NC Medicaid Bulletin

February 2019

All Providers

Out-of-State Providers

ATTENTION: ALL PROVIDERS

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

Program Reminders

There are only three months left to submit an attestation for Program Year 2018.

Providers have until Apr. 30, 2019 to submit a complete and accurate attestation for Program Year 2018. **After that, no changes can be made.** Attestations submitted by Feb. 28, 2019 are guaranteed to be reviewed by program staff prior to the close of Program Year 2018. Attestations submitted between Mar. 1, 2019 and Apr. 30, 2019 are **not** guaranteed to be reviewed by program staff prior to close of Program Year 2018.

In Program Year 2018, providers have the option to attest to Modified Stage 2 Meaningful Use (MU) or Stage 3 MU. For objective and measure requirements, providers should refer to the Centers for Medicare and Medicaid Services (CMS) Specification Sheets.

- Click here for CMS' Modified Stage 2 MU Specification Sheets
- Click here for CMS' Stage 3 MU Specification Sheets

When attesting in Program Year 2018, an eligible professional's (EP) Promoting Interoperability (PI) reporting period must be from calendar year 2018 and may be any continuous 90-day period or full calendar year in which a provider successfully demonstrates MU of certified EHR technology (CEHRT).

Providers who were paid for Program Year 2017 using a 90-day patient volume reporting period from calendar year 2017, may use the same patient volume reporting period to attest for Program Year 2018.

The attestation guides are updated each year, so providers are encouraged to use the updated attestation guide every year they attest. The attestation guides may be found on the right-hand side of 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 eligible to participate in program years 2017 to 2021.

Visit the program website for more information.

For assistance, please email the NC Medicaid EHR Incentive Program's dedicated help desk at NCMedicaid.HIT@dhhs.nc.gov. Help desk hours are 8 a.m. to 4 p.m., Monday through Friday.

Program Year 2019 Announcements

All EPs attesting in Program Year 2019 will be required to attest to Stage 3 MU and will be required to use a 2015 Edition of certified EHR technology.

CMS has updated its Promoting Interoperability Program website with Program Year 2019 information and details including the 2019 Medicaid Eligible Professional specification sheets.

For more information, visit https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2019ProgramRequirementsMedicaid.html.

Program Year 2019 clinical quality measures are available for review on the eCQI website.

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

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NCTracks Provider Training Available in February 2019

Registration is open for the February 2019 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. **Please note that the WebEx information has changed.** See the Training Enrollment Instructions below for details.

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.

Prior Approval Dental/Ortho (WebEx)
Feb. 13, 2019, 9:30 a.m. - noon
This course shows authorized users how to electronically submit and inquire about prior approval requests for dental and orthodontic procedures. At the end of this training the user will be able to submit and inquire about dental prior approval requests.

Submitting Dental/Ortho Claims (WebEx)
Feb. 13, 2019, 1:00 p.m. – 4:00 p.m.
This course will focus on how to submit dental and orthodontic claims. At the end of training, as an authorized user, you will be able to:

- Create a dental claim via the NCTracks web portal
- Submit a dental claim
- Save a draft claim
- Use claims draft search
- Submit a claim
- View results of a claim submission

Submitting Institutional Prior Approvals (On-site)
Feb. 14, 2019, 9:30 a.m. – 12:00 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. It will also cover inquiring about those requests to determine their status. After completing this course, authorized users will be able to submit prior approvals and inquire about prior approvals.

Submitting Institutional Claims (On-site)
Feb. 14, 2019, 1:00 p.m. – 4:00 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, as an authorized user, you 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

Submitting Medical Prior Approvals (On-site)
Feb.19, 2019, 9:30 a.m. – 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 inquiring about PAs to check on status.

Submitting Professional Claims (On-site)
Feb. 19, 2019, 1:00 p.m. – 4:30 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 and view the results of a claim submission.

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.

To access WebEx online training sessions:

1. From an internet browser, enter the URL https://srameeting.webex.com/meet/paynet
2. Enter your first and last name
3. Enter your email address

If this is your first time using the new CSRA Web Meeting, it is suggested that you begin the process 15 minutes prior to the start of the call. This will allow you sufficient time to download the required software to access the Web Meeting. To hear the audio portion of the class, dial: 1-800-747-5150. Enter Access code 8700322.

