CHIP) – also known as N.C. Health Choice (NCHC) – will have the option to enroll using a lite- or full-enrollment application.

If a provider chooses to enroll using the lite-enrollment application the following will apply:

- The provider will complete an abbreviated application.
- Enrollment is limited to one year.
- Credentialing and background checks will be required including fingerprinting, if applicable.

If the provider chooses to enroll using the full-enrollment application the following will apply:

- The provider will complete a full-enrollment application.
- Enrollment will extend beyond one year.
- The provider is required to complete re-verification every five years.
- Credentialing and background checks will be required including fingerprinting, if applicable.
- The provider will be required to pay the \$100 N.C. application fee during enrollment and re-verification.

**Note:** A provider has the option to change from lite enrollment to full enrollment by submitting a Manage Change Request (MCR). The provider will be required to pay the \$100 N.C. application fee.

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

## Attention: All Providers

# Sterilization Consent Form Requirements

As of June 1, 2017, N.C. Division of Medical Assistance (DMA) has revised Clinical Policy 1E-3, *Sterilization Procedures*, and the Sterilization Consent Form requirements to comply with requirements from the Centers for Medicare & Medicaid Services (CMS).

1. Providers can access the Sterilization Consent Form from the [DMA forms web page](#). Clicking on the words “Sterilization Consent Form,” will send providers to the [Sterilization Consent Form](#) located on the U.S. Department of Health & Human Services website. Providers may choose to pre-populate information prior to printing the consent form. Signature fields may not be pre-populated.
2. The surgeon’s NPI **must be added to the top left** of the consent form. The beneficiary’s identification number **must be added to the top right** of the Sterilization Consent Form. This must be done after the sterilization procedure has been completed and before submitting the consent form to N.C. Department of Health and Human Services (DHHS) fiscal contractor at:  
  
CSRA  
P.O. Box 30968  
Raleigh, NC 27622
3. Providers should check future Medicaid Bulletins for updates related to the facility NPI.
4. If the correct Sterilization Consent Form is not submitted to the DHHS fiscal contractor with the recipient signature date on or after Aug. 1, 2017, the Sterilization Consent Form will receive a permanent denial. Providers must begin using the [Sterilization Consent Form](#) located on the U.S. Department of Health and Human Services website immediately.
5. When completing the Sterilization Consent Form, the complete name of the person or facility that provided the information to the beneficiary concerning the sterilization procedure is required. Abbreviations of the facility name or physician’s name, initials, or “doctor on call” are not acceptable.

## Other Sterilization Policy Changes

1. ICD-10 procedure codes 0UB70ZZ, 0UB73ZZ, 0UB74ZZ, 0UB77ZZ, and 0UB78ZZ have been added to the Sterilization Procedure policy.
2. Bilateral **partial** salpingectomy (BPS) has been added as an acceptable type of sterilization procedure. DMA has determined that removal of the entire fallopian tube is not acceptable, unless medically necessary. If it is necessary to remove the entire

fallopian tube, documentation to support medical necessity must be submitted with the Sterilization Consent Form to the address listed in the second bullet.

For more information, providers should refer to the Clinical Coverage Policy 1E-3, *Sterilization Procedures*. Providers with questions can contact the CSRA Call Center at 1-800-688-6696 or [NCTracksprovider@nctracks.com](mailto:NCTracksprovider@nctracks.com).

**Clinical Policy and Programs**  
**DMA, 919-855-4260**

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## **Attention: Community Care of North Carolina/Carolina ACCESS Providers**

### **R**eminder about Community Care of NC/Carolina ACCESS Payment Authorization

**Note:** This is a revision to the article, *Carolina ACCESS Payment Authorization*, which was posted in the [November 2016 Medicaid Bulletin](#)

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 will not be available effective May 1, 2017, or,
- Make requests to NCTracks for CCNC/CA overrides for services provided after Oct. 31, 2016.

Providers should not receive claims denials due to CCNC/CA payment authorization for dates of service after Oct. 31, 2016. Providers 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](mailto:NCTracksProvider@nctracks.com).

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

## Attention: Durable Medical Equipment Providers

### **C**linical Coverage Policy 5A: Durable Medical Equipment and Supplies has been Divided into Three Parts

To produce a more convenient experience for stakeholders, **as of June 1, 2017**, the unwieldy Durable Medical Equipment and Supplies policy has been divided into three parts. No policy language has been changed. The divisions were made along clinical specialty lines. The titles for the three policies which replace Clinical Coverage Policy 5A are:

- 5A-1, *Physical Rehabilitation Equipment and Supplies*
- 5A-2, *Respiratory Equipment and Supplies*
- 5A-3, *Nursing Equipment and Supplies*

#### **Additional Resources**

Links to the new policies can be found on DMA's [Durable Medical Equipment](#) web page.

**DMA Clinical Policy and Programs**  
**DME section, 919-855-4310**

## Attention: Nurse Practitioners and Physician Assistants

### Billing Code Update for Nurse Practitioners and Physician Assistants

Since the transition to NCTracks, the N.C. Division of Medical Assistance (DMA) has received calls concerning claim denials for some services provided by nurse practitioners (NPs) and physician assistants (PAs).

