N.C. Medicaid Bulletin
July 2017

In This Issue ……..……. Page

Providers are responsible for informing their billing agency of information in this bulletin.

Personal Care Services Providers

Private Duty Nurses

Attention: All Providers

NC Medicaid Electronic Health Record Incentive Program Announcement

NC-MIPS is Open for Program Year 2017

The N.C. Medicaid Incentive Payment System (NC-MIPS) is currently accepting Program Year 2017 Modified Stage 2 and Stage 3 Meaningful Use (MU) attestations.

Note: If the provider was paid for Program Year 2016 using a patient volume reporting period from calendar year 2016, they may use the same patient volume reporting period when attesting in Program Year 2017.

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

For objective and measure requirements, providers should refer to the CMS Modified Stage 2 or Stage 3 MU specification sheets.

For program announcements, resources and information, visit the N.C. Medicaid EHR Incentive Program web page.

Program Year 2017 'Quick Tip' Webinar Series

The 'Quick Tip' webinar series gives providers key information in webinars that are less than 10 minutes long. These webinars have been updated to reflect the requirements and resources available for Program Year 2017. Providers are encouraged to visit the N.C. Medicaid EHR Incentive Program web page under the 'Resources and Webinars' tab and watch these webinars before attesting in Program Year 2017.

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

Return to Top

Attention: All Providers

Pharmacy Behavioral Health Clinical Edits

On May 1, 2017, new pharmacy point of sale (POS) clinical edits for behavioral health medications became effective for pediatric and adult beneficiaries prescribed such medications. These edits are specifically related to dosage and quantity prescribed which exceeds the Food and Drug Administration (FDA) approved maximum dosage, dosage schedule and in class therapeutic duplication.

A 90-day grace period is in place to allow providers and pharmacists an opportunity to identify and address any therapeutic issues that may be impacted by these new POS behavioral health clinical edits. Pharmacists are encouraged to contact prescribers if they identify any beneficiary that may be affected. **The edits will deny pharmacy claims beginning on July 30, 2017.** Bypassing the edit will require an override that should be used by the pharmacist when the prescriber provides clinical rationale for the therapy issue identified by the edit. The edit override is 10 entered in a submission clarification code field.

The edit descriptions for pediatrics and adults follow.

- Quantities more than the dosages recommended by the FDA for the atypical antipsychotics
- Quantities more than the dosages recommended by the FDA for the antidepressants
- Quantities more than the dosages recommended by the FDA for attention deficit/attention deficit hyperactivity disorder ADD/ADHD medications
- Concomitant use of three or more atypical antipsychotics
- Concomitant use of two or more antidepressants (selective serotonin reuptake inhibitor - SSRIs)
- Concomitant use of two or more antidepressants (selective serotonin reuptake inhibitor - SSRIs)
- Concomitant use of two or more anxiolytics
- Quantities more than the dosages recommended by the FDA for the behavioral health medications (does not include antidepressants, atypical antipsychotics, stimulants and ADD/ADHD medications)

Note: Concomitant use is 60 or more days of overlapping therapy.

Outpatient Pharmacy Services
DMA, 919-855-4300

Attention: All Providers

Sterilization Consent Form Requirements

Note: This is an update to the June 2017 Medicaid Bulletin. The fourth bullet (highlighted) is the change.

As of June 1, 2017, N.C. Medicaid amended 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 complete the form for each individual or pre-populate information on the site, prior to printing the consent form. Signature fields may not be pre-populated.

2. Once the beneficiary has had the surgery and before submitting the completed consent form to N.C. Department of Health and Human Services (DHHS) fiscal contractor, 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. Forms without this information cannot be processed.

   Mail completed sterilization consents to:

   CSRA
   P.O. Box 30968
   Raleigh, NC 27622

3. Providers should check future Medicaid Bulletins for updates related to the facility NPI.

4. DMA will continue to accept old forms with recipient signature dates prior to Aug. 1, 2017 and the form is completed in accordance to DMA policy. The Sterilization Consent Form located on the HHS website must be used **when signed by the recipient on or after Aug. 1, 2017**. If the correct form is not submitted, the Sterilization Consent Form will receive a permanent denial. Providers are encouraged to begin using the Sterilization Consent Form located on the U.S. Department of Health and Human Services website immediately.

5. The complete name of the individual or facility that provided 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 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.

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.

Clinical Policy and Programs
DMA, 919-855-4260

Return to Top

Attention: All Providers

Abortion Procedure Code 88304

Since July 1, 2013, some abortion-related claims billed with procedure code 88304 (surgical pathology, gross and microscopic examination) have processed in error. Normally, these claims would pend for nurse review and be subject to a variety of edits. For example, all provider types submitting claims for reimbursement – including any associated services following an abortion – will be denied or recouped if the abortion statement on file is invalid or missing. The abortion-related claims billed with procedure code 88304 did not pend for nurse review.

This issue has been resolved. A provider notification will be posted in a Medicaid Bulletin when claim reprocessing is required.

For more information, providers should refer to Clinical Coverage Policy 1E-2, *Therapeutic and Non-therapeutic Abortions*, on DMA's Obstetrics and Gynecology Clinical Coverage Policy web page.

Providers with questions can contact the CSRA Call Center at 1-800-688-6696 (phone), 919-710-1965 (fax) or NCTracksprovider@nctracks.com.

