



# N.C. Medicaid Bulletin

## August 2017

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*Providers are responsible for informing their billing agency of information in this bulletin.  
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**Attention: All Providers****Physician Medicare Crossover Claims Subject to 3 Percent Rate Reduction****Issue**

N.C. Session Law 2013-360, subsequently modified by Session Law 2014-100, required a 3 percent rate reduction in 10 Medicaid and N.C. Health Choice services. The 3 percent rate reduction for physician services was implemented March 1, 2015, for current claims and going forward. The rate reduction was applied to most previously paid claims over multiple checkwrites in early 2015. However, the Physician Medicare Crossover Claims were not reprocessed during this time.

**Action**

The Physician Medicare Crossover Claims will be reprocessed to apply the 3 percent rate reduction, and overpayments will be recouped.

**Timing**

This claim reprocessing was originally planned to begin in April 2017. However, several reprocessed claims in the initial batch denied for edit 01760 - MISSING MEDICARE LINE OTHER PAYER INFORMATION. This issue has been resolved. Applicable Physician Medicare Crossover claims will be reprocessed over the next several weeks and will be reflected in the checkwrites between August 15 and Sept. 26, 2017. (There will be one additional checkwrite cycle after analysis of the reprocessed claims. The date of the final checkwrite cycle has not yet been determined.)

**Remittance Advice**

Reprocessed claims will be displayed in a separate section of the paper Remittance Advice with a unique Explanation of Benefits (EOB) code 10301 – REPROCESSED FOR 3 percent REDUCED PHYSICIAN RATE- MEDICARE CROSSOVER ONLY. The 835 electronic transactions will include the reprocessed claims along with other claims submitted for the checkwrite. (There is no separate 835.)

**Important Reprocessing Information**

Reprocessing does not guarantee payment for the claims. The overpayments on Physician Medicare Crossover claims will be recouped. Also, while some edits will be bypassed as part of the claim reprocessing, such as edit 01760, changes made to the system since the claims were originally adjudicated may apply to the reprocessed claims. Therefore, the reprocessed claims could deny.

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

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

### **Additional Information**

- Medicaid Special Bulletin - [April 27, 2017](#)
- Medicaid Special Bulletins - [Feb. 20, 2015](#) and [April 2015](#)
- January 2014 Medicaid Bulletin (*3 Percent Rate Reduction*, page 3)
- [N.C. Session Laws 2013-360](#) and [2014-100](#)

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

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### **Attention: All Providers**

## **Clinical Coverage Policies**

The following new or amended combined N.C. Medicaid and N.C. Health Choice clinical coverage policies are available on Medicaid's Clinical Coverage Policy web pages:

- 8C, *Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers* – 07/01/17
- 1A-41, *Office-Based Opioid Treatment: Use of Buprenorphine and Buprenorphine-Naloxone* – 08/01/17
- 1E-2, *Therapeutic and Non-therapeutic Abortions* – 08/01/17
- 1T-2, *Special Ophthalmological Services* – 08/01/17

These policies supersede previously published policies and procedures.

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

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**Attention: All Providers****C**laims Reprocessing Notice**Reprocessing of Claims Due to Pharmacy Reimbursement Methodology Changes**

This reprocessing notice applies to pharmacy claims processed and paid in NCTracks from Jan. 1 through July 30, 2016.

**Background**

On Jan. 11, 2016, the Centers for Medicare & Medicaid Services (CMS) notified the Division of Medical Assistance (DMA) that consistent with CFR 430.20, State Plan Amendment (SPA14-147) was approved effective Jan. 1, 2016. The approved SPA specifies that the state will use an average acquisition cost (AAC) reimbursement methodology to reimburse brand and generic drug ingredient costs. The National Average Drug Acquisition Cost (NADAC) will be used to determine the AAC when NADAC is available. If NADAC pricing is not available, the state will calculate the AAC as the Wholesale Acquisition Cost (WAC) + 0 percent. Reimbursement methodology will continue to include the lesser of NADAC or WAC in absence of NADAC, the State Maximum Allowable Cost (SMAC) rate on file and the usual and customary (U&C) price submitted. The amendment also specifies that the state pay pharmacies a tiered dispensing fee as follows:

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

Refer to the June and July 2016 Pharmacy newsletters on the [Medicaid website](#) for a complete explanation of the Pharmacy Reimbursement Methodology Changes. **These changes were implemented in NCTracks on July 31, 2016.**

**Action**

A sample set of claims will be pulled and pended for analysis in advance of the claims reprocessing. These claims/ transactions will post to the Remittance Advice (RA) in the Aug. 1, 2017, checkwrite but will not have financial activity.

