NC Medicaid Bulletin
December 2018

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ATTENTION: ALL PROVIDERS

Proposed Clinical Coverage Policies for Public Comment

As of Dec. 1, 2018, there are no NC Medicaid policies posted for public comment.

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

NC Medicaid Clinical Policy, (919) 855-4260

ATTENTION: ALL PROVIDERS

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

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

- 8A-1, Assertive Community Treatment (ACT) Program – Nov. 15, 2018
- 8A-2, Facility-Based Crisis Management for Children and Adolescents – Nov. 15, 2018
- 8C, Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers – Nov. 15, 2018
- 8D-1, Psychiatric Residential Treatment Facilities for Children under the Age of 21 – Nov. 15, 2018
- 9, Outpatient Pharmacy Program – Nov. 15, 2018 (Amended Date: Nov. 1, 2018)
- 1H, Telemedicine and Telepsychiatry – Dec. 1, 2018

These policies supersede previously published policies and procedures.

NC Medicaid Clinical Policy, (919) 855-4260

ATTENTION: ALL PROVIDERS

Clinical Coverage Policy (CCP) 1-H, Telemedicine and Telepsychiatry

System changes have been completed to allow non-psychiatric Nurse Practitioners and Physician Assistants to receive reimbursement for the following CPT codes when provided via telemedicine/telepsychiatry:

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- 90791 – Psychiatric Diagnostic Evaluation
- 90792 – Psychiatric Diagnostic Evaluation with Medical Services

Nurse Practitioners and Physician Assistants enrolled in the Medicaid or NC Health Choice program who provide this service may bill Medicaid or NC Health Choice.

NC Medicaid, (919) 855-4320

ATTENTION: ALL PROVIDERS

Diagnosis Codes Being Added to Exemption List for the Annual Office Visit Limit

Medicaid has designated specific ICD-10-CM diagnosis codes that do not count toward the annual visit limitation. These codes are reviewed regularly and updated as appropriate. The following ICD-10-CM codes will be added to this list of diagnosis codes for claims with dates of service on or after Jan. 1, 2019:

- F11.20 (OPIOID DEPENDENCE, UNCOMPLICATED)
- Z79.891 (LONG TERM [CURRENT] USE OF OPIATE ANALGESIC)

Visit NC Medicaid Annual Visit for more information.

GDIT, (800) 688-6696

ATTENTION: ALL PROVIDERS

The Affiliation Edit: What It Is and How to Prevent It

Some providers may have seen 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 on their claim remittance advice (RA). This edit is in place to ensure billing providers are affiliated with the rendering (individual) providers for whom they are billing to prevent inaccurate payment or fraud. The edit will apply if a rendering/ individual provider is required for the claim and the rendering/individual provider's NPI is not affiliated with the billing provider.

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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. The rendering provider should complete an abbreviated MCR to add the provider group NPI to the Affiliated Provider page to avoid claim denials. Abbreviated MCRs are processed on submission.

NC Medicaid Provider Services, 919-855-4050

ATTENTION: ALL PROVIDERS

Errors on Provider Records in NCTracks

Ed. Note: This article was originally published in the November 2018 NC Medicaid Bulletin.

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

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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.
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

Money Follows the Person Project Update and Application Change

The Money Follows the Person Demonstration Project (MFP) team 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 effective for participation requests starting Jan. 1, 2019, and will be available on the MFP website after Dec. 1, 2018.

Money Follows the Person, (855) 761-9030

ATTENTION: ALL PROVIDERS

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

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.

Eligible Professionals (EPs) may continue to use a 90-day Promoting Interoperability (PI) reporting period when attesting in Program Year 2018. 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.

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.

December Deadline for a Two-part Attestation

Dec. 31, 2018, is the last day for EPs who have met MU in a previous program year to submit a Program Year 2018 attestation in two parts.

EPs who have met MU in a previous program year are required to report a full calendar year of CQM data. This means CQMs cannot be reported in NC-MIPS until after Jan. 1, 2019. EPs who would like an early review of requirements, excluding CQMs, may submit their attestation in two parts until Dec. 31, 2018.