Clinical Policy and Programs
DMA, 919-855-4260

Return to Top

Attention: All Providers

NCTracks Provider Training Available in July 2017

Registration is open for several instructor-led training courses for providers that will be held in July 2017. The duration varies depending on the course.

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

On-site courses include hands-on training and are limited to 45 participants. They are offered in-person at the CSRA facility at 2610 Wycliff Road in Raleigh.

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

Enrollment Specialist User Roles, Abbreviated Manage Change Requests and Upload Documents (WebEx)

- Monday, July 3 – 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 applications

Dental Helpful Hints (WebEx)

- Thursday, July 6 – 1 to 3 p.m.

This course will provide users with tips for requesting Dental Prior Approval (PA) and dental claim submissions 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 Institutional Prior Approvals (On-site)

- Friday, July 7 – 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 will also cover PA inquiry to check on the status of a PA Request.

Submitting Institutional Claims (On-site)

- Friday, July 7 – 1 to 4 p.m.

This course will focus on how to submit institutional claims via 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, and view the results of a claim submission. The course is being offered in-person at the CSRA facility at 2610 Wycliff Road in Raleigh. It includes hands-on training and will be limited to 45 participants.

Submitting Pharmacy Prior Approvals (WebEx)

- Tuesday, July 11 – 9 to 11 a.m. (WebEx)

This course will show participants how to submit and inquire about Pharmacy Prior Approval (PA) Requests on the NCTracks Provider Portal. It will also cover Prior Approval Inquiry to check on the status of the Pharmacy PA request.

Ortho Helpful Hints (WebEx)

- Wednesday, July 19 – 1 to 3 p.m.
- Monday, July 31 – 1 to 3 p.m.

This course discusses some helpful tips to remember when submitting a request for Orthodontic Prior Approval (PA).

Note: This course will **not** provide instructions on how to submit an Orthodontic Prior Approval At the end of the training, providers will be able to:

- Identify the three methods of PA submission
- Identify how to upload documents when submitting PAs via NCTracks or to existing PAs
- Identify the most common errors when completing the American Dental Association form
- Identify common errors that require requests for PA additional information
- Request payment for orthodontic records
- Submit PA for orthodontic treatment requiring orthognathic surgery
- Use the Orthodontic PA attachment forms

Fingerprinting Required Application Process (WebEx)

- Tuesday, July 25 – 1 to 4 p.m.
- Thursday, July 27 – 1 to 4 p.m.
- Friday, July 28 – 1 to 4 p.m.

This course will guide the user on completing the Fingerprinting Required application process in NCTracks.

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

- Identify the provider types that are required to complete the fingerprinting application
- Understand the notification process
- Navigate NCTracks Provider Portal to complete and submit a fingerprinting application

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-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

Return to Top

Attention: All Providers

Affiliation Claim Edit and Edit Capability – Clarification

Note: This is the last bulletin that DMA Provider Services will publish this article

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.

Provider Services
DMA, 919-855-4050

Return to Top

Attention: All Providers

Provider 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.

CSRA, 1-800-688-6696

Return to Top

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. Medicaid 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.

Provider Services
DMA, 919-855-4050

Return to Top

Attention: All Providers

Prior Approval for Spinal Surgeries Required Aug. 1, 2017

Note: This is an update to an article published in the May 2017 Medicaid Bulletin.

Session Law 2011-145 HB 200 Section 10.37(a)(11)(g)(4) requires N.C. Medicaid 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) requires PA.

The implementation date for the new clinical coverage and spinal surgery PA requirement is **Aug. 1, 2017**. Providers will be able to electronically submit PA requests for spinal surgery on this date for dates of service on or after August 1.

Note: PA must be granted prior to the service being rendered in order to be reimbursed.

Refer to the April 2017 Medicaid Bulletin article, *New Coverage and Prior Approval Requirements for Spinal Surgeries*, for information regarding PA requirements and exemptions.

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

Return to Top

Attention: All Providers

Medicaid 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. Medicaid program 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.

Provider Services
DMA, 919-855-4050

Return to Top

Attention: All Providers

Request for Disproportionate Share Hospital Data for MEDICARE: Change in Process-Update

Note: This article was originally published in the June 2017 Medicaid Bulletin. It is being republished with updates.

Effective July 1, 2017, Medicaid and N.C. Health Choice Providers (NCHC) should 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 should no longer manually submit Medicare DSH eligibility verification and claims data requests to the N.C. Medicaid program.

This change in process will enable the following:

PS&R Reports

Hospitals will receive PS&R data from NCTracks by submitting a CSRA PS&R Detailed Report Request Form located under the heading Provider Forms on the Provider Policies, Manuals, Guidelines and Forms page of the NCTracks provider portal. The form includes information regarding the cost of the report.

Eligibility Verification

Hospitals will receive recipient eligibility verifications from NCTracks through the X12 270 Transaction Method, at no cost.

X12 270 Transaction Method

Hospitals with a large volume of recipient eligibility verifications should submit batch uploads in the X12 270 transaction format. For information on how to format these files, refer to the 5010 ASC X12 TR3 national standard guidelines. Unique requirements for NCTracks can be found in the 270/271 Health Care Eligibility Benefit Inquiry and Response Companion Guide located on the Trading Partner page of the NCTracks provider portal.

Providers who submit X12 batch uploads are considered to be "trading partners" and are required to be authorized to submit electronic transactions in NCTracks. For more information on how to obtain authorization to submit electronic transactions, refer to the "How to Select a Billing Agent and Other Claim Submission Options in NCTracks" user guide under the heading Provider Record Maintenance on the Provider User Guides and Training page of the NCTracks provider portal. Additional information may be found in the NCTracks Trading Partner Connectivity Guide on the Trading Partner page.

