



January 2014 Medicaid Bulletin

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Attention: All Providers

DHHS and Medicaid Reform Open Forum: January 15, 2014

The Medicaid Reform Advisory Group will hold its second meeting January 15, 2014, where beneficiaries, providers and other stakeholders will publicly share brief comments about how to create a healthier North Carolina through Medicaid reform. The meeting will be held at:

State Library/Archives and History Building
109 East Jones St.
Raleigh NC 27601

The meeting will be held from 9 a.m. to 4:30 p.m. Directions and parking information can be found at statelibrary.ncdcr.gov/directions.html.

How to Get Involved

Those who would like to speak at the January meeting can email their request to medicaidreform@dhhs.nc.gov **no later than Monday, January 6, 2014.**

A recording will be available on the Medicaid reform Website at www.ncdhhs.gov/medicaidreform for those who cannot attend the public forum. Interested parties also can email comments about Medicaid reform to medicaidreform@dhhs.nc.gov.

All advisory group meetings are open to the public. The next meeting will be scheduled for February 2014.

About Medicaid Reform

Medicaid reform has three objectives mandated by the legislature:

- Create a predictable and sustainable Medicaid program for N.C. taxpayers
- Provide care for the whole person by uniting physical and behavioral health care
- Increase administrative ease and efficiency for N.C. Medicaid providers.

Known as the “Partnership for a Healthy North Carolina,” the N.C. Department of Health and Human Services (DHHS) has been gathering broad input about Medicaid reform from wide variety of stakeholders since the beginning of 2013. DHHS will present its proposal to the General Assembly March 17, 2014.

The Medicaid Reform Advisory Group was formed in 2013, and was instructed by the General Assembly to obtain broad stakeholder input in a public forum, and ensure transparency in the proposal development process. The information will be used by DHHS as it prepares its proposal.

During the first advisory group meeting held December 5, 2013, DHHS shared the current Medicaid situation and outlook, and the principles and process for the reform effort. Presentations and audio files are on the DHHS Medicaid reform Website at www.ncdhhs.gov/medicaidreform.

Medicaid Reform Advisory Group Members

The advisory group has three citizens appointed by Governor Pat McCrory, a state representative and senator:

- **Dennis Barry** (Guilford County), advisory group chair - Barry is CEO emeritus of Cone Health, a multihospital system serving the Piedmont region of North Carolina.
- **Peggy Terhune, Ph.D.** (Randolph County) – Dr. Terhune is the executive director/CEO of Monarch since 1995. She has worked with people with disabilities for more than 35 years.
- **Richard Gilbert, M.D., M.B.A.** (Mecklenburg County) - Dr. Gilbert has served as the chief of staff for Carolinas Medical Center and was the chief of the Department of Anesthesiology for Carolina's Medical Center for 20 years.
- **Representative Nelson Dollar** (Wake) – Rep. Dollar was appointed by House of Representatives Speaker Thom Tillis.
- **Senator Louis Pate** (Lenoir, Pitt, Wayne) – Sen. Pate was appointed by Senate President Pro-Tempore Phil Berger.

More Information

Information about the Medicaid reform process information is posted on www.ncdhhs.gov/medicaidreform. To receive DHHS updates, go to www.ncdhhs.gov/signup.htm and select “Medicaid Reform.” Updates also will be posted in the monthly Medicaid Bulletin.

DHHS Medicaid Reform, www.ncdhhs.gov/medicaidreform

Attention: All Providers

3 Percent Rate Reduction

A Shared Savings Plan was enacted by the [N.C. General Assembly, Session Law 2013-360, Section 12H.18 \(b\)](#). Effective January 1, 2014, reimbursement rates for the following services rendered to Medicaid and N.C. Health Choice beneficiaries will be reduced by 3 percent:

- Inpatient hospital
- Physician, (excluding primary care providers who have attested for the enhanced reimbursement until January 1, 2015)
- Dental
- Optical services and supplies
- Podiatry
- Chiropractors
- Hearing aids
- Personal care services
- Nursing homes
- Adult care homes
- Dispensing drugs

Note: The 3 percent reduction for pharmacies will apply only to dispensing fees. The 3 percent reduction to dispensing fees is in addition to the drug reimbursement changes required by [N.C. Session Law 2013-363, Section 4.13](#), which are also effective January 1, 2014.

N.C. Division of Medical Assistance (DMA) is consulting with providers to develop a shared savings plan to implement by July 1, 2014, with provider payments beginning January 1, 2015. The shared savings plan shall provide incentives to provide effective and efficient care that results in positive outcomes for Medicaid and N.C. Health Choice beneficiaries.

DMA will host a series of Webinars in January to provide stakeholders with an overview of the Shared Savings Plan and solicit ideas on the shared savings methodology. More information regarding the Shared Savings Plan, including upcoming Webinar dates, is available at www.ncdhhs.gov/dma/plan/.

Questions, comments and/or recommendations regarding the Shared Savings plan can be sent to DMA.NCSharedSavings@lists.ncmail.net.