Part 1 of the attestation 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.

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. 2, 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.

This process does not increase or reduce the information being submitted but allows for expedited review prior to the attestation tail period.

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EPs who have not attested to MU in a previous program year, and have only attested to Adopt, Implement, Upgrade (AIU), may report 90 days of CQM data and will see no change in the attestation process in NC-MIPS.

EPs who have attested with the NC Medicaid EHR Incentive Program in a previous program year will be automatically directed to the appropriate page when attesting in NC-MIPS.

EPs who attested with another state should email NCMedicaid.HIT@dhhs.nc.gov prior to attesting for Program Year 2018.

On Jan. 2, 2019, EPs will no longer have the option to submit their attestation in two parts. Beginning Jan. 2, 2019, all EPs will be required to submit all information on NC-MIPS and email the signed attestation packet before program staff can review the attestation.

Attestations submitted after Feb. 28, 2019, are **not** guaranteed to be reviewed by program staff prior to close of 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

Telephonic Evaluation and Management is Again Being Offered for the 2018-2019 Influenza Season

In response to the anticipated higher than normal number of influenza cases this coming season, effective December 1, 2018, North Carolina Medicaid is offering telephonic evaluation and management services to beneficiaries who are actively experiencing flu-like symptoms. The purpose of this service is to assist primary care providers assessing established patients over the telephone to gather additional information.

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Telephonic evaluation and management services must be rendered by a physician, nurse practitioner, or physician assistant actively enrolled in North Carolina Medicaid and NCTracks. Services are only to be rendered to established patients or legal guardian of an established patient.

Telephonic evaluation and management services are not to be billed if clinical decision making dictates a need to see the beneficiary within 24 hours for an office visit or next available appointment. In those circumstances, the telephone consultation shall be considered a part of the office visit.

If the telephone call follows an office visit performed and reported within the past seven calendar days for the same diagnosis, then the telephone services are considered part of the previous office visit and are **not** separately billed.

CPT Codes to be reported for telephonic evaluation and management services are:

- **99441:** Telephone evaluation and management service by a physician or other qualified healthcare professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
- **99442:** 11-20 minutes of medical discussion
- **99443:** 21-30 minutes of medical discussion

ICD-10 diagnosis codes to be reported with telephonic evaluation and management services is:

- **Z20.828:** Contact with and (suspected) exposure to other viral communicable disease.

Dates of service for reporting of telephonic evaluation and management codes coincide with the annual flu season. Claims for telephonic calls related to flu-like illness will be denied for dates of service **after April 30, 2019.** Providers may be subject to post-payment review. Rates for the new service have been posted on the Medicaid website under Provider Fee Schedules.

NC Medicaid, (919) 855-4320

ATTENTION: HOSPITAL PROVIDERS

Hospital Outpatient Claims Audits Resume

NC Medicaid has instructed Health Management System (HMS) to resume audits of hospital outpatient claims. These reviews are commencing now, as the claims adjustment reason code issue has been resolved. NC Medicaid appreciates the assistance of the provider workgroups to identify issues and confirm improvements once system enhancements were completed. HMS will also continue its other assigned third-party liability reviews.

Providers with overpayments on their accounts should electronically submit adjusted claims to NCTracks. If claims are outside the 18-month adjustment period, refunds should be submitted to NCTracks using the Provider Refund Request Form.

The instructions and the form are on the NCTracks Provider Portal under the "Provider Forms" section at nctracks.nc.gov/content/public/providers/provider-manuals.html.

