NC Medicaid Bulletin
August 2019

ATTENTION: ALL PROVIDERS
Clinical Coverage Policy Update: 1A-12 Breast Surgeries

Clinical Coverage Policy 1A-12 Breast Surgeries (which can be accessed at: https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/physician-clinical-coverage-policies) has been updated to reflect changes throughout the policy.

Several additions have been added to male gynecomastia and breast reconstruction sections.

Language for mastectomy coverage has been updated to "Mastectomy or Breast Conserving Surgery is covered when it is medically necessary."

Breast Reconstruction, including tissue expanders and implant material had a limit of "once per occurrence of breast cancer" removed. No limit has been designated.

All ICD-10 codes have been removed.

Refer to policy Section 5.1 for Prior Approval requirement.

NC Medicaid Clinical Policy and Programs, (919) 813-5550 or (888) 245-0179

ATTENTION: ALL PROVIDERS
New Coverage for Low-Dose Lung Cancer Screening

Effective July 1, 2019, providers may request, perform and bill for low-dose lung cancer screening utilizing healthcare common procedure coding system (HCPCS) code G0297 (low-dose CT scan [LDCT] for lung cancer screening). This service was previously requested and performed under current procedural terminology (CPT) code 71250 (computed tomography, thorax; without contrast material). Prior approval is dependent on the beneficiary's eligibility at the time of service. Please refer to clinical coverage policy 1K-7, (which can be accessed at: https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/radiology-clinical-coverage-policies) prior approval for imaging services, for information regarding PA requirements. G0297 will also be available to perform and bill in the IDTF setting.

GDIT, (800) 688-6696

ATTENTION: ALL PROVIDERS
Clinical Coverage Policy Update

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

- 9, Outpatient Pharmacy Program – July 15, 2019
- 8F, 8F, Research-Based Behavioral Health Treatment (RB-BHT) For Autism Spectrum Disorder (ASD – Aug. 1, 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) 813-5550 or (888) 245-0179

ATTENTION: ALL PROVIDERS
Sterilization Consent Form

The sterilization consent form found on the U.S. Department of Health & Human Services (HHS) website has been updated. The routine Office of Management and Budget (OMB) consent form review process has finalized, and the only change made to the form was the new expiration date of April 30, 2022. Providers should now use this version when submitting the sterilization consent form to the NC Medicaid fiscal agent.

NC Medicaid has been informed that providers are obtaining patient consent for sterilization on this final approved sterilization consent form (exp. date April 30, 2022) with backdating of signatures to a date prior to the new form effective date of May 1, 2019. This is not acceptable and will result in denials.

Links to latest approved consent form:

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 Sterilization link and then 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 will be notified if a change occurs to the sterilization consent form prior to the expiration date of April 30, 2022. Providers with questions can contact the GDIT Call Center at (800)-688-6696 or NCTracksprovider@nctracks.com.

GDIT, (800) 688-6696

ATTENTION: ALL PROVIDERS
Medicaid Claims Documentation

In accordance with 2 CFR part 200, subpart F, the North Carolina Office of the State Auditor (OSA) annually conducts the State Single Audit and accordingly selects a sample of NC Medicaid claims to determine if claims paid by the state were properly supported. During the recent SFY 2018 Single Audit, OSA reviewed claims documentation to ensure payments were made for Medicaid-covered services and to ensure claims followed proper coding and billing rules. Some claims documentation submitted were determined to be inadequate to support payment for services billed and were deemed an error.

Insufficient documentation errors identified in the SFY18 Single Audit included:

- Documentation does not support billed codes/modifiers/claim details
- Licensing/training/credentialing requirements not met
- Required components of service not completed -- provided documentation does not support services appropriate for beneficiary needs
- No documentation of intent to order services and procedures – incomplete or missing signed order or progress note describing intent for services to be provided
- Services not authorized/approved in accordance with program requirements

Providers can reduce the likelihood of future documentation errors by:

- Reviewing the monthly Medicaid Bulletin to stay abreast of changes that may impact billing, licensing, training and credentialing requirements
- Using the NCTracks provider portal to access web-based tutorials, classes and training materials to educate themselves and their billing personnel on all aspects of claims submission
- Implementing an internal quality assurance program which includes performing secondary reviews of claims for proper documentation prior to submission as well as performing periodic self-audits on submitted claims

Contact medicaid.sa@dhhs.nc.gov with any questions.

