NC Medicaid Bulletin

November 2018

All Providers

ATTENTION: ALL PROVIDERS

Proposed Clinical Coverage Policies for Public Comment

Proposed new or amended Medicaid and NC Health Choice clinical coverage policies are posted for comment throughout the month. Visit the Proposed Medicaid and NC Health Choice Policies for current posted policies and instructions to submit a comment.

As of Nov. 1, 2018, the following NC Medicaid policies are open for public comment:

PROPOSED POLICY	COMMENT PERIOD
10B, Independent Practitioners	10/04/2018 through 11/18/2018
Prior Approval Criteria Cystic Fibrosis	10/01/2018 through 11/15/2018
Outpatient Pharmacy Clinical Edits - Behavioral Health - Pediatric	10/01/2018 through 11/15/2018
Outpatient Pharmacy Clinical Edits - Behavioral Health - Adult	10/01/2018 through 11/15/2018
6B, Routine Eye Examination and Visual Aids for Beneficiaries 21 Years of Age and Older New policy documenting restored coverage of routine eye examinations and visual aids for Medicaid beneficiaries 21 years of age and older.	09/26/2018 through 11/10/2018
11A-17, CAR-T Cell Therapy	09/17/2018 through 11/01/2018

NC Medicaid Clinical Policy, (919) 855-4260

ATTENTION: ALL PROVIDERS

Summary of New or Amended Clinical Coverage Policies Posted Since Oct. 1, 2018

The following new or amended Medicaid and NC Health Choice clinical coverage policies were posted since Oct. 1, 2018. Visit the NC Medicaid website to view the policies.

- 1A-41, Office-Based Opioid Treatment: Use of Buprenorphine and Buprenorphine-Naloxone – Oct. 1, 2018
- 1K-7, Prior Approval for Imaging Services – Oct. 1, 2018
- 1E-7, Family Planning Services – Nov. 1, 2018
- 3L, State Plan Personal Care Services (PCS) – Nov. 1, 2018
- 11A-10, Hematopoietic Stem-Cell Transplantation (HSCT) for Central Nervous System (CNS) Embryonal Tumors & Ependymoma – Nov. 1, 2018

These policies supersede previously published policies and procedures.

NC Medicaid Clinical Policy, (919) 855-4260

ATTENTION: ALL PROVIDERS

Revised Effective Oct. 1, 2018: Clinical Coverage Policy IS-4, Genetic Testing; Add Coverage for CPT code 81420 (Fetal Chromosomal Aneuploidy)

Effective Oct. 1, 2018, providers can now bill for CPT code 81420 (fetal chromosomal aneuploidy). Procedure is limited to three units per 365 days.

Clinical coverage policy *1S-4, Genetic Testing,* is in the process of being revised to reflect this change.

Providers are to follow clinical coverage criteria in section 3.2.1 when ordering CPT code 81420.

GDIT Call Center, (800) 688-6696

ATTENTION: PROVIDERS

Revised Effective Oct. 22, 2018 and Oct. 29, 2018: Makena Auto-Injector and Hydroxyprogesterone Caproate Injection Added as Preferred Options on the Preferred Drug List

NC Medicaid has confirmed the market shortage of Makena Injection Single Dose Vial, which is a preferred option in addition to the 5 ml multi-dose vial on the NC Medicaid Preferred Drug List (PDL).

Due to market access issues that caused this shortage, **effective Oct. 22, 2018**, Makena Auto-Injector was moved to preferred status on the PDL. Also, effective **Oct. 29, 2018,** hydroxyprogesterone caproate injection single dose vial was moved to preferred status.