Please complete a separate form for refunds for NC Health Choice recipients. Mail the completed form along with a check to:

Division of Health Benefits
Medicaid Misc. Payments
P.O. Box 602885
Charlotte, NC 28260-2885

The NC Health Choice form and its refunds must be sent to:

Division of Health Benefits
NC Health Choice Misc. Payments
P.O. Box 602861
Charlotte, NC 28260-2861

NC Medicaid Third Party Liability, (919) 814-0240

ATTENTION: PHYSICIANS, PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS

Mogamulizumab-kpkc Injection, for Intravenous Use (Poteligeo®) HCPCS Code J9999: Billing Guidelines

Effective with date of service Oct. 3, 2018, North Carolina Medicaid and NC Health Choice programs cover mogamulizumab-kpkc injection, for intravenous use (Poteligeo), for use in the Physician Administered Drug Program when billed with HCPCS code J9999 - Not Otherwise Classified, Antineoplastic Drugs.

Poteligeo is available as a single-dose vial containing 20 mg/5 mL.

It is indicated for the treatment of adult patients with relapsed or refractory mycosis fungoides or Sézary syndrome after at least one prior systemic therapy.

Recommended Dose

1 mg/kg as an intravenous infusion over at least 60 minutes on days 1, 8, 15 and 22 of the first 28-day cycle and on days 1 and 15 of each subsequent cycle until disease progression or unacceptable toxicity.

See full prescribing information for further detail.

For Medicaid and NCHC Billing

MOGAMULIZUMAB-KPKC INJECTION, FOR INTRAVENOUS USE (POTELIGEO®) ICD-10-CM DIAGNOSIS CODES REQUIRED FOR BILLING
C84.00 - Mycosis fungoides, unspecified site
C84.01 - Mycosis fungoides, lymph nodes of head, face, and neck
C84.02 - Mycosis fungoides, intrathoracic lymph nodes
C84.03 - Mycosis fungoides, intra-abdominal lymph nodes
C84.04 - Mycosis fungoides, lymph nodes of axilla and upper limb
C84.05 - Mycosis fungoides, lymph nodes of inguinal region and lower limb
C84.06 - Mycosis fungoides, intrapelvic lymph nodes
C84.07 - Mycosis fungoides, spleen
C84.08 - Mycosis fungoides, lymph nodes of multiple sites
C84.09 - Mycosis fungoides, extranodal and solid organ sites
C84.10 - Sézary disease, unspecified site
C84.11 - Sézary disease, lymph nodes of head, face, and neck
C84.12 - Sézary disease, intrathoracic lymph nodes
C84.13 - Sézary disease, intra-abdominal lymph nodes
C84.14 - Sézary disease, lymph nodes of axilla and upper limb
C84.15 - Sézary disease, lymph nodes of inguinal region and lower limb
C84.16 - Sézary disease, intrapelvic lymph nodes
C84.17 - Sézary disease, spleen
C84.18 - Sézary disease, lymph nodes of multiple sites
C84.19 - Sézary disease, extranodal and solid organ sites

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- Providers must bill with HCPCS code: J9999 - Not Otherwise Classified, Antineoplastic Drugs
- One Medicaid and NC Health Choice unit of coverage is 1 mg
- Maximum reimbursement rate per unit is $204.66
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC is 42747-0761-01
- 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 PADP, refer to the PADP Clinical Coverage Policy No. 1B, Attachment A, H.7 on the NC Medicaid website.
- Providers shall bill their usual and customary charge for non-340B drugs.
- PDP reimburses for drugs billed for Medicaid and NC Health Choice beneficiaries by 340B participating providers who have registered with the Office of Pharmacy Affairs (OPA). Providers billing for 340B drugs shall bill the cost that is reflective of their acquisition cost. Providers shall indicate that a drug was purchased under a 340B purchasing agreement by appending the "UD" modifier on the drug detail.
- The fee schedule for the Physician Administered Drug Program is available on Medicaid website PADP page.

Information is current as of Oct. 24, 2018, and is not a substitute for professional judgment. For full prescribing information, please refer to current package insert or other appropriate sources prior to making clinical judgments.