Hospitals may also use a Clearinghouse or Billing Agent to submit the X12 270 transactions on their behalf.

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

Return to Top

Attention: All Providers

Change of Ownership for Medicaid and Health Choice Providers Enrolled in Medicare

Note: This article was originally published in the June 2017 Medicaid Bulletin. It is being republished until August 2017.

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

Return to Top

Attention: All Providers

Medicaid Behavioral Health Provider Enrollment

Note: This article was originally published in the June 2017 Medicaid Bulletin. It is being republished until August 2017.

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.

Provider Services
DMA, 919-855-4050

Return to Top

Attention: All Providers

Maintain Eligibility Process

Note: This article was originally published in the June 2017 Medicaid Bulletin. It is being republished until November 2017.

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

Return to Top

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 until August 2017. **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.

Provider Services
DMA, 919-855-4050

Return to Top

Attention: All Providers

Abbreviated Application for Ordering, Prescribing and Referring Practitioners

Note: This article was originally published in the June 2017 Medicaid Bulletin. It is being republished until November 2017.

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, physician 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. OPR practitioners can request a retroactive effective date up to 365 days preceding the date of application.

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 lite provider on their claims when these providers order or refer items or services. NCTracks will not reimburse OPR lite providers when their NPI is used as rendering or attending on a claim.

The following enrollment requirements will apply to OPR lite 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.

Out-of-state and border providers are still subject to the fingerprinting requirement. They may have the process completed in their home state and results stored in PECOS or verified through the state Medicaid agency. If the owner9s) is/are out-of-state, that owner would be required to fingerprint in their home state and send the evidence.

Note: OPR lite providers also request a retroactive effective date up to 365 days preceding the date of application.
Provider Services
DMA, 919-855-4050

Return to Top

Attention: All Providers

Out of State Provider Enrollment

Note: This article was originally published in the June 2017 Medicaid Bulletin. It is being republished until November 2017.

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 full-enrollment application or a lite-enrollment application.

If an out of state 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 an out of state provider chooses to enroll using the full-enrollment application the following will apply:

- The provider will complete a full-enrollment application.
- 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

Return to Top

Attention: All Providers

Ordering, Prescribing and Referring (OPR) Update

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 National Provider Identifier (NPI) of the "OPR Lite" provider on their claims when these providers order or refer items for services. NCTracks will not reimburse the billing provider when an "OPR Lite" provider's 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" provider to a fully enrolled provider if they are to be reimbursed for services as a rendering or attending provider.

Note: OPR providers can request a retroactive effective date up to 365 days preceding the date of application. This will ensure the effective date of enrollment aligns with the date of service for claims pending due to a provider not being enrolled in the Medicaid and NCHC programs.

N.C. Medicaid has extended the use of the NPI Exemption List for providers **through Jan. 31, 2018**. The exemption from the provider enrollment requirement does not include an exemption from the DEA registration requirement for controlled substances. N.C. Medicaid will accept the Supervising Physician's NPI on the claim for any Resident or Intern in a Graduate Dental and Medical Education program when it is appropriate for a claim to be submitted.

In accordance with 42 CFR 415.208, N.C. Medicaid covers billable services of a Resident who performs services outside of the GME program must be fully licensed by North Carolina to practice medicine, osteopathy, dentistry or podiatry **and** be enrolled in N.C. Medicaid. These services are considered to have been furnished by the a fully licensed physician, dentist or podiatrist.

All providers should note that any NPI entered on a claim will be validated, even if it is not required for that service/claim type. The claim will pend for 90 days to allow the attending, ordering, prescribing or referring provider(s) to enroll in the N.C. Medicaid or NCHC program.

If, after 90 days from the date of the claim pending, the attending, ordering, prescribing, or referring provider is not enrolled, the claim will deny with the following EOBs:

EOB	Message
02420	ORDERING PROVIDER INVALID OR NOT ACTIVE ON DATES OF SERVICE
02421	ORDERING PROVIDER INVALID OR NOT ACTIVE ON DATES OF SERVICE. QMB RECIPIENT
02422	REFERRING PROVIDER INVALID OR NOT ACTIVE ON DATES OF SERVICE
02423	REFERRING PROVIDER INVALID OR NOT ACTIVE ON DATES OF SERVICE, QMB RECIPIENT
02425	SERVICE FACILTY PROVIDER INVALID OR NOT ACTIVE ON DATES OF SERVICE. QMB RECIPIENT
02428	OPERATING PROVIDER INVALID OR NOT ACTIVE ON DATES OF SERVICE
02429	OPERATING PROVIDER INVALID OR NOT ACTIVE ON DATES OF SERVICE. QMB RECIPIENT
02430	OTHER OPERATING PROVIDER INVALID OR NOT ACTIVE ON DATES OF SERVICE
02431	OTHER OPERATING PROVIDER INVALID OR NOT ACTIVE ON DATES OF SERVICE. QMB RECIPIENT
02434	ATTENDING PROVIDER INVALID OR NOT ACTIVE ON DATES OF SERVICE
02435	ATTENDING PROVIDER INVALID, OR NOT ACTIVE ON DATES OF SERVICE. QMB RECIPIENT
02437	SERVICE FACILTY PROVIDER INVALID OR NOT ACTIVE ON DATES OF SERVICE
02438	ORDERING PROVIDER REQUIRED
02439	ORDERING PROVIDER MUST BE ENROLLED AS AN INDIVIDUAL PROVIDER
02440	REFERRING PROVIDER REQUIRED
02441	REFERRING PROVIDER MUST BE ENROLLED AS AN INDIVIDUAL PROVIDER
02442	OPERATING PROVIDER REQUIRED

Billing providers should verify the enrollment of the ordering, prescribing or referring practitioner through the "Enrolled Practitioner Search Function" on the NCTracks provider portal before services are provided. This feature allows NCTracks providers to inquire about other providers enrolled in N.C. Medicaid and NCHC. The Enrolled Practitioner Search provides the capability to validate provider information for billing, attending, referring, rendering, ordering and prescribing providers.