Finance Management
DMA, 919-814-0060

Attention: All Providers

Receiving Email Alerts Through NCTracks

Note to Providers: This article was originally published in September 2013.

Providers can subscribe to email alerts through the NCTracks Provider Portal at www.nctracks.nc.gov/. Alerts are sent when there is important information to share between monthly issues of the Medicaid Provider Bulletin. Past email alerts have contained information on these topics:

- 2014 Checkwrite Schedules for Division of Medical Assistance, Division of Mental Health, Division of Public Health, and Office of Rural Health and Community Care
- Schedule of NCTracks Provider Help Centers
- Answers to Questions Posed During the Medicare Crossover Workshop
- Resolution of Pregnancy Medical Home Issue
- Including a Cover Sheet When Submitting Attachments for Prior Approval Requests

To receive email alerts and other communications from NCTracks, visit this page <https://www.nctracks.nc.gov/content/public/providers/provider-announcements.html>. Then click on the “Sign up for NCTracks Communications” link under “Quick Links.” Providers who currently receive email alerts will continue to receive them through NCTracks. No other actions are required.

Email addresses will never be shared, sold or used for any purpose other than Medicaid and N.C. Health Choice email alerts and NCTracks communications.

CSC, 1-800-688-6696

Attention: All Providers

NCTracks Common Questions and Issues

A regularly updated Issues List is available on the NCTracks provider portal at <https://www.nctracks.nc.gov/content/public/providers/nctracks-status-page.html>, reflecting the most common issues affecting providers. Below are some of the questions and issues addressed in the provider portal in December.

EVC Telephone Number Retired

The old EVC telephone number – 1-866-844-1113 – will be retiring on January 15, 2014. Most providers are already using the NCTracks Call Center’s new phone number – 1-800-688-6696 – which took effect July 1, 2013. Once the old number has been retired, providers calling the old EVC number will receive a message directing them to call the new number.

Change in ACA Enhanced Rate Payments for SCHIP / Health Choice

Providers are not eligible to receive Affordable Care Act (ACA) Enhanced Rate Payments for services provided to State Children’s Health Insurance Programs (SCHIP)/N.C. Health Choice (NCHC) beneficiaries. A system change has been implemented to eliminate any future ACA Enhanced Rate Payments for services provided to SCHIP/NCHC recipients. Prior ACA Enhanced rate payments made to providers for SCHIP/NCHC beneficiaries will be recouped at a future date. Providers will be notified prior to the recovery. N.C. Division of Medical Assistance (DMA) is working with CSC to review ACA Enhanced Rate Payments to ensure compliance with the final rule.

Issue with MedSolutions Prior Approvals

Some providers were having problems getting paid for services which required prior approval from MedSolutions. The rendering provider’s claims submitted for these services have been denying stating that there is “NO PA ON FILE.” CSC and MedSolutions investigated this issue. Prior approvals received from MedSolutions **on or after November 11, 2013 are correct** and the claims should process in NCTracks.

Prior approvals received from MedSolutions **between July 1, 2012 and November 11, 2013** have **NOT** been corrected yet. Providers should continue to hold these claims. Providers will be notified via this newsletter when these prior approvals have been corrected and the claims can be refiled.

Hearing Aid Post-Dispensing Evaluation Form Is Required

The Hearing Aid Post-Dispensing Evaluation Form is posted on DMA’s “Forms for Medicaid Providers” Web page at www.ncdhhs.gov/dma/provider/forms.htm. The direct

URL is www.ncdhhs.gov/dma/forms/Hearing_Aid.pdf. This form is required when billing for new hearing aids. Providers should print and sign this form and have the beneficiary or guardian sign it. A signed form and the manufacturer's invoice(s) must be submitted for all new hearing aids. They can be uploaded through the NCTracks Provider Portal or faxed to 919-851-4014.

Orthodontists Can Submit Records Claims Via the Provider Portal

Records Claims can be submitted via the secure NCTracks Provider Portal, which will expedite processing. Orthodontists are encouraged to submit Records Claims via the Provider Portal, rather than on paper. If the Records Claims are submitted on paper, providers should make certain all fields on the claim are completed. Incomplete paper Records Claims will delay processing.

Fields that are frequently incomplete on paper Records Claims include:

- Box 1 – Statement of actual services
- Box 24 – Procedure Date
- Boxes 49 and 54 – Billing and Rendering NPI information

Updated List of Trading Partners Posted on NCTracks Website

An updated list of the trading partners (billing agents and clearinghouses) who have tested and certified with NCTracks has been posted on the [Trading Partner Information page](#) of the Provider Portal. The list includes the names of all certified trading partners in alphabetical order, as well as the ANSI X12 electronic transactions they are certified to submit to NCTracks on behalf of providers. (The list does not include providers who submit their own electronic transactions.)