PROGESTATIONAL AGENTS	
Preferred	**Non-Preferred**
Makena® single dose and multi dose vial (hydroxyprogesterone caproate injection)	~~Makena® Auto-Injector~~
Makena® Auto-Injector	~~hydroxyprogesterone caproate injection single dose vial~~
Compounded 17 P	hydroxyprogesterone caproate injection multi dose vial
hydroxyprogesterone caproate injection single dose vial	

GDIT Call Center, (800) 688-6696

ATTENTION: ALL PROVIDERS

Revised Effective Nov. 1, 2018: Clinical Coverage Policy 11A-10, Hematopoietic Stem-Cell Transplantation (HSCT) for Central Nervous System (CNS) Embryonal Tumors & Ependymoma

Hematopoietic Stem-Cell Transplantation (HSCT) for Central Nervous System (CNS) Embryonal Tumors & Ependymoma, 11A-10 has been revised. The revisions, which will become effective Nov. 1, 2018, will add coverage criteria for tandem autologous stem-cell transplants for high-risk CNS embryonal tumors.

GDIT Call Center, (800) 688-6696

ATTENTION: ALL PROVIDERS

Revised Effective Nov. 1, 2018: Clinical Policy 1E-7, Family Planning Services

Clinical Policy 1E-7, *Family Planning Services*, has been revised and posted on the NC Medicaid website.

1. Ultrasounds:
    a. **MAFDN eligible beneficiaries:**
    Effective Nov. 1, 2018, during the annual exam or interperiodic visit, if the intrauterine contraceptive device (IUD) is malpositioned or the string is missing, providers may check IUD placement by performing an ultrasound. Health record documentation supporting that the ultrasound was performed due to malposition or a missing string must be submitted with the claim. If it is determined that additional medical care is necessary due to an IUD complication, the provider **must** refer the MAFDN eligible beneficiary to the local department of social services, health department, federally qualified health center (community health center) or rural health clinic in their county. If one of the above primary care providers is not available in the county where the beneficiary resides, the beneficiary may seek services in nearby or surrounding counties.

    Prior authorization (PA) will not be required for the following ultrasound codes if the beneficiary has MAFDN eligibility.

    - 76830 – ultrasound, transvaginal

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- 76856- ultrasound, pelvic (nonobstetric), real time with image documentation;
- 76857- ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (e.g., for follicles)

b. Traditional Medicaid beneficiaries

Providers should refer to Clinical Policy 1K-7 Prior Approval for Imaging Services for guidance related to ultrasounds for traditional Medicaid beneficiaries. Health record documentation is not necessary with claim submissions.

2. Effective Nov. 1, 2018, bacterial vaginosis (BV) testing and treatment will be covered for beneficiaries with MAFDN eligibility. The following CPT codes, diagnoses and medications have been added to Clinical Policy 1E-7, *Family Planning Services*:

   CPT codes
   - 87480 – Candida species, direct probe technique
   - 87510 – Gardnerella vaginalis, direct probe technique
   - 87660 – Trichomonas vaginalis, amplified probe technique

   Diagnosis codes
   - N76.0 – acute vaginitis
   - N76.1 – subacute and chronic vaginitis
   - N76.2 – acute vulvitis
   - N76.3 – subacute and chronic vulvitis

   Medications
   - Metronidazole 250mg, 500mg
   - Metronidazole gel 0.75%
   - Clindamycin cream 2%
   - Clindamycin oral 150mg
   - 300mg, Clindamycin ovules100mg
   - Tinidazole 2gm, 1 gm, 500mg, 250mg

3. The medication list has been updated in Clinical Policy 1E-7, *Family Planning Services*. Effective Nov. 1, 2018, Gentamycin 240mg IM has been added for the treatment of gonorrhea.

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4. Effective Nov. 1, 2018, CPT code 36415 (Collection of venous blood by venipuncture) has been added to Clinical Policy 1E-7, *Family Planning Services*. Providers billing for a venipuncture for a MAFDN beneficiary should follow guidelines in Clinical Policy 1S-3, *Laboratory Services*. Only one venipuncture specimen collection is reimbursable to the provider who extracted the specimen, when the specimen is sent to an independent laboratory for testing and **no testing is done in the office.**

5. The list of safety net providers has been removed from Clinical Policy 1E-7, *Family Planning Services*.

6. If a medical condition unrelated to family planning or family planning-related services occurs, or the beneficiary has no need for family planning services, the provider shall refer the beneficiary to the local department of social services, health department, federally qualified health center (community health center) or rural health clinic in their county. If one of the above primary care providers is not available in the county where the beneficiary resides, the beneficiary may seek services in nearby or surrounding counties.