Pharmacy claims processed and paid from January 1 through July 30, 2016, will be reprocessed with the new reimbursement methodology.

## Timing

Applicable pharmacy claims paid between January 1 and July 30, 2016, will be reprocessed according to the updated reimbursement methodology. These reprocessed claims will be reflected in the checkwrites between August 15 and Nov. 21, 2017. (There will be one additional checkwrite cycle after analysis of the reprocessed claims. A notice will be sent when the date of the final checkwrite cycle is determined.)

## Remittance Advice

The reprocessed claims will appear in a separate section of the paper RA with the unique Explanation of Benefits (EOB) code 06025 - CLAIM REPROCESSED TO PAY USING NADAC (NATIONAL AVERAGE DRUG ACQUISITION COST) PRICING METHODOLOGY. The EOB 06025 will only appear on the paper RA and will not appear on the X12 835. The 835 electronic transactions will include the reprocessed claims along with other claims submitted for the checkwrite. (There is no separate 835.)

**Note:** Reprocessing does not guarantee payment for the claims. Pharmacy claims will be reprocessed with the new reimbursement methodology. Also, while some edits may be bypassed as part of the claim reprocessing, changes made to the system since the claims were originally adjudicated may apply to the reprocessed claims. Therefore, the reprocessed claims could deny.

**The claim reprocessing will likely result in a recoupment of funds.** If there are not sufficient funds from claims paid in the August 15 through Nov. 21, 2017, checkwrites to satisfy the recoupment, an Accounts Receivable (AR) will be created. Recoupment of the AR will begin with the subsequent NCTracks checkwrite and the recoupment process will continue at each checkwrite until the full amount due is recouped.

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

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

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**Attention: All Providers and Pharmacists****Updated Prior Approval Criteria for Opioid Analgesics**

Effective Aug. 27, 2017, prior approval will be required for opioid analgesic doses for N.C. Medicaid and N.C. Health Choice (NCHC) beneficiaries which:

- Exceed 120 mg of morphine equivalents per day
- Are greater than a 14-day supply of any opioid, or,
- Are non-preferred opioid products on the [NC Medicaid Preferred Drug List \(PDL\)](#)

The prescribing provider may submit prior authorization requests to NCTracks through the NCTracks portal or by fax. New opioid analgesic prior authorization forms and revised clinical coverage criteria will be available on the NCTracks website.

Beneficiaries with diagnosis of pain secondary to cancer will continue to be exempt from prior authorization requirements.

This change also includes a new feature for prescribers to view only lock-in drugs or opioid analgesics when performing medication history searches for beneficiaries.

**CSRA, 1-866-246-8505**

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**Attention: All Providers****Spinal Surgeries Prior Approval Clarification**

**Note:** This is an update to an article previously published in the [July 2017 Medicaid Bulletin](#).

Beginning **Aug. 1, 2017**, providers will be able to electronically submit prior approval (PA) through NCTracks for spinal surgery for dates of service on or after **Sept. 1, 2017**. Voided PA requests submitted prior to August 1 will need to be reentered.

**Note:** PA must be granted **prior** to the service being rendered in order to be reimbursed. Clinical Coverage Policy 1A-30, *Spinal Surgery*, will be published to the Medicaid website on Aug. 1, 2017.

In addition, due to recent stakeholder feedback, the psychiatric evaluation has been removed from the PA requirements for spinal surgery.

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**

**Attention: All Providers****The Office of the State Auditor: Single Audit - 2017**

In accordance with [2 CFR part 200, subpart F](#), the N.C. Office of the State Auditor (OSA) annually selects a sample of N.C. Medicaid and N.C. Health Choice (NCHC) claims to determine the State's accuracy and error rate for claims paid in the prior state fiscal year (July through June). The Office of Compliance & Program Integrity (OCPI) is in the process of sending out record request notifications to providers with a claim in the sample. To minimize costs and prevent delays, OCPI may contact providers by phone to verify the mailing address for these record requests.