Updated Version of EOB to HIPAA Code Crosswalk Posted on NCTracks Portal

An updated version of the EOB Code Crosswalk to HIPAA Standard Codes has been posted on NCTracks' Provider Policies, Manuals and Guidelines Web page at <https://www.nctracks.nc.gov/content/public/providers/provider-user-guides-and-training.html>. This version reflects changes made to the system since go-live, as well as corrections to the previous version. The crosswalk is in a standard Microsoft Excel format, which can be viewed online or downloaded. It has built-in filters allowing providers to search for a particular code. The crosswalk may help providers understand the codes on 835 transactions and the Remittance Advice.

Java Quick Reference for SkillPort Posted on NCTracks Website

SkillPort, the Learning Management System for NCTracks, requires the use of Java. The Java requirements are explained by clicking on the "System Requirements" link at the bottom of every NCTracks Web page. In addition, a Java Quick Reference document,

developed by SkillPort, is now available on the NCTracks' Provider Training Web page at <https://www.nctracks.nc.gov/content/public/providers/provider-user-guides-and-training/provider-training.html>. This document describes some common issues regarding the use of Java with SkillPort and how to resolve them.

Using the Coordination of Benefits Segment When Filing Claims for Dually-Eligible Beneficiaries

When filing claims for dually-eligible beneficiaries receiving services not covered by third-party insurance, providers need to submit the Coordination of Benefits segment instead of paper vouchers. See the Job Aid "How to Indicate Other Payer Details on a Claim in NCTracks and Batch Submissions" on the NCTracks' [Provider User Guides and Training page](#) for instructions on completing the Coordination of Benefits segment.

In addition, the legacy system used occurrence code 25 to denote that beneficiaries' third-party coverage was terminated, and it used occurrence code 24 to denote that the services were not covered by the beneficiaries' third-party insurance. Providers can still submit these codes to NCTracks, but the system will not use the information to adjudicate the claim. The Coordination of Benefits segment, to reflect third-party insurance information, is required by NCTracks for claims processing.

CSC, 1-800-688-6696

Attention: All Providers

NCTracks Tips of the Month: Prior Approval

Entering Prior Approval Requests on the Provider Portal

When entering Prior Approval (PA) requests on the secure NCTracks Provider Portal, providers have to select the appropriate Health Plan. The definitions of the two options in the drop down box for Division of Medical Assistance (DMA) providers are:

- NC XIX – Medicaid
- NC XXI – Health Choice

The Roman numerals refer to the number of the entitlement in the Social Security Act, e.g., Medicaid is Title XIX (19). Select the appropriate beneficiary Health Plan and proceed with entering the PA request. Choosing the correct Health Plan is important to avoid any delay in the evaluation of the PA request.

Prior Approval Number Not Needed on Claims

Many services require PA before they can be rendered. However, the PA number is not required on the claim when it is submitted to NCTracks and it is not used in processing the claim. The system will automatically match the claim information to the appropriate PA in the system. Including the PA number on the claim has no effect on the payment of the claim.

For more Information

For more information about prior approval, visit DMA’s Prior Approval Web page at: www.ncdhhs.gov/dma/provider/priorapproval.htm.

CSC, 1-800-688-6696

Attention: All Providers

Revised Medicaid Investigation and Oversight

The N.C. Division of Medical Assistance (DMA) and Public Consulting Group (PCG) are piloting a more proactive process for conducting post-payment reviews, Program Integrity referral investigations and oversight of provider compliance with administrative, billing and clinical coverage policies. **This is a new initiative that is separate from PCG’s previous Post-Payment Review contract.**

The revised PCG review process focuses on creating shorter time frames, whenever possible, and a limited use of extrapolation. An increased focus on provider education and ongoing monitoring will reduce the likelihood of future inappropriate billing, program abuse and fraud.

The new post-payment review process is a two-pronged approach that pairs a focused investigation and review process with an ongoing monitoring process. Specific tasks and goals include:

(a) Investigation of Incidents, Complaints, Referrals and Grievances Submitted to Medicaid Program Integrity

PCG will implement a focused, flexible process to manage and investigate complaints, questions, referrals and concerns regarding the delivery and billing of services by Medicaid providers. Examples of revisions to the PCG post-payment review process include:

1. PCG will focus on specific types of claims, time frames and beneficiaries who were included in a Program Integrity complaint or referral, instead of obtaining a random sample of claims and potentially initiating a large scale review for each referral. This will occur whenever possible, taking into account the nature of the allegations, apparent extent of concerns or data analysis findings.
2. PCG will issue Warning Letters, Educational Letters and request for providers to complete Corrective Action Plans, when appropriate.
3. If a post-payment review or referral investigation appears to reveal an overpayment, the Tentative Notice of Overpayment issued to the provider may be limited to the specific focus of the complaint or referral.

(b) Ongoing Oversight

PCG will routinely conduct smaller scale post-payment reviews to detect provider claim and compliance errors in a timelier manner. This will optimize a provider’s ability to address and correct issues that may have resulted in adverse review findings.

