



## February 2014 Medicaid Bulletin

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## 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/](http://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:

- New Prior Approval Announcements Page on Portal
- Common Error – Faxing Claims for American Dental Association (ADA) Forms
- Holiday and Checkwrite Schedule
- Clarification on Bill Type for Home Health Claims
- Permits and Onsite Visits for Pharmacy and Durable Medical Equipment (DME) Providers

To receive email alerts and other communications from NCTracks, visit this page <https://www.nctracks.nc.gov/content/public/providers/provider-announcements.html>. Use the link “Click here to join mailing list” under the heading “Sign Up for NCTracks Communications” in the upper right corner of the page. 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 Tip of the Month: Supported Browsers

### Verifying NCTracks System Requirements and Supported Browsers

There are specific system requirements for using the NCTracks Website, which can be found by clicking on the “[System Requirements](#)” link in the footer of every NCTracks Web page.

Examples of currently supported browsers include Internet Explorer versions 8 and 9, as well as Mozilla Firefox version 4 and above. The Website generally works well with Google Chrome, although it is not a supported browser.

If you are using an unsupported browser, you may not be able to use the Website as intended (e.g., buttons on the screen that cannot be clicked, buttons that have an odd shape or location, and text that appears skewed or distorted). Providers using unsupported browsers can install Mozilla Firefox, which is free.

Providers without an appropriate version of Java or Flash may be prompted to upgrade before they can continue working in the NCTracks portal. Providers who are uncertain about performing the upgrade should work with their technical support team.

The NCTracks team is evaluating newer versions of browsers and other applications required by the system – such as Java and Flash – and will be making updates to the system once they have been tested and verified. As new versions of browsers and other required applications are approved, an announcement will be posted on the portal, and the “[System Requirements](#)” page will be updated.

**CSC, 1-800-688-6696**

**Attention: All Providers****NCTracks Updates****2014 Checkwrite Schedule**

The 2014 Checkwrite Schedule can be found under “Quick Links” on the NCTracks Provider Portal at <https://nctracks.nc.gov/content/public/providers.html>, as well as on Division of Medical Assistance (DMA) Calendar Web Page at [www.ncdhhs.gov/dma/provider/calendar.htm](http://www.ncdhhs.gov/dma/provider/calendar.htm).

**New Pharmacy Prior Approval (PA) Fax Number**

There is a new toll-free Pharmacy Prior Approval (PA) fax number – **1-855-710-1969** – which providers should begin using immediately. The new fax number will enable pharmacy PA requests to be routed more quickly to the appropriate NCTracks team. The old Pharmacy PA fax number is still available, but may be phased out at a future date.

**Update on MedSolutions PAs**

As noted in the [January 2014 Medicaid Bulletin](#), an issue was identified with billing providers getting paid for services which required PA from MedSolutions. The rendering provider's claims submitted for these services have been denying with the statement “NO PA ON FILE.” CSC and MedSolutions addressed this issue and PAs received from **July 1, 2013 and on** should process correctly.

**New User Guide for Entering Dental PA in NCTracks**

A new User Guide, *How to Enter a Dental or Orthodontic Prior Approval in NCTracks*, has been posted to the NCTracks Provider Portal on the Provider User Guides and Training page at <https://www.nctracks.nc.gov/content/public/providers/provider-user-guides-and-training.html>. The new User Guide provides step-by-step instructions for entering dental PA requests into the NCTracks Provider Portal.

**New User Guide Posted to Portal – Updating Accreditation(s)**

A new User Guide, *How to Add or Update Accreditation on the Provider Profile in NCTracks*, has been posted to the NCTracks Provider Record Maintenance section of the Provider User Guides and Training Web page at <https://www.nctracks.nc.gov/content/public/providers/provider-user-guides-and-training.html>. The new User Guide provides step-by-step instructions for adding or updating provider accreditation information using the Manage Change Request process.

## **Provider Taxonomy Lookup Web Page Updated**

The N.C. Office of Medicaid Management Information System Services (OMMISS) Provider Taxonomy Lookup Web Page at <http://ncmmis.ncdhhs.gov/taxonomy.asp> has been updated with the latest taxonomy information from the NCTracks provider file. By entering a National Provider Identifier (NPI) or Employer Identification Number (EIN), providers can look up the locations and taxonomy codes that should be used in billing NCTracks. **However, the most current provider information is always found by using the Enrollment Status and Management button in the secure NCTracks Provider Portal.**

## **Reminder for Providers**

As indicated in the [\*Replacement MMIS Provider Claims and Billing Assistance Guide\*](#), providers should remember to verify a Medicaid beneficiary's eligibility and identity **each time** a service is rendered. Providers may verify a beneficiary's Medicaid eligibility through the NCTracks Provider Portal, Automated Voice Response System (AVRS), or EDI (batch).

## **EVC Telephone Number Retired**

The old Enrollment, Verification, and Credentialing (EVC) telephone number, 1-866-844-1113, was retired on January 15, 2014. Providers should use 1-800-688-6696.