The record request contains a list of the documents that must be submitted to OCPI for review. The requested documents **should** be sent as soon as possible, but no later than 30 calendar-days after receipt of the letter. OCPI is requesting providers with more than 25 pages of documentation scan the documents and send them on an **encrypted** CD or flash drive, with the **password submitted separately** via email to [Medicaid.sa.dhhs.nc.gov](mailto:Medicaid.sa.dhhs.nc.gov).

During the record request process, OCPI may ask for additional documentation to support the claim payment. Failure of the provider to respond by the stated deadline to a request for documentation may result in the provider being placed on prepayment claims review.

N.C. Medicaid is authorized to access patient records related to the administration of Medicaid, the Medicaid Waiver, and the N.C. Health Choice Program. In addition, when applying for Medicaid benefits, each recipient signs a release authorizing access to his or her Medicaid records by N.C. Medicaid and other appropriate regulatory authorities. It is not necessary for providers to require a signed consent for the release of records from any Medicaid recipient. Providers with questions may contact the Office of the State Auditor at the following email address: [Medicaid.sa@dhhs.nc.gov](mailto:Medicaid.sa@dhhs.nc.gov).

**Office of Compliance & Program Integrity**  
**DMA, 919-814-0172**

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**Attention: All Providers****T**herapeutic and Non-Therapeutic Abortions

As of Aug. 1, 2017, Medicaid has revised Clinical Policy 1E-2, *Therapeutic and Non-Therapeutic Abortions*. **Effective Oct. 1, 2017**, providers must use the abortion statement located on the [N.C. Medicaid's forms web page](#). If the correct abortion statement is not submitted to N.C. Department of Health and Human Services (DHHS) fiscal agent, CSRA, with a physician signature date on or after Oct. 1, 2017, **the abortion statements will be denied**.

- The abortion statement must be printed on the provider's professional letterhead. All claims will deny until the appropriate statement is on file.
- Abortion statements and health records may be submitted with the abortion claim in NCTracks. Alternatively, providers may mail abortion statements and health records, if applicable, to DHHS fiscal contractor:

CSRA  
P.O. Box 30968  
Raleigh, NC 27622

- If the beneficiary's name on the claim and the name on the abortion statement are different, a signed name change statement must be submitted with a copy of the abortion statement and health records. Name change statements must be written on the provider's office letterhead and signed by a representative of the provider's office.
- The signature of the physician performing the abortion procedure must include the providers first and last name. Initials are not acceptable and will result in abortion statement denial.

Providers should refer to Clinical Policy 1E-2, *Therapeutic and Non-Therapeutic Abortions*, for CPT and ICD-10 procedure and diagnosis code updates related to abortion claim submission on [Medicaid's 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**

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

Registration is open for several instructor-led training courses for providers that will be held in August 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.

**Create and Submit a Prior Approval for Durable Medical Equipment and Home Health Supplies Using Electronic Signature (WebEx)**

- Tuesday, August 1 – 1:00 p.m. to 3:00 p.m.

This course is about the electronic-signature (e-signature) process that allows the requesting provider to answer all questions related to the recipient's medical status when entering a Prior Approval (PA) request on the Provider portal. The PA request will then be sent to the prescribing provider for review and the providing provider will sign an attestation statement saying that he/she agrees with the information entered by the requesting provider. At the end of training, providers will be able to:

- Assign a user role to a provider
- Assign a Durable Medical Equipment (DME) PA request to the prescribing provider
- Assign a Home Health Supply PA request to the prescribing provider
- Access the notification of the PA request within NCTracks Provider Portal Message Center
- Accept a PA request and confirm with an electronic signature
- Reject a PA request and send back to the requesting provider
- Revise a PA request and re-assign to the prescribing provider

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

- Friday, August 4 – 9:30 a.m. to noon

This course will cover submitting prior approval (PA) requests to help ensure compliance with Medicaid clinical coverage policy and medical necessity. It also will cover PA inquiry to check on the status of a PA Request.

**Submitting a Professional Claim (On-site)**

- Friday, August 4 – 1 to 4 p.m.