1. Providers who have recently completed a corrective action plan, and those who are identified through data analytics as being at high risk for non-compliance, will be prioritized for ongoing and routine reviews
2. When subsequent post-payment reviews reveal that provider non-compliance or inappropriate billing practice concerns are continuous or may be worsening, further action may be considered. Such actions may include an expanded post-payment review with extrapolation of overpayments

DMA and PCG will provide more information to providers in the coming weeks and months.

Program Integrity
DMA, 919-814-0000

Attention: All Providers and Hospitals**NC Medicaid EHR Incentive Program: January 2014
Payment Update****Attestation Tail Period**

The N.C. Medicaid Electronic Health Records (EHR) Incentive Program's 120-day tail period gives **Eligible Hospitals (EHs) until January 28, 2014** and **Eligible Providers (EPs) until April 28, 2014** to attest for a Program Year 2013 incentive payment. Send attestations early to avoid delays in processing time. No extensions will be granted. EH attestations will be denied if not resolved by January 28, 2014; EP attestations will be denied if not resolved by April 30, 2014. If denied for 2013, EPs and EHs can still attest for Program Year 2014 with no penalty.

N.C. Immunization Registry Exclusion

EHs and EPs participating in the N.C. Medicaid EHR Incentive Program may continue to claim an exclusion for the immunization registry measure in order to meet Stage 1 and Stage 2 Meaningful Use (MU) criteria.

The N.C. Immunization Registry is working toward accepting data electronically. Continue to visit DMA's EHR Incentive Program Web page for updates.

Special Reporting Period for Program Year 2014

EHs and EPs attesting for a 365-day MU reporting period in Program Year 2014 will instead report MU as indicated below:

- Fiscal quarter in the current fiscal year for EHs
- 90-days in the current calendar year for EPs

Both EHs and EPs will begin a 365-day MU reporting period in Program Year 2015. EPs attesting to adopting, implementing or upgrading (AIU) in program year 2014 may do so beginning **January 1, 2014**. EPs attesting for MU in Program Year 2014 may do so beginning **April 1, 2014**.

Program year 2014 has been open for EHs since October 1, 2013.

Computer System Upgrades

All **EHs and EPs** attesting in Program Year 2014 will be required to upgrade to the 2014 EHR certification standards set forth by the Office of the National Coordinator (ONC) and Centers for Medicare & Medicaid Services (CMS). To allow EHs and EPs to adjust to the system upgrades accommodating these 2014 certification standards,

CMS is allowing all program participants a one-time fiscal quarter (for EHs) or 90-day (for EPs) MU reporting period.

EHs and EPs must remember to update their CMS registration with their new EHR certification number prior to attesting with N.C. Medicaid for MU. To check if a computer system is compliant with the new 2014 certification standards, visit www.healthit.gov/policy-researchers-implementers/certified-health-it-product-list-chpl.

Demographic Information in NC-MIPS

If the North Carolina demographic information is not automatically populating within the N.C. Medicaid Incentive Payment System (NC-MIPS), EPs and EHs should reference NCTracks to verify their information. If there are discrepancies between the information on file with CMS and NCTracks, call the following numbers to reconcile and update the information:

- NCTracks (CSC) Call Center: 1-866-844-1113 or 1-800-688-6696
- CMS EHR Information Center: 1-888-734-6433 or 1-888-734-6563

Those with questions should email the N.C. Health Information Technology (HIT) program at NCMedicaid.HIT@dhhs.nc.gov

Don't Have a Medicaid Provider Number (MPN)?

As of July 1, 2013, providers who enroll in Medicaid are no longer issued a Medicaid Provider Number. Providers who were registered with N.C. Medicaid on or after July 1, 2013, can enter a Medicaid Provider Number (MPN) of "XXXXXXX." Such providers may receive a pop-up warning message indicating the MPN is invalid. Ignore the pop-up warning and move forward with the attestation.

First of the Year Reminders

As a reminder, if practice information changes (e.g., new demographic information, EHR certification number, etc.) providers need to update information in the CMS Registration & Attestation System (R&A).

Examples of providers who might need to update their R&A information include those who:

1. Have changed practices since their last attestation
2. Did not enter their EHR certification number during CMS registration
3. Have switched from Medicare to Medicaid (not applicable for dually eligible EHs)
4. Have moved here from another state
5. Are new to both the Medicare and Medicaid EHR Incentive Programs.

Changes submitted on the CMS R&A will be reflected in NC-MIPS within 48 hours.

**N.C. Medicaid Health Information Technology (HIT)
DMA, NCMedicaid.HIT@dhhs.nc.gov; 919-814-0180**

Attention: All Providers

Clinical Coverage Policies

The following new or amended combined N.C. Medicaid and N.C. Health Choice clinical coverage policies are available on the DMA's Clinical Policy Web page at www.ncdhhs.gov/dma/mp/:

- 10A, Outpatient Specialized Therapies (12/1/13)
- 10B, Independent Practitioners (IP) (12/1/13)
- 10C, Local Education Agencies (LEAs) (12/1/13)

These policies supersede previously published policies and procedures.