GDIT, (800) 688-6696

ATTENTION: PHYSICIANS, PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS

Cemiplimab-rwlc Injection, for Intravenous Use (Libtayo®) HCPCS Code J9999: Billing Guidelines

Effective with date of service Oct. 8, 2018, North Carolina Medicaid and NC Health Choice programs cover cemiplimab-rwlc injection, for intravenous use (Libtayo) for use in the Physician Administered Drug Program when billed with HCPCS code J9999 - Not Otherwise Classified, Antineoplastic Drugs.

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Libtayo is available as a single-dose vial containing 350 mg per 7 mL. It is indicated for the treatment of patients with metastatic cutaneous squamous cell carcinoma (CSCC) or locally advanced CSCC who are not candidates for curative surgery or curative radiation.

Recommended Dose

350 mg as an intravenous infusion over 30 minutes every 3 weeks

See full prescribing information for further detail.

For Medicaid and NCHC Billing

CEMIPLIMAB-RWLC INJECTION, FOR INTRAVENOUS USE (LIBTAYO®) ICD-10-CM DIAGNOSIS CODES REQUIRED FOR BILLING
C44.02 - Squamous cell carcinoma of skin of lip
C44.121 - Squamous cell carcinoma of skin of unspecified eyelid, including canthus
C44.122 - Squamous cell carcinoma of skin of right eyelid, including canthus
C44.129 - Squamous cell carcinoma of skin of left eyelid, including canthus
C44.221 - Squamous cell carcinoma of skin of unspecified ear and external auricular canal
C44.222 - Squamous cell carcinoma of skin of right ear and external auricular canal
C44.229 - Squamous cell carcinoma of skin of left ear and external auricular canal
C44.320 - Squamous cell carcinoma of skin of unspecified parts of face
C44.321 - Squamous cell carcinoma of skin of nose
C44.329 - Squamous cell carcinoma of skin of other parts of face
C44.42 - Squamous cell carcinoma of skin of scalp and neck
C44.520 - Squamous cell carcinoma of anal skin
C44.521 - Squamous cell carcinoma of skin of breast
C44.529 - Squamous cell carcinoma of skin of other part of trunk
C44.621 - Squamous cell carcinoma of skin of unspecified upper limb, including shoulder
C44.622 - Squamous cell carcinoma of skin of right upper limb, including shoulder
C44.629 - Squamous cell carcinoma of skin of left upper limb, including shoulder
C44.721 - Squamous cell carcinoma of skin of unspecified lower limb, including hip
C44.722 - Squamous cell carcinoma of skin of right lower limb, including hip
C44.729 - Squamous cell carcinoma of skin of left lower limb, including hip
C44.82 - Squamous cell carcinoma of overlapping sites of skin
C44.92- Squamous cell carcinoma of skin, unspecified

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- Providers must bill with HCPCS code: J9999 - Not Otherwise Classified, Antineoplastic Drugs
- One Medicaid and NC Health Choice unit of coverage is 1 mg
- Maximum reimbursement rate per unit is $28.08
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC is 61755-0008-01
- 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 PADP, refer to the PADP 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 340B participating providers who have registered with the Office of Pharmacy Affairs (OPA). Providers billing for 340B drugs shall bill the cost that is reflective of their acquisition cost. Providers shall indicate that a drug was purchased under a 340B purchasing agreement by appending the "UD" modifier on the drug detail.
- The fee schedule for the Physician Administered Drug Program is available on the Medicaid website PADP page.
- Information current as of 10/24/2018 and is not a substitute for professional judgment. For full prescribing information, please refer to current package insert or other appropriate sources prior to making clinical judgments.

GDIT, (800) 688-6696

ATTENTION: OUT-OF-STATE PROVIDERS

Policy Clarification for Out-of-state Providers

Out-of-state providers, including border-area providers, must be enrolled in Medicare or their home-state Medicaid program to enroll in North Carolina Medicaid and NC Health Choice programs. If Medicare participation cannot be verified, NCTracks will contact the home-state Medicaid program for verification.

Required Medicare participation based on taxonomy will be verified, and home-state Medicaid participation will not be required.