**CSC, 1-800-688-6696**

**Attention: All Providers**

**Non-Emergent Transportation Providers**

N.C. Medicaid is developing the enrollment criteria for Non-Emergent Medical Transportation (NEMT).

Until the enrollment criteria are complete, providers who submit an NEMT application will be denied. A denied NEMT application does **not** guarantee a refund of any paid enrollment fees.

Updates to this policy will be posted on the N.C. Division of Medical Assistance (DMA) Website at [www.ncdhhs.gov/dma](http://www.ncdhhs.gov/dma).

**Provider Services**  
**DMA, 919-855-4050**

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**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 N.C. Division of Medical Assistance (DMA) Website at [www.ncdhhs.gov/dma/mp/](http://www.ncdhhs.gov/dma/mp/):

- *3L, Personal Care Services (12/1/13)*
- *10A, Outpatient Specialized Therapies (1/15/14)*
- *10B, Independent Practitioners (IP) (1/15/14)*
- *10C, Local Education Agencies (LEAs) (1/15/14)*

These policies supersede previously published policies and procedures.

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

**To: All Providers**

## **NC RAC II (North Carolina Recovery Audit Contractor)**

The N.C. Division of Medical Assistance (DMA) Program Integrity Unit has designated Health Management Systems (HMS) as an authorized agent to periodically conduct audits and post-payment reviews of Medicaid and N.C. Health Choice paid claims in order to identify program abuses and overpayments.

Beginning in March 2013, HMS conducted post-payment reviews of Inpatient Hospital claims. Of the 3,150 claims reviewed to date, 776 claims were improperly paid and a Tentative Notice of Overpayment letter (TNO) was sent to the provider.

An explanation of the denial codes used to determine improper payments – and the number of claims falling into each category – are as follows:

### **Denial Codes**

- **A02** – Services rendered did not require inpatient level of care

Not all clinical services require an admission for an acute hospital stay. A lower level of care, such as observation or outpatient setting, is appropriate when the severity of illness, intensity of service and treatment rendered does not warrant an inpatient level of care.

- **B05** – Services rendered should have been billed as outpatient

The service order was written for observation level of care only.

- **B07** – No Service Orders

Required physician inpatient service orders were not reflected in the medical record.

- **L02** – Incomplete Medical Record

Insufficient documentation was received to support the inpatient hospital services billed. With each medical record request, HMS provides a list of required documents to be submitted. Claims are reviewed to determine if medical necessity – as well as the type and amount of services billed – are supported by that documentation. It is the provider's responsibility to ensure all information that supports the services billed is sent in for review.

Denial Code	Denial Reason	Total Denials	Overpayment Amount	Percent of Denials
A02	Services rendered did not require inpatient level of care	642	\$2,088,315.77	83%
B05	Services rendered should have been billed as outpatient	38	\$ 154,004.56	5%
B07	No required physician inpatient service orders	23	\$ 82,768.13	3%
L02	Incomplete Medical Record	73	\$ 245,422.50	9%

**Tips to Avoid Future Denials**

Below is a list of tips to help providers avoid future denials. They are based on the results to date and trends identified.

- Respond to Medical Records Requests as quickly as possible.
- Send all documentation requested as outlined in the insert provided with each Medical Records Request letter. Contact HMS with any questions about what to submit prior to sending the record.
- Providers sending records electronically should receive email verification from HMS that the records have been received. If no email verification has been obtained, contact HMS to confirm receipt of the records.
- Ensure that all files are properly named and encrypted before transmittal to HMS. Any variance from the established process could cause transmission failures and delay the review.
- Essential documents to support services billed include records of services and care provided, as well as physician orders which were written prior to services being provided. For example, a patient coming into the Emergency Room must have a specific order to be admitted to an Observation bed, if needed. The patient must also have a separate order to be admitted to an inpatient level of care, if medically necessary.

**Program Integrity**  
**DMA, 919-647-8000**



**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 N.C. 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: Behavioral Health Providers, NC Innovations Waiver Providers and LME-MCOs**

**T** **echnical amendments to the Innovations Waiver**

The Centers for Medicaid services (CMS) has approved a technical amendment to the N.C. Innovations Waiver with the following changes:

1. Health Coverage for Workers with Disabilities (HCWD) has been added as an eligibility category to the Innovations Waiver.
2. Food thickeners for adults with Dysphagia are available under the Assistive Technology-Equipment and Supplies service definition.

These changes are effective retroactively to October 1, 2013.

**Behavioral Health Services**  
**DMA, 919-855-4290**

## Attention: Community Care of NC/Carolina ACCESS (CCNC/CA) Providers

### Community Care of NC/Carolina ACCESS Overrides

A Community Care of NC/Carolina ACCESS (CCNC/CA) Primary Care Provider (PCP) is the only medical provider who can provide services to a CCNC/CA beneficiary without authorization. **All other medical providers must obtain authorization from the beneficiary's CCNC/CA PCP of record prior to rendering treatment unless the specific service is exempt from CCNC/CA authorization.**

For a listing of exempt services, see the Provider Claims and Billing Assistance Guide at <https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>.