Long-Acting Reversible Contraception: Intrauterine Device

Effective Nov. 1, 2018, when it has been confirmed that an intrauterine device (IUD) has been expelled, providers may reinsert a replacement IUD without any waiting period.

GDIT Call Center, 1-800-688-6696

ATTENTION: ALL PROVIDERS

Revised Effective Dec. 31, 2018 and May 1, 2019: Clinical Coverage Policy 1E-3, Sterilization Procedures

Effective Dec. 31, 2018, CPT code 58565 (Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants) will no longer be covered by NC Medicaid.

Effective May 1, 2019, CPT code 58340 (catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography) will no longer be covered by NC Medicaid.

For more information, providers should refer to the Clinical Coverage Policy 1E-3, *Sterilization Procedures*.

GDIT Call Center, 1-800-688-6696

ATTENTION: ALL PROVIDERS

Errors on Provider Records in NCTracks

Enrollment applications submitted with incorrect data including name, Social Security number (SSN) and date of birth (DOB) result in application denials and withdrawals. As a result, providers must submit new applications and pay any applicable fees. This delay can impact the fingerprint processing and may put providers at risk of suspension or termination for failure to complete the recredentialing/reverification process by the due date.

Providers, Office Administrators and Enrollment Specialists must ensure the data entered on an application is correct. Name, SSN and DOB should match the data on government-issued identification documents such as a driver's license or Social Security card.

Errors in the provider name, SSN, DOB or Employer Identification Number (EIN) cannot be corrected within an application. Instead, providers must submit a request to NCTracks asking for corrections to be made. Correction requests may be submitted by email to NCTracksprovider@nctracks.com. Any required documentation must be included in the submission (see chart below).

Once corrections have been made in NCTracks, providers may resume submission of any enrollment-related documents. **Note:** Although providers are also permitted to submit documents by fax or mail, these methods can delay processing.

Fax: (855) 710-1965
Mail: GDIT, Provider EVC Unit, P.O. Box 300020, Raleigh, NC 27622-8020

TYPE OF CHANGE	REQUIRED DOCUMENTATION
Individual Legal Name	• Copy of license/accreditation (if required by taxonomy) reflecting the correct name. • Copy of marriage license or legal name change document reflecting the correct name.
Organization/Group Legal Name	• Copy of IRS letter reflecting the correct name. • Copy of license/accreditation (if required by taxonomy) reflecting the correct name.

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TYPE OF CHANGE	REQUIRED DOCUMENTATION
Employer Identification Number (EIN)	Copy of IRS letter reflecting the correct EIN. **Note:** The IRS letter only needs to be submitted if the EIN change is NOT due to a Change of Ownership (CHOW). If the EIN change is due to a CHOW, the provider should terminate the current record with the CHOW reason and then enroll the new record with the new EIN.
Date of Birth (DOB)	Copy of birth certificate, driver's license, passport or other form of legal identification reflecting the correct DOB. **Note:** If the DOB is incorrect for a Managing Employee or Owner, it can be changed through an MCR by end-dating the incorrect information. Credentialing may be required.
Gender	Copy of birth certificate or driver's license indicating the correct gender.
Social Security Number (SSN)	Copy of Social Security card representing the correct SSN. **Note:** If the SSN is incorrect for a Managing Employee or Owner, it can be changed through an MCR by end-dating the incorrect information. Credentialing may be required.