Note: The response to the Enrolled Practitioner Search only includes individual providers who are actively enrolled in N.C. Medicaid or NCHC on the date of inquiry. Information contained in the database is maintained by the individual provider and is subject to change daily. To access this feature, click on the Enrolled Practitioner Search button on the lower left side of the NCTracks Provider Portal home page. There is a Job Aid to assist providers under Quick Links on the Enrolled Practitioner Search page.

Stakeholder meetings will begin on July 14 and July 28 at 10 a.m. The call-in number for stakeholder meeting is 919-733-2511. Additional details regarding training will be provided in future Medicaid Bulletin articles. Also, review N.C. Medicaid's Frequently Asked Questions (FAQs) regarding OPR Requirements.

Provider Services
N.C. Medicaid, 919-855-4050

Return to Top

Attention: All Providers

Revised Clinical Policy No: 1T-2 Special Ophthalmological Services

The North Carolina Division of Medical Assistance (DMA) has revised Clinical Policy No: 1T-2 Special Ophthalmological Services to add new ICD 10 codes that were effective 10/1/2016 and to delete the ICD-10 codes that were end dated on 9/30/16. The codes that were added, effective 10/01/2016, support the medical necessity for two of the procedures in this policy: 1) Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI) procedures and 2) Fundus Photography. The specific ICD-10 codes in the policy must be used so that claims can be paid correctly.

The following ICD10 codes for SCODI are added to this policy:

ICD-10-CM Code(s)		
Service Provided SCODI		
H40.1110 H40.1111 H40.1112 H40.1113 H40.1114 H40.1120 H40.1121 H40.1122 H40.1123 H40.1124 H40.1130 H40.1131 H40.1132 H40.1133 H40.1134		

The following ICD10 codes for SCODI are end dated in this policy:

ICD-10-CM Code(s)		
Service Provided SCODI		
H40.11x0 H40.11x1 H40.11x2 H40.11x3 H40.11x4		

The following ICD10 codes for Fundus Photography are added to this policy:

ICD-10-CM Code(s)		
Service Provided Fundus Photography		
E10.3211 E10.3212 E10.3213	E11.3211 E11.3212 E11.3213	E13.3211 E13.3212 E13.3213

E10.3291	E11.3291	E13.3291
E10.3292	E11.3292	E13.3292
E10.3293	E11.3293	E13.3293
E10.3311	E11.3311	E13.3311
E10.3312	E11.3312	E13.3312
E10.3313	E11.3313	E13.3313
E10.3391	E11.3391	E13.3391
E10.3392	E11.3392	E13.3392
E10.3393	E11.3393	E13.3393
E10.3411	E11.3411	E13.3411
E10.3412	E11.3412	E13.3412
E10.3413	E11.3413	E13.3413
E10.3491	E11.3491	E13.3491
E10.3492	E11.3492	E13.3492
E10.3493	E11.3493	E13.3493
E10.3511	E11.3511	E13.3511
E10.3512	E11.3512	E13.3512
E10.3513	E11.3513	E13.3513
E10.3521	E11.3521	E13.3521
E10.3522	E11.3522	E13.3522
E10.3523	E11.3523	E13.3523
E10.3531	E11.3531	E13.3531
E10.3532	E11.3532	E13.3532
E10.3533	E11.3533	E13.3533
E10.3541	E11.3541	E13.3541
E10.3542	E11.3542	E13.3542
E10.3543	E11.3543	E13.3543
E10.3551	E13.3551	E13.3551
E10.3552	E11.3552	E13.3552
E10.3553	E11.3553	E13.3553
E10.3591	E11.3591	E13.3591
E10.3592	E11.3592	E13.3592
E10.3593	E11.3593	E13.3593
E10.37X1	E11.37X1	E13.37X1
E10.37X2	E11.37X2	E13.37X2
E10.37X3	E11.37X3	E13.37X3
		O24.415
		O24.425
		O24.435

Clinical Policy and Programs
DMA, 919-855-4260

Return to Top

Attention: Behavioral Health Service Providers

Nurse Practitioner Credentialing in Outpatient Clinical Policy 8C

This bulletin informs Local Management Entities-Managed Care Organizations (LME-MCOs) and providers about amendment to nurse practitioner (NP) credentialing requirements located in Clinical Coverage Policy 8C, *Outpatient Behavioral Health Services Provided by Direct - Enrolled Providers*, Section 6.1.