**Medical providers should not direct beneficiaries to request overrides from the N.C. Division of Medical Assistance (DMA), CSC (NCTracks), or local departments of social services.**

When services are rendered to a CCNC/CA beneficiary without first obtaining authorization from the CCNC/CA PCP and the PCP refuses to authorize retroactively, medical providers may request an override.

**CCNC/CA overrides are authorizations issued by the NCTracks Customer Support Center for CCNC/CA enrolled beneficiaries.**

- Override requests will only be considered if extenuating circumstances – beyond the control of the parties involved in the claim – affected the beneficiary's access to medical care.
- Overrides will **not** be considered for current, future, or past dates of service unless the CCNC/CA PCP of record has been contacted and refused to authorize treatment.

**Medical providers needing a Carolina ACCESS override must submit a DMA CA Override Request Form to the NCTracks Customer Support Center.**

There are two preferred methods for submitting an Override Request:

- **Telephone** – The provider can call NCTracks to request an Override for future dates of service or if the patient is in the doctor's office waiting for treatment. The NCTracks number is 1-800-688-6696.
- **Fax** – The provider can fax the Override Request Form to NCTracks. The fax number is 855-710-1964.

A copy of the DMA CA Override Request Form may be found on DMA's CCNC/CA Web page at

[www.ncdhhs.gov/dma/ca/ccncproviderinfo.htm](http://www.ncdhhs.gov/dma/ca/ccncproviderinfo.htm).

Those with questions regarding Carolina ACCESS may contact their Regional Consultant. Contact information for Regional Consultants is available at [www.ncdhhs.gov/dma/ca/MCC\\_0212.pdf](http://www.ncdhhs.gov/dma/ca/MCC_0212.pdf).

**CCNC/CA, Managed Care  
DMA, 919-855-4780**

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**Attention: N.C. Health Check and N.C. Health Choice Providers**  
**NCCI Billing Guidance for Health Check and N.C. Health Choice  
Wellness and Vaccination Claims**

**Note:** Information in this article was published in the April 2013 Medicaid Bulletin.

On **January 1, 2013**, Centers for Medicare & Medicaid Services (CMS) implemented new National Correct Coding Initiative (NCCI) editing for vaccine administration. On **February 7, 2013**, CMS provided the following guidance:

When a vaccine is administered on the same day as a wellness examination (99381-99397), the wellness examination code must be billed with modifier 25.

CMS implemented these edits to prevent inappropriate payment for wellness services when the beneficiary only receives an immunization. **Previously denied claims for wellness examinations conducted on the same day as vaccine administrations can be resubmitted with modifier 25 appended to the wellness exam code.**

This guidance can be used in addition to the N.C. Division of Medical Assistance (DMA) instructions on the use of EP (Medicaid) or TJ (N.C. Health Choice) modifiers when filing claims for well-child visits. This guidance replaces the information provided in the article titled [Billing Guidance for NCCI Denials for Health Check and N.C. Health Choice Wellness Claims and Additional Screenings](#), which appeared in the April 2013 Medicaid Bulletin.

For additional information about Medicaid NCCI, visit the U.S. Medicaid's NCCI Web page at [www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html).

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

**Attention: N.C. Medicaid Health Check and N.C. Health Choice Providers**

**NCCI Billing Guidance for Six New Practitioner and Outpatient Hospital Procedure-to-procedure (PTP) Edits**

The January 1, 2014 version of the Medicaid National Correct Coding Initiative (NCCI) practitioner and outpatient hospital procedure-to-procedure (PTP) edits included six new edits which the Centers for Medicare & Medicaid Services (CMS) has decided to delete in the April 1, 2014 version of the edit files, retroactive to January 1, 2014. The edits are listed below. Providers may choose to delay submission of claims affected by these edits until after April 1, 2014. If providers submit claims prior to that date and the column 2 code is denied by the Medicaid NCCI PTP edit, they may resubmit the denied claim after April 1, 2014.

<b>Column 1 Code</b>	<b>Column 1 CPT Code Descriptor</b>	<b>Column 2 Code</b>	<b>Column 2 CPT Code Descriptor</b>
19282	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including mammographic guidance (List separately in addition to code for primary procedure)	19281	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including mammographic guidance
19284	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)	19283	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance
19286	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)	19285	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance
19288	Placement of breast localization device(s) (e.g. clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)	19287	Placement of breast localization device(s) (e.g. clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including magnetic resonance guidance

37237	Transcatheter placement of an intravascular stent(s) (except lower extremity, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery (List separately in addition to code for primary procedure)	37236	Transcatheter placement of an intravascular stent(s) (except lower extremity, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery
37239	Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; each additional vein (List separately in addition to code for primary procedure)	37238	Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein

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

**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/](http://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
<b>February 2014</b>	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
<b>March 2014</b>	03/06/14	03/11/14	04/12/14
	03/13/14	03/18/14	04/19/14
	03/20/14	03/25/14	04/26/14
	03/27/14	04/01/14	04/02/14

*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.*

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

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