NC Medicaid Office of Compliance and Program Integrity, (919) 527-7749

ATTENTION: ALL PROVIDERS
Americans with Disabilities Act

The Americans with Disabilities Act (ADA), and other federal laws, prohibit discrimination and seek to ensure equal opportunity for persons with disabilities in employment, state and local government services, public accommodations, commercial facilities and transportation.

In certain circumstances, providers are required to provide reasonable accommodations to qualified individuals with disabilities to ensure access to services. Accommodations could include a variety of things, including but not limited to the provision of auxiliary aids and availability of interpreters.

For individuals who are deaf, blind, deaf-blind, or hard of hearing, effective communication is paramount to achieving equal access to services. "Effective communication" is information that is equally clear and understandable to all parties. In a healthcare setting the lack of effective communication can lead to misdiagnoses and improper medical treatment, among other detrimental outcomes. All providers are expected and legally required to ensure that individuals with disabilities are provided with the resources reasonably necessary to ensure effective communication.

Communication aids could include: American Sign Language (ASL), written English, or Braille. Providers should cooperate with individuals to determine the best way to ensure effective communication for both the individual and the healthcare provider. As an example, if the most effective means of communication is through the use of ASL, the provider should utilize a qualified sign language interpreter which allows both parties to communicate in their preferred and natural language. Chapter 90D of the North Carolina General Statutes requires sign language interpreters to be licensed in order to provide services for a fee.

Expenses associated with hiring a translator or providing any other reasonably necessary communication aid are accounted for in Medicaid reimbursement rates. Failure to provide reasonably necessary accommodations to ensure effective communication is a direct violation of federal law and regulation as well as the Provider Administrative Participation Agreement ("Provider Agreement") entered into by all Medicaid providers.

There are no circumstances under which the cost of providing reasonable accommodations may be passed on to the individual seeking services. The Department is authorized to withhold payment and/or terminate the Provider Agreement of a Medicaid provider that fails to comply with any applicable federal laws including the ADA.

Staff members from the NC Division of Services for the Deaf and Hard of Hearing (DSDHH) are available to provide consultation, guidance, and training to healthcare providers at no charge for purposes of ensuring effective communication for all individuals. Contact information the DSDHH regional centers can be found at www.ncdhhs.gov/dsdhh/where.htm.

The following is a list of licensed sign language interpreters in North Carolina by region.

DSDHH Statewide Licensed Interpreter Area Directories:

• Asheville
• Charlotte
• Greensboro
• Morganton
• Raleigh
• Wilmington
• Wilson
• Cued Language Transliterators (statewide)
• Interpreting Service Agencies (statewide)

Guidelines for procuring interpreting/transliterating services are available to assist healthcare providers in selecting an interpreter who is qualified to interpret in healthcare settings at available at: www.ncdhhs.gov/dsdhh/services/hiring_SLI.htm.

Additional Resources:

• ADA
• ADA Business Brief

• NC Interpreter/Transliterator Law

NC Division of Services for the Deaf and the Hard of Hearing (919) 874-2212 or (800) 851-6099

ATTENTION: ALL PROVIDERS

Provider Enrollment for Presumptive Eligibility Transitioning to NCTracks

Effective July 28, 2019, the presumptive eligibility provider enrollment process will be transitioned from NC Medicaid to NCTracks. NCTracks will assume the enrollment process for providers of presumptive eligibility for pregnant women and hospital providers of presumptive eligibility for Medicaid programs.

The requirements are not changing; however, the processes are slightly different for hospital-only providers and other medical/Medicaid providers. Separate presumptive eligibility provider agreements will be available on the NCTracks Provider Enrollment page under *Quick Links* (on the right side of the page) as of Monday, July 29, 2019, following implementation of the transition.