Effective July 1, 2017, Clinical Coverage Policy 8C will be amended to reflect the following requirements applicable to NPs not certified as Psychiatric Mental Health Nurse Practitioners (PMHNP):

- "Nurse Practitioners not certified as PMHNP may be eligible to provide psychiatric services to Medicaid beneficiaries if they meet all the requirements listed below, as demonstrated to the credentialing body of the Prepaid Inpatient Health Plan (PIHP):

    a. Documentation that they have three (3) full-time years of psychiatric care and prescribing experience under licensed psychiatric supervision including psychiatric assessments and psychotropic medication prescribing; and

    b. A signed supervision agreement with a North Carolina Licensed Psychiatrist that covers prescribing activities; and

    c. Continuing education requirements, going forward, which include 20 hours each year focused on psychiatric physiology, diagnosis, and psychopharmacology. (21 NCAC 36.0807)

- The PIHP credentialing body and the Medical Director are responsible for assessing the qualifications of Nurse Practitioners not yet certified as Psychiatric Mental Health Nurse Practitioners and for monitoring the supervision and continuing education requirements.

- Waiver of the requirement for three years of supervised psychiatric experience for a NP not yet certified as a PMHNP must be based on access needs of the PIHP, documented in the records of the credentialing body, approved by the PIHP Medical Director, and reassessed on an annual basis. Other details in items b. and c. above apply."

The goal in developing this policy is to assure that qualified NPs are working within the behavioral health system, and to provide flexibility so that access to services are not impacted. Additionally, we intend to establish a work group with LME-MCO representatives and state staff to develop a standard procedure for requesting a waiver for the three years of experience.

For more information, contact Kelsi A. Knick at Kelsi.Knick@dhhs.nc.gov or 919-855-4288.

Behavioral Health Policy Section
DMA, 919-855-4290

Attention: Durable Medical Equipment Providers

Clinical Coverage Policies 5A-1, 5A-2, 5A-3: Compliance with CMS Home Health Final Rule, 42 CFR, Part 440.70

The following policy updates will become **effective July 1, 2017**. These updates will bring the state's Durable Medical Equipment and Supplies (DME) policies into compliance with the Centers for Medicare & Medicaid Services (CMS) Home Health Final Rule, 42 CFR, Part 440.70.

Updates common to 5A-1, 5A-2 & 5A-3

The following sections now read as follows:

1. **Section 1.1.1 Definition of Durable Medical Equipment**:
   - Durable Medical Equipment is primarily and customarily used to serve a medical purpose, is generally not useful to an individual in the absence of a disability, illness or injury, can withstand repeated use, and can be reusable or removable.

2. **Section 1.1.2 Definition of Medical Supplies**:
   - Medical Supplies are health care related items that are consumable or disposable, or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness or injury.

3. **Section 1.2 Categories of Durable Medical Equipment and Supplies, opening sentence**:
   - Durable Medical Equipment and Supplies refers to the following categories of equipment and related supplies:

4. **Section 3.2.1 Specific criteria covered by both Medicaid and NCHC**:
   - Medicaid and NCHC cover medical equipment and related supplies when ALL the following requirements are met:

     a. the item is ordered by a physician, physician assistant, or nurse practitioner;

     b. the item is medically necessary to maintain or improve a beneficiary's medical, physical or functional level, and appropriate for use in any non-institutional setting in which normal life activities take place;

     c. a documented face-to-face encounter with the beneficiary and the ordering physician, physician assistant, or nurse practitioner related to the primary reason the beneficiary requires durable medical equipment and supplies has occurred no more than six (6) months prior to the start of services; and

     d. the beneficiary's need for durable medical equipment and supplies is reviewed by the ordering physician, physician assistant, or nurse practitioner at least annually.

5. **Section 5.6.1 Delivery directly to the beneficiary**, **sentence three**:
   - The provider shall ensure the equipment or supply is appropriate for the beneficiary's needs, and the beneficiary will be educated on the lifetime expectancy and the warranty of the item.

6. **Section 7.2 Record Keeping**, **requirement f.**
   - A full description of any service or repairs, including details of parts and labor, applicable warranty information, and the date of the service or repair. If the item is removed from the beneficiary's environment for service or repair, record the date of removal and the date of return.

Updates specific to each of the three parts of the DME policy

1. **Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies:**
   - In addition to the common updates indicated above, language also was changed to comply with **3.2.1.b** above in the following subsections: **5.3.1, 5.3.4, 5.3.5, 5.3.6, 5.3.11, 5.3.12, 5.3.13, 5.3.14 and 5.3.15**.

2. **Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies:**
   - In addition to the common updates indicated above, language also was changed to comply with **3.2.1.b** above in the following subsections: **5.3.1, 5.3.2 and 5.3.4**.

3. **Clinical Coverage Policy 5A-3, Nursing Equipment and Supplies:**
   - In addition to the common updates indicated above, language also was changed to comply with **3.2.1.b** above in the following subsections: **5.3.3, 5.3.6 and 5.3.7**.

Implications for the Prior Authorization process and record keeping

Effective July 1, 2017, for the initiation of medical equipment and supplies, documentation of a face-to-face encounter between the ordering practitioner and the beneficiary, having occurred no more than six months prior to the start of services and being related to the primary reason the beneficiary requires medical equipment and supplies, **must be submitted with the Certificate of Medical Necessity/Prior Authorization (CMN/PA) request**.

If PA is not required for the medical equipment and supplies in question, then the DME provider should keep the documentation of the face-to-face encounter on file with the completed Request for Prior Approval CMN/PA form (DMA-372-131).

The requirement for the ordering physician's annual review of the beneficiary's need for medical equipment and supplies can be met by completion of a new CMN/PA form at least annually.