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

Attention: All Providers

N.C. Health Choice Children Moving to Medicaid

Effective January 1, 2014, the U.S. Affordable Care Act (ACA) and applicable regulations consolidated many health-related eligibility groups for children under age 19 into one group. Certain mandatory and optional groups in place prior to 2014 have been moved into newly consolidated infants and children groups. The ACA mandates a minimum Medicaid income limit of 133% of the Federal Poverty Level (FPL) for children under age 19.

Children whose income is greater than the Medicaid for Infants and Children (MIC) limit, but less than 133% FPL will now receive coverage under a new Medicaid to Infants and Children plan (MIC-1). They are separately identified from regular MIC and North Carolina Health Choice (NCHC) beneficiaries for reporting and Federal Medicaid Assistance Percentage (FMAP) purposes.

Children who are current NCHC recipients with income less than 133% FPL were moved to MIC-1 on December 20, 2013.

New Medicaid cards were issued to all children transitioned from NCHC to Medicaid. Behavioral Health providers who serve these children should contact and coordinate with their Local Management Entity-Managed Care Organization (LME-MCO) for any transition issues.

**Recipient and Provider Services
DMA, 919-855-4000**

Attention: All Providers**CPT Code Update 2014**

Note: Go to this Web page at <https://nctracks.nc.gov/content/public/providers/provider-announcements/Claims-With-New-2014-Codes-to-Pend.html> to see last minute information about code implementation.

Effective with date of service January 1, 2014, the American Medical Association (AMA) has added new CPT codes, deleted others, and changed the descriptions of some existing codes. (For complete information regarding all CPT codes and descriptions, refer to the 2014 edition of *Current Procedural Terminology*, published by the AMA.)

Providers should note the full descriptions as well as all associated parenthetical information published in this edition when selecting a code for billing services to the N.C. Division of Medical Assistance (DMA).

New CPT codes that are covered by the N.C. Medicaid program are effective with date of service January 1, 2014. Claims submitted with deleted codes will be denied for dates of service on or after January 1, 2014. Previous policy restrictions continue in effect unless otherwise noted. This includes restrictions that may be on a deleted code that are continued with the replacement code(s).

New Covered CPT Codes (effective 01/01/2014)									
10030	19081	19082	19083	19084	19085	19086	19281	19282	19283
19284	19285	19286	19287	19288	23333	23334	23335	33366	34841
34842	34843	34844	34845	34846	34847	34848	37217	37236	37237
37238	37239	37241	37242	37243	37244	43191	43192	49193	43194
43195	43196	43197	43198	43211	43212	43213	43214	43229	43233
43253	43254	43266	43270	43274	43275	43276	43277	43278	49405
49406	49407	52356	64616	64617	64642	64643	64644	64645	64646
64647	77293	80155	80159	80169	80171	80175	80177	80180	80183
80199	80203	87661	88343	92521	92522	92523	92524	93582	

End-Dated CPT Codes (effective 12/31/2013)									
13150	19102	19103	19290	19291	19295	23331	23332	32201	37204
37205	37206	37207	37208	37210	42802	43219	43328	43256	43258
43267	43268	43269	43271	43272	43456	43458	44901	47011	48511
49021	49041	49061	50021	58823	64613	64614	75960	77031	77032
92506									

New CPT Codes Not Covered by Medicaid or NCHC									
99446	99447	99448	99449	99481	99482	66183	81287	81504	81507
90673	90687	90688	93583	94669	97610				
All Category II and III Codes are not covered									

New Covered HCPCS Codes (effective 01/01/2014)									
D2949	D3355	D3356	D3357	J0151	J0401	J0717	J1442	J1446	J1556
J1602	J3060	J3489	J7301	J7316	J9047	J9262	J9306	J9354	J9371
J9400	L0641	L0642	L0643	L0648	L0651	Q3027	Q3028	T4544	

All new Level II HCPCS codes are considered non-covered unless listed as covered.

Billing Information

CPT Code	Billing Information	Diagnosis Editing	Prior Approval
33366	Requires two physician operators and both must bill with modifier 62.	n/a	n/a

Additional information will be published in future general Medicaid bulletins as necessary.

Clinical Policy and Programs
DMA, 910-581-9876

Attention: Ambulance Providers

Billing Ambulance Claims in NCTracks

Note: This article was originally published in December 2013.

All ambulance providers billing straight Medicaid claims or claims requiring a Medicare override are to continue billing with an institutional claim (UB-04/837I transaction) in NCTracks until further notice. Ambulance providers billing with Medicare payments are to continue to bill on professional claims.

Billing will be updated with a new ambulance policy, but until that time ambulance providers billing straight Medicaid claims or claims requiring a Medicare override with a professional claim (CMS-1500/837P transaction) will receive a denial and be instructed to rebill on an institutional claim.