This course will focus on how to submit a professional claim via the NCTracks Provider Portal. At the end of training, providers will be able to:

- Enter a professional claim
- Save a draft claim
- Use the Claims Draft Search tool
- Submit a claim
- View the results of a claim submission

**Submitting Dental and Orthodontic Claims (WebEx)**

- Tuesday, August 15 – 1 to 4 p.m.

This course will focus on how to submit dental and orthodontic claims via the NCTracks Provider Portal. At the end of training, providers will be able to:

- Enter dental and orthodontic claims
- Save a draft claim
- Use the Claims Draft Search tool
- Submit a claim
- View the results of a claim submission

**Submitting Institutional Prior Approvals (On-site)**

- Thursday, August 17 – 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)**

- Thursday, August 17 – 1 to 4 p.m.

This course will focus on how to submit an institutional claim 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
- View the results of a claim submission

### **New Office Administrator (WebEx)**

- Friday, August 18 – 9 a.m. to 11 a.m.

This course shows authorized users the process for changing the current Office Administrator (OA) to a new OA for an individual provider or organization with a National Provider Identification (NPI) number, or an Atypical Provider. At the end of training, authorized users will be able to:

- Update the OA for an individual provider and an organization
- Upgrade existing users to managing relationships

### **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**

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

**Note:** This is the last bulletin in which DMA Provider Services will publish this article.

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.

Per [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.**

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**

# **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 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 should use the appropriate MU attestation guide while attesting. The guides provide detailed instructions and can be found on the right-hand side of NC-MIPS.

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.

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

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

**Note:** This is the last bulletin in which DMA Provider Services will publish this article.

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). Responses will be posted on the NCTracks provider portal Frequently Asked Questions (FAQ) page.

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

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## **Attention: All Providers**

### **C**hange of Ownership for Medicaid and Health Choice Providers Enrolled in Medicare

**Note:** This is the last bulletin in which DMA Provider Services will publish this article.

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**

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

**Note:** This is the last bulletin in which DMA Provider Services will publish this article.

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 NCTracks 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****A**bbreviated 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 who solely order, refer, or prescribe items for NC Medicaid or NC Health Choice (NCHC) beneficiaries **must** enroll in the Medicaid program. 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 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 owner is out-of-state, that owner would be required to fingerprint in their home state and send the evidence to NC Medicaid.

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

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**Attention: All Providers****O**ut 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.
- There is no application fee for lite-enrollment.

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.

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**Attention: All Providers****R** **Request for Disproportionate Share Hospital Data for MEDICARE:  
Change in Process-Update**

**Note:** This article was published with updates in the [June 2017 Medicaid Bulletin](#). It is being republished until September 2017.

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](#) web page of the NCTracks provider portal. The form includes information regarding the submission request, cost and delivery of the report.

**Eligibility Verification**

Hospitals will conduct recipient eligibility inquiry and response verifications from NCTracks through the X12 270/271 Transaction Method, at no cost.

*X12 270 Transaction Method*

Hospitals with a large volume of recipient eligibility inquiry 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 NCTracks 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**

### **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**

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**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 reenrollment 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 recredentialing 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 NCTracks 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**

### **Qualifications and Requirements Checklist**

**Note:** This is the last bulletin in which CSRA will publish this article.

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 NCTracks Call Center at 1-800-688-6696 (phone) or [NCTracksprovider@nctracks.com](mailto:NCTracksprovider@nctracks.com).

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

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

21552 (A)	21552 (B)	23120 (A)	23120 (B)	29822 (A)	29822 (B)	43651 (A)
43651 (B)	53447 (A)	53447 (B)	57455	57455 (B)	58340	58340 (B)
61340 (A)	61340 (B)	64491	64491 (B)	64492	64492 (B)	64493
64493 (B)	64494	64494 (B)	64495	64495 (B)	64634	64634 (B)
64636	64636 (B)	67810	67810 (B)	71275	71275 (B)	74740
74740 (B)	76831	76831 (B)	96360 (B)	96361 (B)	96409 (B)	

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

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

The Medicaid website has a complete list of [previously denied billing codes for NP, PAs and Certified Nurse Midwives](#).