NC Medicaid Provider Services, (919) 855-4050

ATTENTION: ALL PROVIDERS

NCTracks Document Upload Capacity Increased

The Upload Documents page on the Secure Provider Portal now allows providers to upload up to 20 enrollment-related documents, an increase over the previous maximum of 10 documents. This feature may, for example, be of use to a provider needing to upload documents in support of an affirmative response to an exclusion sanction question or a provider responding to a notice advising that an application is incomplete and additional documentation is required.

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ATTENTION: ALL PROVIDERS

New Application Withdrawal Option

Providers now have the option to withdraw an application by clicking on the “Withdraw” hyperlink on the Status and Management page of their NCTracks record. The “Withdraw” hyperlink is in the Submitted Application section in the Status column.

With this new option, providers may withdraw an application electronically, which eliminates uploading or submitting a withdrawal request by email, fax or mail.

Prior to withdrawing the application, the system will ask: "Are you sure you want to withdraw your application?”

Once confirmed, the application will be immediately withdrawn.

Once withdrawn, an application cannot be pulled back for processing. Providers will be required to submit a new application, which may require a $100 application fee.

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The electronic withdrawal process pertains to applications that are:

- In review
- Returned
- Pending payment

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ATTENTION: ALL PROVIDERS

NCTracks Provider Training Available in November 2018

Registration is open for the November 2018 instructor-led provider training courses listed below. Slots are limited.

WebEx courses can be attended remotely from any location with a telephone, computer and internet connection. Onsite courses include hands-on training and are limited to 45 participants. They are offered in-person at the GDIT facility at 2610 Wycliff Road in Raleigh.

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

AMH Attestation (WebEx)
Friday, Nov. 9, 2018, 9:30–11 a.m.

This course will guide the user through completing the Advanced Medical Home Tier Attestation via the secure Provider Portal.

Create and Submit a PA for DME and Home Health Supply using Electronic Physician Signature (WebEx)
Tuesday, Nov, 13, 2018, 10 a.m.–Noon

This course teaches:

- The step-by-step process for an Office Administrator to assign a user role
- The step-by-step process for a Requesting DME and Home Health Supply Provider to assign a PA request to the Prescribing Provider
- The step-by-step process for a Prescribing Provider to review a PA request and electronically sign the Prior Approval Request

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Prior Approval Pharmacy (WebEx)
Tuesday, November 13, 2018, 1-2:30 p.m.
Tuesday, November 27, 2018, 1-3 p.m.

This course will cover:

- Submitting Pharmacy Prior Approval requests, to help ensure compliance with Medicaid clinical coverage policy and medical necessity
- Inquiring about Pharmacy Prior Approval requests to determine their status

Prior Approval Institutional (Onsite)
Thursday, Nov. 15, 2018, 9:30 a.m.-Noon

This course will cover submitting prior approval requests with a focus on nursing facilities to help ensure compliance with Medicaid clinical coverage policy and medical necessity, including inquiring about those requests to determine their status.

After completing this course, authorized users will be able to:
- Submit prior approval requests
- Inquire about the status of prior approval requests

Submitting an Institutional Claim (Onsite)
Thursday, Nov. 15, 2018, 1-4 p.m.

This course will focus on how to submit an Institutional Claim with emphasis on long-term care and secondary claims.

At the end of training, providers who are authorized users will be able to:
- Enter an Institutional Claim
- Save a draft
- Use the Claims Draft Search tool
- Submit a claim
- View results of a claim submission

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Submitting Medical Prior Approval (Onsite)
Monday, Nov. 29, 2018, 9:30 a.m.-Noon

This course shows authorized users how to electronically submit and inquire about prior approvals for different kinds of medical services. After completing this course, authorized users will be able to submit Prior Approvals electronically and conduct electronic inquiries about Prior Approvals.

Submitting Professional Claims (Onsite)
Monday, Nov. 29, 2018, 1– 4 p.m.