To successfully administer screenings, application fees and revalidation requirements, as specified in the Code of Federal Regulations at 42 CFR 455.410, 42 CFR 455.414, 42 CFR 455.450 and 42 CFR 455.460, states **must** validate Medicare enrollment and, for out-of-state providers, proof of home state Medicaid participation. States can rely on the results of other states' screenings, eliminating additional costs and burdens to state Medicaid programs and providers.

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Although this is not a new policy, the Provider Permission Matrix will be updated to reflect this requirement. A Provider Enrollment FAQ has been posted.

NC Medicaid Provider Services, (919)-855-4050

ATTENTION: FQHC AND RHC PROVIDERS

Change In Scope of Services (CISS) Policy

In accordance with the North Carolina's Medicaid State Plan, Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) may request a "rate adjustment due to change in scope of services."

As of April 9, 2018, NC Medicaid instituted a policy regarding Change in Scope of Services. To request a change in scope of service, the provider must submit all necessary documentation in accordance with the change in scope of service policy located at:

- FQHCs: https://medicaid.ncdhhs.gov/providers/programs-services/medical/federally-qualified-health-centers
- RHCs: https://medicaid.ncdhhs.gov/providers/programs-services/medical/Rural-Health-Clinics

Important Dates

Prior to January 1, 2019:
One-time exception: FQHCs/RHCs may submit a change in scope of service request for each unique 12-month cost reporting period in which a qualifying change in scope of service occurred since the base year(s) used to establish the provider's unique PPS rate. For each change in scope of service requested the provider must be able to fully document costs per Paragraph 3 in the change in scope of service policy. Requested extensions will be reviewed on a case by case basis.

After January 1, 2019:
FQHCs/RHCs may request a change in scope of service once per 12-month period. The request may be based on the first (or subsequent) full year (12-month cost report) in which the cost for the change in scope of service was present.

For providers that have multiple qualifying changes in scope in a single cost report year, please refer to the CISS policy location referenced above.

For an approved CISS rate to be implemented before the beginning of the provider's fiscal year, the FQHC/RHC must submit the CISS request 90 days prior to the beginning of the provider's next fiscal year.

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The State will evaluate the submitted documentation and notify the FQHC/RHC within 90 days whether the proposed change meets criteria for a change in scope.

The FQHC/RHC's per-encounter PPS rate will be adjusted to account for increases or decreases in the scope of services and calculated on an incremental basis subject to criteria listed in the change in scope of service policy 4. (a-f). The policy is subject to change on an as-needed and/or annual basis.

NC Medicaid Provider Reimbursement, (919)-814-0060

ATTENTION: NURSING FACILITIES, ACUTE CARE HOSPITALS AND STATE OPERATED FACILITIES

Preadmission Screening Resident Review (PASRR) Program Update

New Help Desk Number

Effective November 30, 2018, the NC PASRR Help Desk Number changed. The new toll-free number is 888-245-0179. You can also reach the help desk by calling 919-813-5550. Support staff is available Monday – Friday from 8:00 am – 5:00 pm except for observed state holidays.

New Fax Number for PASRR Related Documents

Effective December 1, 2018, the fax number to submit PASRR related documents changed to 919-224-1072. Please address all fax submissions to "NC Medicaid PASRR". The previous fax number is no longer available to submit PASRR related documents. When submitting PASRR related documents for review, please limit fax submissions to the information that has been requested. By limiting the faxes to the information requested, review and response will be more efficient.

Uploading PASRR related documents to NCMUST

Providers have always had the ability to upload PASRR related documents directly to the NCMUST application. Please upload information directly to the NCMUST application whenever possible. Information that is uploaded to the NCMUST application is available immediately to PASRR reviewers and is reviewed faster thereby providing a PASRR number in a timelier manner.

Those with questions regarding the PASRR program may contact the NC Medicaid Clinical Policy Long-Term Services and Supports Section at 919-855-4364.

NC Medicaid Long-Term Services and Supports, (919)-855-4364