In **3.2.1.b** above, the reference to an item being "…appropriate for use in any non-institutional setting in which normal life activities take place" has been clarified by CMS in the Federal Register, Vol 81, No 21 as "…items that are necessary for everyday activities and not specialized for an institutional setting."

Additional Resources

For additional information, link to the N.C. Medicaid Durable Medical Equipment web page and the CMS final rule at 42 CFR Part 440.

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

Return to Top

Attention: Early Intervention Providers of Community Based Rehabilitative Services and Behavioral Health Local Management Entities - Managed Care Organizations (LME-MCOs)

Prior approval for Community Based Rehabilitative Services (CBRS) for beneficiaries over three years of age

Prior approval for Community Based Rehabilitative Services (CBRS) for beneficiaries over three years of age must be requested as a non-covered state plan service under Early and Periodic Screening Diagnosis and Treatment (EPSDT). Approval under EPSDT must be based on findings of medical necessity and determination that there is no other comparable service to meet the child's need.

Behavioral health requests for Medicaid beneficiaries over the age of three years of age must be submitted to the appropriate LME-MCO for review. Behavioral health providers who provide services to children over the age of three years must be contracted and credentialed with the LME-MCO to provide services.

The Procedure Code for CBRS is H0036 with Modifier HI. NC Tracks will deny Fee for Service claims for H0036 HI when billed for a child over the age of three years.

If you have questions, please contact the Division of Medicaid Behavioral Health Unit at 919-855-4290.

Return to Top

Attention: Nurse Practitioners, Physicians and Physicians Assistants

Avelumab injection, for intravenous use (Bavencio) HCPCS code J9999: Billing Guidelines

Effective with date of service April 1, 2017, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover avelumab injection for intravenous (IV) use (Bavencio) through the Physician's Drug Program (PDP) when billed with HCPCS code J9999 – Not otherwise classified, Antineoplastic drug. Bavencio is currently commercially available as single-use vials: 200 mg/10 mL (20 mg/mL).

Bavencio is indicated for the treatment of adults and pediatric patients 12 years of age and older with metastatic Merkel cell carcinoma (MCC). This indication is approved under accelerated approval. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis codes required for billing are:
    - C4A.0 - Merkel cell carcinoma of lip
    - C4A.10 – Merkel cell carcinoma of unspecified eyelid, including canthus
    - C4A.11 – Merkel cell carcinoma of right eyelid, including canthus
    - C4A.12 – Merkel cell carcinoma of left eyelid, including canthus
    - C4A.20 – Merkel cell carcinoma of unspecified ear and external auricular canal
    - C4A.21 – Merkel cell carcinoma of right ear and external auricular canal
    - C4A.22 – Merkel cell carcinoma of left ear and external auricular canal
    - C4A.30 – Merkel cell carcinoma of unspecified part of face
    - C4A.31 – Merkel cell carcinoma of nose
    - C4A.39 – Merkel cell carcinoma of other parts of face
    - C4A.4 – Merkel cell carcinoma of scalp and neck
    - C4A.51 – Merkel cell carcinoma of anal skin
    - C4A.52 – Merkel cell carcinoma of skin of breast
    - C4A.59 – Merkel cell carcinoma of other part of trunk
    - C4A.60 – Merkel cell carcinoma of unspecified upper limb, including shoulder
    - C4A.61 – Merkel cell carcinoma of right upper limb, including shoulder
    - C4A.62 – Merkel cell carcinoma of left upper limb, including shoulder
    - C4A.70 – Merkel cell carcinoma of unspecified lower limb, including hip
    - C4A.71 – Merkel cell carcinoma of right lower limb, including hip
    - C4A.72 – Merkel cell carcinoma of left lower limb, including hip
    - C4A.8 – Merkel cell carcinoma of overlapping sites
    - C4A.9 – Merkel cell carcinoma, unspecified
    - C7B.1 – Secondary Merkel cell carcinoma

- Providers must bill with HCPCS code: J9999 - Not otherwise classified, Antineoplastic drug
- One Medicaid unit of coverage is 1 mg
- The maximum reimbursement rate per unit is $8.12 per 1 mg
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs is 44087-3535-01
- The NDC units should be reported as "UN1".
- For additional information, refer to the January 2012, Special Bulletin, *National Drug Code Implementation Update*.
- For additional information regarding NDC claim requirements related to the PDP, refer to the *Clinical Coverage Policy No. 1B, Physician Drug Program*, Attachment A, H.7 on the N.C. Medicaid website.
- Providers shall bill their usual and customary charge for non-340-B drugs.
- PDP reimburses for drugs billed for N.C. Medicaid and NCHC beneficiaries by 340-B participating providers who have registered with the Office of Pharmacy Affairs (OPA). Providers billing for 340-B drugs shall bill the cost that is reflective of their acquisition cost. Providers shall indicate that a drug was purchased under a 340-B purchasing agreement by appending the "UD" modifier on the drug detail.
- The fee schedule for the PDP is available on DMA's PDP web page.

CSRA 1-800-688-6696

Return to Top

Attention: Orthotics and Prosthetics Providers

Clinical Coverage Policy 5B, Orthotics & Prosthetics: Compliance with CMS Home Health Final Rule, 42 CFR, Part 440.70

The following policy updates will become **effective July 1, 2017**. These updates will bring the state's Durable Medical Equipment and Supplies (DME) policies into compliance with the Centers for Medicare & Medicaid Services (CMS) Home Health Final Rule, 42 CFR, Part 440.70

1. **Section 1.0 Description of the Procedure, Product, or Service.** The last paragraph now reads:
   - Refer to the Orthotic and Prosthetic Devices Fee Schedule for more information. The fee schedule is available on the N.C. Medicaid website.