This course will focus on how to submit a Professional Claim. At the end of training, as an authorized user, the user will be able to do the following:

- Enter a Professional claim
- Save a Draft
- Use Claims Draft Search
- Submit a claim
- View results of a claim submission
- Void and Replace paid claims

Training Enrollment Instructions

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

Refer to the Provider Training page of the public Provider Portal for specific instructions on how to use SkillPort. The Provider Training page also includes a quick reference regarding Java, which is required for the use of SkillPort.

GDIT, (800) 688-6696

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Updates to the NC Medicaid Electronic Health Record (EHR) Incentive Program

The NC Medicaid EHR Incentive Program's Quick Tip Webinar Series has been updated to reflect the rules and regulations for Program Year 2018. These short webinars explain each piece of the attestation process and most of them do so in roughly five-minutes or

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less. Topics include patient volume, resources when attesting, auditing, Clinical Quality Measures (CQM) and more. These webinars can be found on the "Resources and Webinars" tab of the program website.

The NC Medicaid EHR Incentive Program's frequently asked questions have also been updated with new information for Program Year 2018. Visit the program FAQ page to learn more.

Promoting Interoperability Reporting Period

Per the updated IPPS Final Rule released Aug. 2, 2018, the EHR reporting period will now be referred to as the Promoting Interoperability (PI) reporting period. The PI reporting period is any continuous 90-day period or full calendar year within the program year in which a provider successfully demonstrates meaningful use (MU) of certified EHR technology. Providers will see this change when attesting in NC-MIPS.

NC Medicaid EHR Incentive Payment System (NC-MIPS) is Open for Program Year 2018

NC-MIPS is accepting Program Year 2018 Modified Stage 2 and Stage 3 MU attestations.

TIP: Providers who were paid for Program Year 2017 using a 90-day patient volume reporting period from May 1, 2017 through Dec. 31, 2017, may use the same patient volume reporting period to attest now for Program Year 2018.

In Program Year 2018, eligible professionals (EPs) may continue using a 90-day PI reporting period. EPs may attest with a 90-day CQM reporting period if they **only** attested to adopt, implement or upgrade (AIU) thus far **and** will be attesting to MU for the first time in Program Year 2018. They will see no changes to the attestation process in NC-MIPS.

However, EPs who have met MU in a previous program year will be required to use a full calendar year CQM reporting period in Program Year 2018. Since the CQM reporting period must be a full calendar year for these EPs, they will not be able to submit CQM data in NC-MIPS until Jan. 1, 2019. EPs who would like an early review of requirements, excluding CQMs, will be allowed to submit their attestation in two parts.

Part 1 of the attestation may be submitted between May 1, 2018 and Dec. 31, 2018. It includes demographic, license, patient volume and MU objective data. EPs will **not** be required to sign or email any documentation for Part 1. The signed attestation packet will be emailed only once—after submission of CQMs.

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After Part 1 is submitted on NC-MIPS, program staff will conduct validations. Program staff will notify EPs of any discrepancies, giving EPs ample time to address any issues.

After Part 1 is validated, EPs may return Jan. 1, 2019 through April 30, 2019, to submit their CQM data on NC-MIPS. After submitting that information on NC-MIPS, providers will email the signed attestation packet and CQM report from the EP's EHR to NCMedicaid.HIT@dhhs.nc.gov to complete Part 2 of the attestation.

Providers may complete a Program Year 2018 attestation through April 30, 2019, but if submitted after Feb. 28, 2019, review by program staff prior to close of NC-MIPS is **not** guaranteed.

Note: This process does not increase or reduce the information being submitted, but allows EPs to complete their attestation in a 12-month window instead of four months.

EPs who attested in NC-MIPS in a previous year will be automatically directed to the appropriate page in NC-MIPS. EPs who attested with another state should email NCMedicaid.HIT@dhhs.nc.gov prior to attesting for Program Year 2018.