Clinical Policy

DMA, 919-855-4100

Attention: Durable Medical Equipment Providers and Pharmacists

Procedure for Billing Durable Medicaid Equipment Diabetes Supplies

A completed and signed Certificate of Medical Necessity/Prior Approval (CMN/PA) is required for all Durable Medical Equipment (DME) items billed under Medicaid DME. The required form is titled “Request for PA CMN/PA (DMA372-131).” It is located on the NCTracks’ Provider Web page at <https://www.nctracks.nc.gov/content/public/providers.html> under the “Prior Approvals” tab. **Only the form with the red “CSC” logo in the top left corner will be accepted.**

For all items **requiring** prior approval, the DME supplier should complete the CMN/PA form and have the prescriber sign it. The form can be submitted to NCTracks via mail, fax, or by completing a PA request on NCTracks’ secure Provider Portal and uploading it as an attachment. (The fax number and address are in the Contact Information document posted under Quick Links on NCTracks’ Provider Portal home page.)

For all DME items **not requiring** prior approval, the DME supplier should still complete the CMN/PA form and have the prescriber sign the completed form. The DME provider/pharmacy should keep it on file. In order for pharmacies to bill for these products, they must be contracted with Medicaid DME.

Instructions for Billing Ketone Test Strips

Urine and blood ketone test strips are billed through Medicaid DME and do not require prior approval. The CMN/PA form should be kept on file with the DME provider.

HCPCS Code	Description
A4250	Urine ketone test or reagent strips or tablets, quantity of 100 (one per month). Pharmacy must be a DME provider and bill product as DME.
A4252	Blood ketone test or reagent strips, quantity of 100 (per calendar month), manually priced. Pharmacy must be a DME provider and bill product as DME, submitting the claim and copy of invoice.

Instructions for Billing Blood Glucose Test Strips

For Roche Test Strips

HCPCS Code	Blood Glucose test strips (Roche products)
A4253	Blood glucose test or reagent strips, quantity of 50 strips <u>Age 21 and over</u> : four boxes per month billed Point of Sale (POS) <u>Ages 0-20</u> : Up to four boxes per month billed POS Pharmacy must be a DME provider and bill product as DME for quantity up to six boxes

For any quantities outside of the four for adults and six for children, the pharmacy must be a DME provider. The pharmacy must also submit the CMN/PA form and receive approval. The NU and U9 modifier must appear on both the CMN/PA form and the claim.

Blood Glucose test strips (brands other than Roche)

A request for prior approval using the CMN/PA form may be considered if the designated preferred manufacturer’s glucose meter is incompatible with the beneficiary’s current insulin pump. Quantity limits still apply. The pharmacy must be a DME provider and bill products as DMEs using the U9 modifier to indicate that test strips have been authorized for payment.

Outpatient Pharmacy Services
DMA, 919-855-4300

Attention OB/GYN Providers

Coverage of Tdap During Pregnancy

The Advisory Committee on Immunization Practices (ACIP) recommends that healthcare personnel should administer Tdap vaccine during pregnancy for pregnant women who have not previously received a Tdap vaccine, preferably during the third or late second trimester (after 20 weeks' gestation). If not administered during pregnancy, Tdap vaccine should be administered immediately postpartum.

The N.C. Division of Medical Assistance (DMA) has reviewed the current obstetric policy and made a recommendation regarding Tdap vaccine during pregnancy and the postpartum period. The interpretation of the current obstetric policy is to cover Tdap administration according to ACIP guidelines.

Effective for dates of service on or after November 21, 2013, providers may file claims for Tdap vaccine to DMA's fiscal agent for reimbursement. Questions should be directed to CSC at 1-800-688-6696 or 866-844-1113.

OB/GYN Services
DMA, 919-855-4320

Attention: Pharmacy Providers

Pharmacy Reimbursement Changes

[N.C. General Assembly, Session Law 2013-360](#), **Section 4.13** mandates the following changes to drug reimbursement effective January 1, 2014:

1. The reimbursement for the Enhanced Specialty Discount Drug list will change from Wholesale Acquisition Cost (WAC) + 2.2 percent to WAC + 1 percent
2. The State’s Estimated Acquisition Cost for non-specialty drugs will change from WAC + 6 percent to WAC + 2.7 percent
3. The percentage mark up for the State Maximum Allowable Cost (SMAC) program will change from 192.5 percent to 150 percent of the lowest cost generic drug
4. The rate for dispensing brand drugs will change from \$3.00 to \$2.00
5. The rates for dispensing generic drugs will change to the following tiers:

Percentage Tier Rate	Generic Dispensing Fee
Greater than or equal to 80%	\$7.75
Greater than or equal to 75% and less than 80%	\$5.50
Greater than or equal to 70% and less than 75%	\$2.00
Less than 70%	\$1.00

**Outpatient Pharmacy
DMA, 919-855-4300**

Attention: Personal Care Services (PCS) Providers**P**re-Admission Screening and Resident Review (PASRR)
Required for Medicaid Eligible Individuals Only