**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.

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

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**Attention: Nurse Practitioners, Physicians and Physicians Assistants****Durvalumab Injection, For Intravenous Use (Imfinzi): HCPCS Code J3590 - Unclassified Biologics: Billing Guidelines**

Effective with date of service May 15, 2017, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover durvalumab injection, for intravenous use (Imfinzi) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3590 - Unclassified Biologics. Imfinzi is currently available as a 500 mg/10mL (50 mg/mL) solution and a 120 mg/2.4mL (50 mg/mL) solution in single-dose vials.

Imfinzi is a programmed death-ligand 1 (PD-L1) blocking antibody indicated for the treatment of patients with locally advanced or metastatic urothelial carcinoma who have disease progression during or following platinum-containing chemotherapy and have disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy.

This indication is approved under accelerated approval based on tumor response rate and duration of response. 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 code required for billing are:
  - C65.1 - Malignant neoplasm of right renal pelvis
  - C65.2 - Malignant neoplasm of left renal pelvis
  - C65.9 - Malignant neoplasm of unspecified renal pelvis
  - C66.1 - Malignant neoplasm of right ureter
  - C66.2 - Malignant neoplasm of left ureter
  - C66.9 - Malignant neoplasm of unspecified ureter
  - C67.0 - Malignant neoplasm of trigone of bladder
  - C67.1 - Malignant neoplasm of dome of bladder
  - C67.2 - Malignant neoplasm of lateral wall of bladder
  - C67.3 - Malignant neoplasm of anterior wall of bladder
  - C67.4 - Malignant neoplasm of posterior wall of bladder
  - C67.5 - Malignant neoplasm of bladder neck
  - C67.6 - Malignant neoplasm of ureteric orifice
  - C67.7 - Malignant neoplasm of urachus
  - C67.8 - Malignant neoplasm of overlapping sites of bladder
  - C67.9 - Malignant neoplasm of bladder, unspecified
  - C68.0 - Malignant neoplasm of the urethra
- Providers must bill with HCPCS code: J3590 - Unclassified Biologics
- One Medicaid unit of coverage is 1 mg. NCHC bills according to Medicaid units. The maximum reimbursement rate per unit is: \$7.51 per 1 mg.



- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs are: 00310-4500-12, 00310-4611-50
- 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 [PDP Clinical Coverage Policy No. 1B](#), Attachment A, H.7 on DMA's website.
- Providers shall bill their usual and customary charge for non-340B drugs.
- PDP reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340-B participating providers who have [registered with the Office of Pharmacy Affairs \(OPA\)](#). Providers billing for 340-B drugs shall bill the cost that is reflective of their acquisition cost. Providers shall indicate that a drug was purchased under a 340-B purchasing agreement by appending the “UD” modifier on the drug detail.
- The fee schedule for the PDP is available on Medicaid’s [PDP web page](#).

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

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## 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 Aug 1, 2017**, the following policies are open for public comment on the [Proposed Clinical Coverage Policies web page](#):

Proposed Policy	Date Posted	Comment Period End Date
Preferred Drug List (PDL)	07/19/17	09/02/17
PA Criteria: Anti-Inflammatory Medications	07/06/17	08/20/17
PA Criteria: Spinraza	07/06/17	08/20/17
PA Criteria: Systemic Immunomodulators	07/06/17	08/20/17
PA Criteria: Cystic Fibrosis	07/06/17	08/20/17
PA Criteria: Hepatitis C Virus Medications	06/22/17	08/06/17

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**Checkwrite Schedule**

<b>Month</b>	<b>Checkwrite Cycle Cutoff Date*</b>	<b>Checkwrite Date</b>	<b>EFT Effective Date</b>
<b>August 2017</b>	08/04/17	08/08/17	08/09/17
	08/11/17	08/15/17	08/16/17
	08/18/17	08/22/17	08/23/17
	08/25/17	08/29/17	08/30/17
<b>September 2017</b>	09/01/17	09/06/17	09/07/17
	09/08/17	09/12/17	09/13/17
	09/15/17	09/19/17	09/20/17
	09/22/17	09/26/17	09/27/17
	09/29/17	10/03/17	10/04/17

\* Batch cutoff date is previous day

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**Sandra Terrell, MS, RN**  
**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**

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