Requesting Presumptive Eligibility

Eligible providers must complete the appropriate presumptive eligibility provider application available on the NCTracks Provider Enrollment page under *Quick Links*, and send it to PresumptiveEligibility@gdit.com. NCTracks will send a welcome letter acknowledging receipt of the request. If any information is missing or inaccurate, NCTracks will send a return email to the provider indicating what information on the agreement is incorrect, and the provider will be asked to submit a corrected agreement.

Once all information is received, reviewed and deemed correct, NCTracks will upload the signed agreement along with any supplemental documents submitted into the provider's record. The DHB beneficiary services department will contact the provider to schedule the required training. Beneficiary services will conduct the training and notify NCTracks when the training has been successfully completed. NCTracks will then send an approval letter to the provider that includes the provider's name, NPI and effective date of enrollment. The effective date of enrollment in the presumptive eligibility program is the initial date the provider successfully completed the required training.

GDIT, (800) 688-6696

ATTENTION: ALL PROVIDERS

Disaster Relief Enrollment Application Streamlined

Effective July 28, 2019, an expedited disaster relief provider enrollment application process will be available during times of disaster such as a State of Emergency. This abbreviated enrollment application will collect limited information to enroll a provider for a limited time (120 days) and will be available to in-state, out-of-state (OOS) and border providers that are not yet enrolled in NC Medicaid, including individual providers and organizations.

For the disaster relief provider enrollment application only, federal application requirements may be waived (training, site visit, federal/state fees, background checks, and fingerprinting).

The enrollment application process will be expedited. NCTracks will verify the provider's enrollment status with Medicare or the provider's home state Medicaid agency to ensure the provider is in good standing. NCTracks will deny the disaster relief provider enrollment application if the provider is not in good standing.

More information will be provided during a disaster which deems the disaster relief provider enrollment application necessary for relief efforts.

GDIT, (800) 688-6696

ATTENTION: ALL PROVIDERS

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

NC-MIPS is Open for Program Year 2019

The NC Medicaid EHR Incentive Payment System (NC-MIPS) is only accepting Program Year 2019 Stage 3 Meaningful Use (MU) attestations.

All eligible professionals (EPs) attesting in Program Year 2019 will be required to attest to Stage 3 MU and use a 2015 edition of certified EHR technology (CEHRT).

In Program Year 2019, EPs may continue to use a 90-day MU reporting period. The MU reporting period must be from calendar year 2019 and will be any continuous 90-day period in which an EP successfully demonstrates MU of CEHRT.

EPs who were paid for Program Year 2018 using a 90-day patient volume reporting period from calendar year 2018 have the option to use the same patient volume reporting period to attest for Program Year 2019.

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

Program Year 2019 Webinar Series

The NC Medicaid EHR Incentive Program's webinar series has been updated to reflect the rules and regulations for Program Year 2019. Webinar topics include patient volume, auditing, MU and clinical quality measures (CQM) in Program Year 2019, the attestation

process, and more. These webinars can be found on the 'Resources and Webinars' tab of the program website.

The Two-Part Attestation Process

All EPs who have 90 days of MU objective data that meets CMS' requirements may submit their demographic, license, patient volume and MU objective data in NC-MIPS beginning **May 1, 2019**.

In Program Year 2019, EPs who have successfully attested to MU in a previous program year will be required to use a full calendar year CQM reporting period. Returning meaningful users who would like an early review of requirements, excluding CQMs, may submit their attestation in two parts. Part 1 of the attestation may be submitted **now** through Dec. 31, 2019.

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

Submitting in two parts also allows ample time for EPs to address any attestation discrepancies. These EPs will return to NC-MIPS after Jan. 1, 2020 to submit their CQM 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 in January 2020.

EPs who have only attested to adopt, implement, upgrade (AIU), may use a 90-day CQM reporting period and may submit a complete attestation in NC-MIPS beginning May 1, 2019.

EPs will be automatically directed to the appropriate page in NC-MIPS.

For more information on the two-part attestation process, please email NCMedicaid.HIT@dhhs.nc.gov.