Effective January 1, 2013, a U.S. Department of Justice Settlement Agreement requires that individuals requesting admission to Adult Care Homes (ACH) be pre-screened for serious mental illness. However, the Division of Health Services Regulation (DHSR) temporary rule, 10A NCAC 14K .0101, Preadmission Screening for Adult Care Home Residents, expired on November 26, 2013. **Therefore, effective November 26, 2013, private pay individuals are no longer required to be screened through the PASRR process. The PASRR process is only required for Medicaid-eligible individuals.**

The N.C. Division of Medical Assistance (DMA) Clinical Coverage Policy 3L remains in effect and requires that Medicaid beneficiaries residing in, or applying for admission to, an ACH be screened for serious mental illness prior to an assessment for Personal Care Services (PCS) using the Pre-Admission Screening and Resident Review (PASRR). Medicaid beneficiaries currently receiving PCS in an ACH do **not** need to complete the PASRR process.

In order to implement legislated changes to PCS in Session Law 2013-306, DMA has revised Clinical Coverage Policy 3L in accordance with G.S. 108A-54.2. The policy revision process includes approval by the Physician Advisory Group. ACH providers licensed under G.S. 131D-2.4 do not receive prior approval to render or bill for PCS without verification of a PASRR number. This does not require persons already residing in ACH who are already receiving PCS to be screened. The policy will be implemented upon the effective date of the State Plan Amendment implementing the legislated changes to PCS.

Clinical Coverage Policy 3L can be found on DMA's Clinical Coverage Policy Web page at www.ncdhhs.gov/dma/mp/.

**Home and Community Care
DMA, 919-855-4340**

Attention: Personal Care Services (PCS) Providers

Personal Care Services Program Highlights

Note: This article does not apply to providers billing for Personal Care Services (PCS) under the Community Alternatives Program (CAP) program.

QiReport

QiReport is an integrated Web service designed to support the operation of the PCS program. Using QiReport, the PCS Independent Assessment Entity (IAE) – Liberty Healthcare NC – organizes and tracks PCS service requests, assessments and notifications. PCS provider agencies access QiReport to receive and acknowledge service referrals, view assessments and communicate electronically with the IAE. DMA uses QiReport to oversee the PCS program and manage its usage. QiReport is developed and hosted by VieBridge, Inc.

- **QiReport User Registration** - Only registered users can access and use QiReport. To learn more about the registration process for QiReport visit https://www.qireport.net/docs/Consolidated_ProviderRegistration_20130909.pdf.
- For instructions on how to log in using an N.C. Identification (NCID) username and password visit <https://www.qireport.net/docs/NCID%20Instructions%20v2.pdf>.
- **Program Support** – Providers who need information or assistance regarding a service request or a PCS assessment can contact the Liberty Healthcare – NC Support Center at **1-855-740-1400**.
- **QiReport Support** – Providers with questions about how to access QiReport or how to use QiReport, can contact the VieBridge Support Center at **1-888-705-0970**.

The PCS Program encourages providers to register as a user of the QiReport Provider Interface. To register, providers must complete the QiReport Registration form. The registration form is available on the DMA's PCS page at www.ncdhhs.gov/dma/pcs/pas.html under "Forms." Once the registration form is complete, it should be sent to VieBridge, Inc. QiReport Support:

Fax: 919-301-0765

Mail: VieBridge, Inc., QiReport Team, 8130 Boone Boulevard, Suite 350,
Vienna, VA 22182

Screening for Serious Mental Illness (SMI) in Adult Care Homes

Effective January 1, 2013, all Medicaid beneficiaries referred, or seeking admission to, Adult Care Homes licensed under G.S. 131D-2.4 must be screened through the Preadmission Screening and Resident Review (PASRR). Adult Care Home providers licensed under G.S. 131D-2.4 will **not** receive prior approval to bill PCS without verification of PASRR number. To learn more about the PASRR process for Adult Care Homes G. S. 131D-2.4 view the attached Special bulletin at:

www.ncdhhs.gov/dma/bulletin/pdfbulletin/0313-Special_Bulletin-PASRR.pdf

PASRR Contacts:

Barbara Flood – EAST - 919-218-3872, barbara.flood@dhhs.nc.gov

Ed Crofts – WEST - 828-413-2686, ed.crofts@dhhs.nc.gov

Patricia McNear – CENTRAL – 919-981-2580, patricia.mcnear@dhhs.nc.gov

Bill Joyce – CENTRAL & FLOATING – 336-312-0212, bill.joyce@dhhs.nc.gov

Linda Jennings – for status of PASRR – 919-981-2580,
linda.jennings@dhhs.nc.gov

Stakeholder Meetings

PCS Stakeholder Meetings are held on the third Thursday of each month. Meeting agendas (which will include times and meeting locations), handouts, and minutes are available for download on the DMA's PCS Web page at www.ncdhhs.gov/dma/pcs/pas.html. Stakeholders should continue to submit questions by email to PCS_Program_Questions@dhhs.nc.gov.