DMA has recently provided instructions to NCTracks on updating the claims processing system. The following procedure code list has been updated to include additional NP and PA taxonomies. The newly added codes are:

10121	10121 (B)	20553 (B)	20938 (A)	29325	29325 (B)	70540
70540 (B)	70542	70542 (B)	70543	70543 (B)	70551	70551 (B)
70553	70553 (B)	71551	71551 (B)	71552	71552 (B)	72141
72141 (B)	72195	72195 (B)	72197	72197 (B)	73218	73218 (B)
73219	73219 (B)	73220	73220 (B)	73222	73222 (B)	73223
73223 (B)	73718	73718 (B)	73719	73719 (B)	73720	73720 (B)
73722	73722 (B)	73723	73723 (B)	74181	74181 (B)	74182
74182 (B)	74183	74183 (B)				

**\*Codes marked with an (A) were updated for modifier 82 only**

**\*Codes marked with a (B) were updated for modifier 59 only**

A complete list of [accepted codes for the Nurse Practitioners and Physician Assistants](#) (as well as certified nurse midwives) can be found on the Claims and Billing Section of the DMA web site.

**Note:** Codes currently in process for system updates will be published once system modifications are completed. New code problems will be addressed as DMA Clinical Policy becomes aware of them. The new codes will be placed on the website and providers will be informed through the Medicaid Bulletin.

**CSRA, 1-800-688-6696**

**Attention: Nurse Practitioners, Physician Assistants and Physicians****Eteplirsen injection, for intravenous use (Exondys 51): Change in Coverage**

Effective May 16, 2017, the N.C. Medicaid Program will cover Exondys 51 (Eteplirsen) **only** through the Outpatient Pharmacy Program. Exondys 51 is **not** covered when billed through the Physician's Drug Program (PDP) with HCPCS code J3490. Claims submitted for Exondys 51 with HCPCS code J3490 **will be denied**.

Prior authorization (PA) through the Outpatient Pharmacy Program is required for coverage of Exondys 51. If PA is granted, the maximum length of authorization is six months.

Prescribers must request PA by contacting CSRA at 1-866-246-8505 (phone) or 1-855-710-1969 (fax). The criteria and PA request form are also available on the [NCTracks Prior Approval Drugs and Criteria web page](#).

More information can be found at the N.C. Division of Medical Assistance (DMA) [Outpatient Pharmacy Program web page](#). DMA's approved PDP list is found on the [DMA PDL web page](#).

**CSRA 1-800-688-6696**



**Attention: Pharmacists and Prescribers****Clinical Pharmacist Practitioner – Update**

**Note: The implementation date previously posted in the *April 2017 Medicaid Bulletin* has been delayed until Oct. 1, 2017. DMA will notify providers of the new implementation date in future bulletin articles.**

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.

CPP individual providers shall directly enroll in the N.C. Medicaid and N.C. Health Choice (NCHC) programs through NCTracks, using the taxonomy code 1835P0018X. The 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: Pregnancy Medical Home Providers

### **P**regnancy Medical Home procedure code S0281

Pregnancy Medical Home (PMH) providers are being denied for procedure code S0281 (medical home program, comprehensive care coordination and planning, maintenance) if the current billing provider and the history billing providers are not the same. An issue arises when a practice has several locations; each location may have an individual NPI. The OB package code is reimbursed at one location and the patient receives postpartum care at a different location, **within the same practice**. PMH providers that have submitted a claim for S0281 and received a denial with EOB 04018 (payment of the appropriate postpartum service to this billing provider is required to meet Medicaid guideline for reimbursement of this code), **after** the OB package code is reimbursed, should resubmit denied claims through NCTracks.

NCTracks has been updated to allow reimbursement for procedure code S0281 when the current billing provider NPI (S0281) and the history billing provider NPI (the provider that billed for the OB package) of the PMH, **are different**. CPT procedure code S0281 should be billed upon completion of the comprehensive postpartum visit. Claims resubmitted must meet time limit requirements.

For more information, providers should refer to the N.C. Division of Medical Assistance [Obstetrics and Gynecology Clinical Coverage Policy web page](#). Providers with questions can contact the CSRA Call Center at 1-800-688-6696 or [NCTracksprovider@nctracks.com](mailto:NCTracksprovider@nctracks.com).

**Clinical Policy and Programs**  
**DMA, 919-855-4260**

## Proposed Clinical Coverage Policies

Per NCGS §108A-54.2, proposed new or amended Medicaid clinical coverage policies are available for review and comment on the N.C. 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 because 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 June 1, 2017**, the following policies are open for public comment:

Proposed Policy	Date Posted	Comment Period End Date
1B-1, Botulinum Toxin Treatment: Type A (Botox, Dysport and Xeomin) and Type B (Myobloc)	06/01/17	07/16/17
1B-3, Intravenous Iron Therapy	06/01/17	07/16/17
1S-8, Drug Testing for Opioid Treatment and Controlled Substance Monitoring	04/27/17	06/11/17

### Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date*	Checkwrite Date	EFT Effective Date
<b>June 2017</b>	06/02/17	06/06/17	06/07/17
	06/09/17	06/13/17	06/14/17
	06/16/17	06/20/17	06/21/17
	No checkwrite week of June 19 – 23, 2017		
	06/30/17	07/05/17	07/06/17
<b>July 2017</b>	07/07/17	07/11/17	07/12/17
	07/14/17	07/18/17	07/19/17
	07/21/17	07/25/17	07/26/17
	07/28/17	08/01/17	08/02/17

\* Batch cutoff date is previous day

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**Director of Clinical and Operations**  
**Division of Medical Assistance**  
**Department of Health and Human Services**

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**Paul Guthery**  
**Executive Account Director**  
**CSRA**