For those practices unsure if a new provider can participate in the NC Medicaid EHR Incentive Program in Program Year 2018, please email the provider's NPI to NCMedicaid.HIT@dhhs.nc.gov and program staff will determine if the provider previously attested with another practice. As a reminder, EPs must have successfully participated in a Medicaid EHR Incentive Program at least once before the end of Program Year 2016 to be able to participate in Program Years 2017 to 2021.

Visit the program website for more information.

NC Medicaid EHR Incentive Program, NCMedicaid.HIT@dhhs.nc.gov

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ATTENTION: ALL PROVIDERS

Money Follows the Person Project Update and Application Change

The Money Follows the Person Demonstration Project is preparing for the 2019-2023 Medicaid Transition Period and has updated its application for the coming year. MFP will continue to transition individuals on Medicaid from skilled level, long-term care facilities back to the community until all populations are folded into Medicaid Managed Care. The new application will be posted on the MFP website after Nov. 1, 2018. This new application will be effective Jan. 1, 2018, and any application submitted after this date must use the new application.

Money Follows the Person, (855) 761-9030

ATTENTION: ALL PROVIDERS

Are You in Compliance with North Carolina Law?

Ed.—This article was originally published in the October 2018 Medicaid Bulletin.

One of the goals of a transformed health care system is for real-time clinical and demographic data to be made available to all health care providers involved in a patient's care so that they can securely share health information concerning that patient with each other. North Carolina health care providers are required by law to connect with NC HealthConnex, North Carolina's designated health information exchange, by specific deadlines:

- **June 1, 2018.** Hospitals as defined by G.S. 131E-176(13), physicians licensed to practice under Article 1 of Chapter 90 of the General Statutes, physician assistants as defined in 21 NCAC 32S .0201, and nurse practitioners as defined in 21 NCAC 36 .0801 who provide Medicaid services and who have an electronic health record system.
- **June 1, 2019.** All other providers of Medicaid and state-funded services except dentists, ambulatory surgical centers and pharmacies.
- **Early 2019.** Prepaid Health Plans (PHPs), as defined in S.L. 2015-245 as amended, will be required to connect to the HIE per their contracts with the NC Department of Health and Human Services (NCDHHS). PHPs will be required to submit encounter and claims data by the commencement of the contract with NCDHHS.
- **June 1, 2020.** Local Management Entities/Managed Care Organizations (LMEs/MCOs) will be required to submit encounter and claims data.
- **June 1, 2021.** Dentists and ambulatory surgical centers will be required to submit clinical and demographic data (NCSL 2018-41). Pharmacies will be required to submit claims data once per day, using pharmacy industry standardized formats.

Important Note for Health Care Providers Who Did Not Connect by June 1, 2018

Hospitals, physicians, physician assistants and nurse practitioners, as described above, who did not start the connection process by June 1, 2018, are not in compliance with state law. NC Medicaid will work collaboratively with these providers to bring them into compliance, including issuing corrective action plans. At this time, noncompliant providers will continue to be enrolled in NC Medicaid and, as they file claims, will receive reimbursements for services and treatment of NC Medicaid beneficiaries.

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What Does "Connected" Mean?

To meet the state's mandate, a Medicaid provider is "connected" when its clinical and demographic information pertaining to services paid for by Medicaid and other State-funded health care funds are being sent to NC HealthConnex, at least twice daily—either through a direct connection or via a hub (i.e., a larger system with which it participates, another regional HIE with which it participates or an EHR vendor). Participation agreements signed with the designated entity would need to list all affiliate connections.

The North Carolina Health Information Exchange Authority (HIEA), the state agency managing NC HealthConnex, and NC Medicaid appreciate the many providers who have initiated a connection and are making data available through the system. Medicaid and the HIEA will continue to work closely together to ensure that NC HealthConnex develops to support health care providers and enables all of us to better serve patients and families.

To start the connection process, providers can call HIEA at the number below. Sign up here to be placed on the HIEA's distribution list for monthly updates.

NC HIEA, (919) 754-6912 or hiea@nc.gov