Items and concerns that providers would like addressed during the stakeholder meetings should be submitted at least three days in advance of the regularly scheduled meetings with the notation "FOR STAKEHOLDER MEETING" in the email's subject line. Providers who have additional questions, or would like to join the PCS Stakeholder group, may contact the PCS Program at 919-855-4340.

Adult Care Home FL2s

Beneficiaries seeking admission into Adult Care Homes licensed under G.S 131D-2.4 should continue the process set forth by the N.C. Division of Aging and Adult Services (DAAS) for the State-County Special Assistance Program. Providers should continue to follow requirements of the Adult Care Home Licensure Section, Division of Health Service Regulation (DHSR) for licensure requirements related to the FL-2. A copy of the FL-2 for Adult Care Homes licensed under G.S.131D-2.4 is posted on the forms section on the DMA's PCS Web page.

Appeal Rights

Beneficiaries who receive adverse notices regarding their PCS request have the right to file an appeal. To appeal, the beneficiary must complete and file the Medicaid Beneficiary Services Hearing Request form asking for a hearing with the Office of Administrative Hearings (OAH). Beneficiaries have 30 days from the date on the denial letter to request a hearing.

Filing the Appeal Request

- To file a request for a hearing, beneficiaries must submit a **completed hearing request form** (enclosed only in the beneficiary's mailing). Beneficiaries can also get a duplicate hearing request form by calling DMA at 919-855-4350 or 1-800-662-7030 and asking for Clinical Policy and Programs, Appeals Section.
- Beneficiaries can mail or fax the completed hearing request form to Clerk of Court, Office of Administrative Hearings. The addresses and fax numbers are on the hearing request form.

To learn more about the hearing process, call OAH at 919-431-3000, DMA at 919-855-4350, or the toll-free CARE-LINE at 1-800-662-7030. All of these agencies are available Monday-Friday, 8 a.m.-5 p.m. To speak with a specific Medicaid staff person about the decision, call the name and telephone number listed at the end of the notice.

Personal Care Services Training

Visit DMA's PCS Web page and click on "Trainings" to view all available trainings. Additional plans for provider trainings and Webinars will be announced on the DMA's PCS Web page. Providers with questions regarding trainings can call 919-855-4340 or email PCS_Program_Questions@dhhs.nc.gov.

Personal Care Services (PCS) Program Contacts

To contact the state's PCS program call 919-855-4340 or email PCS_Program_Questions@dhhs.nc.gov. For PCS updates and to access important links visit the DMA's PCS Web page.

Home and Community Care
DMA, 919-855-4340

Employment Opportunities with the N.C. Division of Medical Assistance (DMA)

Employment opportunities with DMA are advertised on the Office of State Personnel’s Website at www.osp.state.nc.us/jobs/. To view the vacancy postings for DMA, click on “Agency,” then click on “Department of Health and Human Services.” If you identify a position for which you are both interested and qualified, complete a state application form online and submit it. If you need additional information regarding a posted vacancy, call the contact person at the telephone number given in the vacancy posting. General information about employment with North Carolina State Government is also available online at www.osp.state.nc.us/jobs/general.htm

Proposed Clinical Coverage Policies

In accordance with NCGS §108A-54.2, proposed new or amended Medicaid clinical coverage policies are available for review and comment on DMA's Website. To submit a comment related to a policy, refer to the instructions on the Proposed Clinical Coverage Policies Web page at www.ncdhhs.gov/dma/mpproposed/. Providers without Internet access can submit written comments to:

Richard K. Davis
 Division of Medical Assistance
 Clinical Policy Section
 2501 Mail Service Center
 Raleigh NC 27699-2501

The initial comment period for each proposed policy is 45 days. An additional 15-day comment period will follow if a proposed policy is revised as a result of the initial comment period. If the adoption of a new or amended medical coverage policy is necessitated by an act of the General Assembly or a change in federal law, then the 45- and 15-day time periods shall instead be 30- and 10-day time periods.

Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
January 2014	01/02/14	01/07/14	01/08/14
	01/09/14	01/14/14	01/15/14
	01/16/14	01/22/14	01/23/14
	01/23/14	01/28/14	01/29/14
	01/30/14	02/04/14	02/05/14
February 2014	02/06/14	02/11/14	02/12/14
	02/13/14	02/19/14	02/20/14
	02/20/14	02/25/14	02/26/14
	02/27/14	03/04/14	03/05/14

Electronic claims must be transmitted and completed by 5:00 p.m. on the cut-off date to be included in the next checkwrite. Any claims transmitted after 5:00 p.m. will be processed on the second checkwrite following the transmission date.

Sandra Terrell, MS, RN
Acting Director
Division of Medical Assistance
Department of Health and Human Services

Paul Guthery
Executive Account Director
Computer Sciences Corp. (CSC)