2. **Section 3.2.1 Specific criteria covered by both Medicaid and NCHC,** now reads:
   - Medicaid and NCHC cover orthotics and prosthetics when ALL the following requirements are met

     a. they are ordered by a physician, physician assistant, or nurse practitioner;

     b. they are medically necessary to maintain or improve a beneficiary's medical, physical or functional level, and appropriate for use in any non-institutional setting in which normal life activities take place;

     c. a documented face-to-face encounter with the beneficiary and the ordering physician, physician assistant, or nurse practitioner related to the primary reason the beneficiary requires orthotics and prosthetics has occurred no more than six (6) months prior to the start of services; and

     d. the beneficiary's need for orthotics and prosthetics is reviewed by the ordering physician, physician assistant, or nurse practitioner at least annually.

3. **Section 7.2 Record Keeping**, **requirement e.** now reads:
   - A full description of any service or repairs, including details of parts and labor, applicable warranty information, and the date of the service or repair. If the item is removed from the beneficiary's environment for service or repair, record the date of removal and the date of return.

4. **Attachment C: How a Beneficiary Obtains Orthotic and Prosthetic Devices**, step one, sentence one now reads:
   - A physician, physician assistant, or nurse practitioner who has personally examined the beneficiary in accordance with **Section 3.2, Specific Criteria Covered**, writes a prescription for the needed orthotic or prosthetic device.

Implications for the Prior Authorization (PA) process and record keeping are the same as those documented in the durable medical equipment and supplies article above.

Additional Resources

For additional information, link to the updated policy on the DMA Medical Equipment Clinical Coverage Policies web page and the CMS final rule at 42 CFR Part 440.

DMA Clinical Policy and Programs
DMEPOS section, 919-855-4310

Return to Top

Attention: Personal Care Services Providers

Early and Periodic Screening, Diagnostic, and Treatment Beneficiaries Turning 21

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal requirement compelling state Medicaid agencies to cover services, products, or procedures for Medicaid beneficiaries under 21 years of age **if** those items are medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a medical screening or examination.

When a Medicaid beneficiary turns 21, they are no longer eligible for EPSDT.

Effective July 1, 2017, Personal Care Services (PCS) beneficiaries receiving PCS under EPSDT will be required to submit a new DMA 3051, Request for Independent Assessment for Personal Care Services Attestation of Medical Need prior to the date of their 21st birthday. The DMA 3051 form must be completed by the beneficiary's primary care physician or the practitioner providing care for the medical, physical, or cognitive condition causing the functional limitation.

If the new request for assessment is not received by the beneficiary's 21st birthday, authorization for PCS will end on the beneficiary's 21st birthday.

Ninety days prior to the beneficiaries 21st birthday, PCS beneficiaries or their legal representative will be notified of this requirement and receive a letter stating that on the beneficiary's 21st birthday, they will no longer be eligible for PCS under EPSDT per Clinical Coverage Policy 3L, *State Plan Personal Care Services*, Section 2.2.1. The letter will also be uploaded to the NCTracks Provider Portal and will include a copy of the DMA 3051.

Once the DMA 3051 is received and processed, Liberty Healthcare Corp. of N.C. will work with beneficiaries to schedule an assessment in the 10 days following the date of the 21st birthday. Retroactive PCS approval will be allowed between the date the beneficiary turns 21 and the assessment approval date for the amount previously awarded (if 80 hours or less) or at 80 hours (if more than 80 hours were previously approved).

Questions may be directed to DMA Clinical Policy at 919-855-4360.

Long-Term Services and Supports
DMA, 919-855-4360

Return to Top

Attention: Private Duty Nursing Providers

Congregate Care Services: Codes Active Under the PDN program

Private Duty Nursing (PDN) allows congregate nursing services where there are two or more Medicaid beneficiaries residing in the same home. Congregate care is limited to a maximum ratio of one private duty nurse to two individuals who receive hourly nursing services. If there are more than two individuals receiving hourly nursing services, the provider should contact an N.C. Medicaid PDN consultant to determine the individual needs for each beneficiary. PDN services will be approved accordingly.

PDN service providers shall report the most specific billing code that accurately describes the procedure or service, and the level of nursing service provided. Providers shall use the applicable modifiers for required billing of PDN services.

HCPCS Code(s)	Program Description
T1000 TD	PDN Nursing Services, RN
T1000 TE	PDN Nursing Services, LPN

The PDN service providers shall report the specific HCPCS codes for beneficiary receiving congregate services:

HCPCS Code(s)	Program Description
S9123	Congregate nursing, RN
S9124	Congregate nursing, LPN

Home Care Services/Community Based Services
DMA, 919-855-4380

Return to Top

Attention: Private Duty Nursing Providers

Timeframe for Obtaining Accreditation for Non-Accredited Private Duty Nursing Services Previously Provided Under the Community Alternatives Program for Children Waiver

Non-accredited nursing service providers previously providing services under the Community Alternatives Program for Children **(**CAP/C) waiver are required to obtain accreditation and meet all required occupational licensing entity regulations by **Feb. 28, 2018.**

Previously, under the provisions of the CAP/C waiver, nursing service providers were not required to be accredited. As the provision of nursing services for CAP/C beneficiaries has been transitioned to the State Plan Private Duty Nursing (PDN) program, these nursing service providers must now be accredited with one the following accreditation agencies per the 2010 Federal Affordable Care Act (ACA):

- Joint Commission
- Community Health Accreditation Partner (CHAP)
- Accreditation Commission for Health Care (ACHC)

In addition, per occupational licensing entity regulations, PDN service providers must hold a current license from the N.C. Division of Health Service Regulation (DSHR), as applicable. PDN service provider entities must be Medicare Certified Home Health Agencies. The home care agency must be an enrolled N.C. Medicaid provider approved by Medicaid to provide PDN services. Each office of the home care agency providing services must have an individual National Provider Identifier (NPI) number.