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, 1-800-688-6696

ATTENTION: ALL PROVIDERS

Endoscopy Code Families Updated in NCTracks

NC Medicaid has completed updating endoscopy codes in NCTracks, aligning base codes with related procedures in the same family as well as creating three new endoscopy families in NCTracks. The newly created endoscopy families are below:

Base Code	Related Procedure Codes
43191	43192, 43193, 43194, 43195, 43196
43197	43198
44380	44381, 44382, 44384

Endoscopy Pricing

A value of '3' in the Multiple Procedure field on the 2019 National Physician Fee Schedule Relative Value File January Release indicates special rules for multiple endoscopic procedures apply if the procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in the endoscopic base code field.

Multiple endoscopy pricing rules will be applied to a group before it is ranked with other procedures performed on the same day (i.e., when multiple endoscopies in the same group reported are reported on the same day as endoscopies from another group, or on the same day as a non-endoscopic procedure).

If an endoscopic procedure is reported with only its base procedure code, no separate payment will be made for the base code. Payment for the base code is included in the payment for the other endoscopy.

If an endoscopic procedure is billed with a 51 modifier with other procedures that are not endoscopies (i.e., surgical procedures), the standard multiple surgery guidelines apply.

Examples of Medicaid Pricing

Multiple endoscopies in the same group

- The system determines the highest paying procedure and allows payment at 100 percent.
- For the other endoscopies, the system subtracts the allowance for the group's base code from the allowance for the related endoscopy and allows the difference.

Multiple endoscopic procedures in different groups

For the first group

- The system determines the allowance for the highest paying procedure and pays at 100 percent.
- The system determines the allowance for the other related endoscopic procedures by subtracting the allowance for the group's base code from the allowance for the related endoscopy and pays the difference.

For the other groups

- The system follows the same method of determining the allowance for each procedure reported within a group.
- The system compares the total allowance for each group; pays the highest paying group at 100 percent and the remaining groups at 50 percent.

Multiple endoscopies in one group reported with one endoscopy from a different group

For the first group

- The system determines the allowance for the highest paying procedure and pays at 100 percent.
- The system determines the allowance for the other related endoscopic procedures by subtracting the allowance for the group's base code from the allowance for the related endoscopy and pays the difference.

For the endoscopy in a different group

- The system considers that code to be a separate group and obtains the allowance for this code.
- The system determines the total allowance for each group and pays the group with the highest allowance at 100 percent and the remaining group at 50 percent.

One endoscopy in one group reported with one endoscopy from a different group

- The system pays the highest paying procedure at 100 percent of the allowance.
- The system pays the other endoscopy at 50 percent of its allowance.

Multiple endoscopies in one group and one is that group's base code reported with multiple endoscopies in a different group

For the group that includes the base code

- The system determines the allowance for the highest paying procedure and pays at 100 percent.
- The system denies the base code because the allowance for the base code is included in the allowance for the highest paying procedure.

For the endoscopies in the other group(s)

- The system determines the highest paying procedure and pays at 50 percent.
- For the remaining endoscopies in that group, the system subtracts the allowance for the base code from the allowance for each endoscopy and pays 50 percent of the difference.

GDIT, 1-800-688-6696

ATTENTION: ALL PROVIDERS

New Rules for Abandoned Applications in NCTracks

Effective Jan. 27, 2019, abandoned applications are subject to new rules in NCTracks. While the process for addressing incomplete applications will not change, the timeframes allowed for the submission of documentation are revised. The new rules apply to all provider applications including Enrollment, Re-enrollment, Manage Change Request, Re-Verification, and Fingerprinting Applications.

If a provider submits an incomplete application to NCTracks, the application will be returned, and an **Application Incomplete Letter** will be sent to the email address of the provider's office administrator (OA) and to the secure NCTracks provider portal message center inbox. The provider will have 30 calendar days to upload the required document(s). Failure to do so will result in an abandoned application and an **Abandoned Application Letter** will be issued.

If a provider uploads documentation that is deemed insufficient, the application will be returned, and an **Application Incomplete Letter** will be sent to the provider. The provider will have 10 calendar days to respond. Failure to respond will result in an abandoned application and an **Abandoned Application Letter** will be issued.