Program Year 2019 CQMs

EPs are required to report on **six** of 50 CQMs. New in Program Year 2019, CMS is encouraging EPs to report at least one outcome measure and one high priority measure. If any outcome or high priority CQMs are relevant to the EP's scope of practice, those should be reported first. If there are no outcome and/or high priority CQMs that are relevant to the EP's scope of practice, the EP may choose to report on any other six CQMs.

Program Year 2019 CQMs are available for review on the eCQI website.

General Reminders

EPs who attested with another state should email NCMedicaid.HIT@dhhs.nc.gov prior to attesting with North Carolina for Program Year 2019.

For those practices unsure if a new provider may participate in the NC Medicaid EHR Incentive Program in Program Year 2019, please email the EP's NPI to NCMedicaid.HIT@dhhs.nc.gov and program staff will determine if the provider previously attested with another practice.

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

ATTENTION: ALL PROVIDERS

Introducing NC's Transition to Medicaid Managed Care: The Crossover Communication Series

Supporting beneficiaries in their transition between the current fee-for-service delivery system and NC Medicaid Managed Care is called transition of care. The transitional period surrounding the launch of Medicaid Managed Care is referenced as crossover.

DHHS will initiate crossover-specific activities in August 2019 and will continue these activities through April 2020. These activities are designed to safeguard continuity of care for beneficiaries. These activities include:

1. Crossover-specific communication and education to providers, beneficiaries and other stakeholders.
2. Time-limited data transfer to ensure Prepaid Health Plans (PHPs) have claims history, prior authorization data and other information necessary to effectively support enrolled beneficiaries.
3. Implementing additional safeguards for high need beneficiaries.
4. Crossover-specific monitoring of the beneficiary and provider transition experience.

Upcoming Opportunities to Learn About Crossover-Related Activities and Processes

Webinar	Date	Summary
Supporting the LTSS Community Through the Transition to Managed Care	Thursday, August 15, 2019 from 1-2 p.m.	This will continue the Long-Term Services and Supports (LTSS) webinar series launched in July 2019 and will focus on crossover-related activity specific to LTSS providers.
NC's Transition to Managed Care: The Crossover Series	Thursday, Sept. 5, 2019 from 1-2 p.m.	This session will provide general crossover guidance, with a focus on identifying beneficiary managed care detail and guidance on submitting prior authorization requests during the crossover period.
NC's Transition to Managed Care: The Crossover Series	Thursday, Sept. 19, 2019 from 1-2 p.m.	This session will be a continuation of the session on Sept. 5, 2019, providing a brief review of topics previously covered and additional guidance for supporting beneficiaries through the transition to Medicaid Managed Care.

For more information about upcoming and previous webinars, visit: https://medicaid.ncdhhs.gov/nc-medicaid-managed-care-training-courses

NC Medicaid Care and Quality

ATTENTION: HOSPICE PROVIDERS

Modification to Hospice Day Count for Two-Tier Calculation

You are receiving this notice in regard to Hospice claims that were adjudicated in NCTracks beginning Jan. 1, 2016.

As per the FY 2016 Hospice Wage Index and Payment Rate Update final rule, the Centers for Medicare & Medicaid Services (CMS) mandated two-tier hospice day count pricing effective Jan. 1, 2016. On Nov. 1, 2017, NCTracks system changes were implemented and all claims for hospice service began to be reimbursed in accordance with the requirements of Hospice Payment Reform.

It was determined that NCTracks system updates were required to correct the two-tier day count based on the hospice election date. This NCTracks system change will be implemented on July 28, 2019, with a retroactive effective date of Jan. 1, 2016.

For more information on the two-tier hospice day count reimbursement, please see the [FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47172)](), [CMS updates to the final rule](), the [January 2016 Medicaid Special Bulletin](), and the [October 2016 Medicaid Bulletin.]()

All claims affected by this change will be reprocessed at a later date. Affected providers will be notified through future Medicaid Bulletins and/or NCTracks provider communications regarding the claims reprocessing schedule.

GDIT, (800) 688-6696