Home Care Services/Community Based Services
DMA, 919-855-4380

Return to Top

Attention: Private Duty Nursing Providers

Private Duty Nursing Clinical Coverage Policies Effective March 1, 2017

Private Duty Nursing (PDN) Clinical Coverage Policy 3G-1, *Private Duty Nursing for Beneficiaries Over 21 Years of Age,* and 3G-2, *Private Duty Nursing for Beneficiaries Under 21 Years of Age,* have been posted to the Medicaid website with an effective date of March 1, 2017. In the past, PDN services were rendered under a single clinical coverage policy. This policy has been split into two policies accounting for differences in coverage for the service population by age.

PDN Clinical Coverage Policy 3G-1 (for Beneficiaries Over 21 Years of Age) contains the following modifications:

- Expansion of definitions and terms
- Identification of PDN Level 1 and Level 2 services
- Clarification of the amount, duration, scope, and sufficiency of PDN services and primary caregiver requirements
- Clarification of initial PDN services requirements – process, documentation, provisional approval and continuation approval
- Removal of the direct service nurse experience requirement, retroactive coverage and verbal orders
- Expansion of expertise areas for nursing supervisors, provider qualifications and occupational licensing entity regulations and emergency changes – additional information

PDN Clinical Coverage Policy 3G-2 (for Beneficiaries Under 21 Years of Age) contains the following modifications:

- Expansion of definitions and terms
- Defined health criteria and medical fragility
- Clarification of the amount, duration, scope, and sufficiency of PDN services and primary caregiver requirements
- Removal and standard PDN and expanded PDN services
- Clarification of initial PDN services requirements – process, documentation, provisional approval and continuation approval

- Removal of the direct service nurse experience requirement, retroactive coverage and verbal orders

- Expansion of expertise areas for nursing supervisors, provider qualifications and occupational licensing entity regulations and emergency changes – additional information

- Clarification of congregate care services and PDN in schools – additional information

Both PDN Clinical Coverage Policies, 3G-1 and 3G-2, can be for in the Community-Based Services Policy webpage section of the Medicaid website.

Home Care Services/Community Based Services
DMA, 919-855-4380

Return to Top

Attention: Private Duty Nursing Providers

Private Duty Nursing Program: Process Updates

Documentation Requirements

Private Duty Nursing (PDN) service providers are reminded of the Prior Authorization (PA) documentation requirements found in Section 5.0 [*Requirements for and Limitations of Coverage*] of Clinical Coverage Policies 3G-1, *Private Duty Nursing for Beneficiaries Age 21 and Older*, and 3G-2, *Private Duty Nursing for Beneficiaries Under 21 years of Age*.

NCTracks PA Entry Notes

PDN service providers are required to enter "one" PA request per beneficiary per certification period, and all supporting documentation must be uploaded to the same active PA throughout the duration of the PA period.

As the transition PAs are entered for an extended time-period, the PDN service provider shall upload the signed CMS-485 every 60 days into the transition PA throughout the date of the extension.

PDN service providers with transitioned Community Alternatives Program for Children (CAP/C) beneficiaries are required to **upload signed CMS-485 forms** (*Home Health Certification and Plan of Care*) and any supporting documents or additional information, if requested, to the current PA in the NCTracks system.

Home Care Services/Community Based Services
DMA, 919-855-4380

Return to Top

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. Medicaid 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 July 1, 2017, the following policies are open for public comment:

Proposed Policy	Date Posted	Comment Period End Date
PA Criteria: Hepatitis C Virus Medications	06/22/17	08/06/17
Outpatient Pharmacy Clinical Edits - Behavioral Health – Adult	06/20/17	07/05/17
Outpatient Pharmacy Clinical Edits - Behavioral Health – Pediatric	06/20/17	07/05/17
5A-1, Physical Rehabilitation Equipment and Supplies	06/15/17	07/15/17
5A-2, Respiratory Equipment and Supplies	06/15/17	07/15/17
5A-3, Nursing Equipment and Supplies	06/15/17	07/15/17
5B, Orthotics & Prosthetics	06/15/17	07/15/17
1B-1, Botulinum Toxin Treatment: Type A (Botox, Dysport and Xeomin) and Type B (Myobloc)	06/01/17	07/16/17
1B-3, Intravenous (IV) Iron Therapy	06/01/17	07/16/17

Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date*	Checkwrite Date	EFT Effective Date
July 2017	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
August 2017	08/02/17	08/08/17	08/09/17
	08/09/17	08/15/17	08/16/17
	08/16/17	08/22/17	08/23/17
	08/23/17	08/29/17	08/30/17

* Batch cutoff date is previous day

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

Paul Guthery
Executive Account Director
CSRA

Return to Top