If a provider responds timely with the submission of additional documentation, but that documentation is deemed insufficient, the application will be returned to the provider and the provider will have a final 10 days to comply. If, at the end of the final 10-day period, the application remains incomplete due to insufficient documentation, the application will be abandoned and an **Abandoned Application Letter** will be issued.

Consequences of abandoned applications

- **Re-verifications**: Providers whose re-verification due dates have passed will be terminated and re-enrollment will be required. Providers whose re-verification due dates have not yet passed still may complete and submit another re-verification application. Applicable fees apply.
- **Enrollment, Re-enrollment, and Manage Change Requests**: Providers will be required to submit a new application and pay any applicable fees.
- **Fingerprinting**: Providers whose fingerprinting applications are abandoned will be terminated.

Providers are encouraged to quickly address incomplete applications to avoid having them be considered abandoned. For additional information on re-verification, fingerprinting, and other applications, refer to the NCTracks provider portal.

GDIT, 1-800-688-6696

ATTENTION: ALL PROVIDERS

NCTracks Common Questions: Currently Enrolled Provider vs. Office Administrator Change Process

This is part of an ongoing series to address common questions NCTracks receives from providers.

There has been some confusion over the difference between the currently enrolled provider (CEP) registration and the office administrator (OA) change process. To understand which you may need to use, please see the explanations below.

CEP registration serves two purposes:

- It was used by providers who were actively billing Medicaid at the time NCTracks went live (Legacy MMIS+ providers who were mailed an NCTracks registration letter with an authorization code, which is required to complete the currently enrolled provider NCTracks registration application) and needed to migrate to the NCTracks system.
- It is used to add an OA to the record when the record is active, but there is no OA on record. This is rare, but still available should a provider need it.

OA change process is used when:

- The previous OA is no longer available.
- You are the OA but you have a new NCID.
- You are an individual provider and you now want to become your own OA.

To update the OA for your provider record, complete a Change Office Administrator Application. For more information, please see the NCTracks Office Administrator (OA) Change Process webpage.

Individual pages for CEP and the OA Change Process can be found on the menu bar from the provider home page.

The OA Change Process webpage offers a *Change Office Administrator Application Guide* under Quick Links for more information on the online process, including some helpful hints. The CEP webpage offers a *Step-by-Step Registration Guide* under Quick Links. Providers are encouraged to review these materials for additional clarification.

GDIT, 1-800-688-6696

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Sterilization Consent Form

The sterilization consent form found on the U.S. Department of Health & Human Services (HHS) website has been updated.

https://www.hhs.gov/opa/sites/default/files/consent-for-sterilization-english-updated.pdf (English)

https://www.hhs.gov/opa/sites/default/files/consent-for-sterilization-spanish-updated.pdf (Spanish)

These links can also be accessed from the NC Medicaid website: https://medicaid.ncdhhs.gov/forms.

Providers can access the Sterilization Consent Form by clicking on the words "Sterilization Consent Form." Providers may choose to complete the form for each individual or pre-populate information on the site prior to printing the consent form. Signature fields may not be pre-populated.

Providers should always use the latest version when submitting the sterilization consent form to the NC Medicaid fiscal agent.

Providers with questions can contact the GDIT Call Center at 1-800-688-6696 or NCTracksprovider@nctracks.com.

GDIT, 1-800-688-6696

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Clinical Coverage Policies

The following new or amended clinical coverage policies are available on NC Medicaid's website at https://medicaid.ncdhhs.gov/:

- 1A-26, Deep Brain Stimulation – 02-01-2019
- 1A-33, Vagus Nerve Stimulation for the Treatment of Seizures – 02-01-2019
- 1K-1, Breast Imaging Procedures – 02-01-2019
- 1K-7, Prior Approval for Imaging Services – 02-01-2019 – 02-01-2019
- 8J, Children's Developmental Service Agencies (CDSAs) – 02-01-2019
- 9B, Hemophilia Specialty Pharmacy Program – 02-01-2019

These policies supersede previously published policies and procedures. 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 and Programs, 919-855-4260

ATTENTION: OUT-OF-STATE PROVIDERS

Policy Clarification for Out-of-state Providers

This article is an update to the article previously published in the December 2018 Medicaid Bulletin.

Out-of-state providers, including border-area providers, must be enrolled in Medicare or their home-state Medicaid program to enroll in NC Medicaid and 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.

This is not a new policy. Please refer to Provider Enrollment Frequently Asked Questions for additional information.

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