



February 2015 Medicaid Bulletin

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*Providers are responsible for informing their billing agency of information in this bulletin.
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Attention: All Providers**NCTracks Updates****'Incident to' Billing for Behavioral Health Can Now Be Billed in Primary Care Office**

As of **November 30, 2014**, "incident to" billing by Physician Assistants and Nurse Practitioners for patients whose primary diagnosis is behavioral health can now be billed through a primary care office. Providers whose claims were denied can rebill the claims to NCTracks. This change was communicated in an NCTracks announcement on December 2, 2014.

Reminder: 2015 Checkwrite Schedules Posted

Two 2015 checkwrite schedules are now available on the NCTracks website. There is one for DMA, and a combined schedule for: the Division of Public Health (DPH), Division of Mental Health/Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) and the Office of Rural Health and Community Care (ORHCC). They can be found under the Quick Links on the right side of the NCTracks Provider Portal home page at <https://www.nctracks.nc.gov/content/public/providers.html>.

In addition, the 2015 checkwrite schedules for DMA, as well as the state holiday schedule, can be found on DMA's Calendar web page at www.ncdhhs.gov/dma/provider/calendar.htm.

Restrictive Coverage Information on Recipient Eligibility Inquiry

As of January 5, 2015, when a recipient has a Living Arrangement Code of 18 (Special Assistance/Institution for Mental Disease), a special message of restricted coverage is sent in the eligibility verification response for the Automated Voice Response System (AVRS), the NCTracks Provider Portal, and the 271 X12 transaction. The specific eligibility verification message/response for each inquiry channel is:

- **AVRS and NCTracks Provider Portal Restrictive Coverage Message:** This is a restrictive coverage category. The recipient is not eligible for Medicaid claims payment.
- **271 Health Care Eligibility Benefit Response:** A number of segments in the 271 Health Care Eligibility Benefit Response, Loop 2110C, will be used to report Living Arrangement Code '18':
 - EB01 segment will have "F" for "Limitations"
 - EB03 segment will have "32" for "Plan Waiting Period"
 - MSG01 segment will have the message "Not eligible for Medicaid claims payment"

Since the restrictive coverage may not apply for an entire month, the specific days of restrictive coverage will be provided, along with the message/response.

For additional information, trading partners should refer to the *270/271 Health Care Eligibility Benefit Inquiry and Response Companion Guide* on the Trading Partner Information page of the NCTracks Provider Portal at <https://www.nctracks.nc.gov/content/public/providers/provider-trading-partners.html>.

Note: Claims submitted for these recipients will be denied if the dates of service on the claims are on or within the days of restrictive coverage and the Living Arrangement Code is 18. Denied claims will fail with Edit 00099 (RECIP IN MENT INST AT DOS) and post EOB 01799 - RECIPIENT IS NOT ELIGIBLE FOR MEDICAID CLAIMS PAYMENT DUE TO CURRENT LIVING ARRANGMENT.

Using the LTC DMA-0100 Form

DMA-0100 Physicians Signature for Authorization of Level of Care is a supplementary form to be used if a prior approval (PA) request for Long Term Care (LTC) was submitted using the NCTracks Provider Portal. *DMA-0100* can be found on the NCTracks PA web page at <https://www.nctracks.nc.gov/content/public/providers/prior-approval.html>.

A fact sheet titled *Using the LTC DMA-0100 Form* is available on the Fact Sheet page of the NCTracks Provider Portal at <https://www.nctracks.nc.gov/content/public/providers/provider-user-guides-and-training/fact-sheets.html>. The fact sheet explains how to fill out and submit the form to NCTracks. Following these guidelines regarding the use of *DMA-0100* will help expedite the review of the LTC prior approval requests.

Update on Claims with New 2015 Codes to Pend

New CPT and HCPCS codes went into effect on January 1, 2015

The N.C. Department of Health and Human Services (DHHS) and CSC are in the process of completing system updates to align our policies with CPT code changes (new codes, covered and non-covered, as well as the end-dated codes), to ensure that claims billed with the new codes will be processed and paid correctly.

Until system modifications are made, claims submitted with new codes will pend as “no fee on file.” These pended claims will be paid when system modifications are complete. No additional action is required by providers to ensure that claims are processed and paid correctly. This is also applicable for Medicare crossover claims.

In the interim, to maintain cash flow, providers may want to split claims and bill new codes on a separate claim. This will ensure that only claims billed with the new procedure codes are pended for processing.

Owner/Managing Relationships of Provider Now Subject to OIG Exclusion

The Office of Inspector General (OIG) of the U.S. Department of Health and Human Services has the authority to exclude individuals and entities from federally-funded healthcare programs. Exclusions are imposed for a number of reasons. **As of January 4, 2015**, the termination of an NCTracks provider may occur due to the identification of an owner/managing relationship with an OIG exclusion. Owners/managing relationships were not previously included in the monthly evaluation process using OIG exclusion data. Providers terminated for this reason will receive a letter that states, “PROVIDER IS TERMINATED DUE TO AN OWNER OR MANAGING EMPLOYEE WITH AN OFFICE OF INSPECTOR GENERAL EXCLUSION FINDING.” The letter will also explain how to request reconsideration of the decision.

For more information about the OIG Exclusions Program, see <http://oig.hhs.gov/exclusions/index.asp>.

Important Information About Sterilization Claims

Electronic Sterilization Claims for Undocumented Aliens

Inpatient delivery claims for “Undocumented Aliens” who had a non-covered sterilization during their stay can be submitted electronically via the NCTracks Provider Portal with non-covered charges listed in the “Non-Covered” column. To receive a reimbursement, providers must meet documentation requirements found in Clinical Coverage Policy 1E-3, *Sterilization Procedures*, located on DMA’s Clinical Coverage Policy web page at www.ncdhhs.gov/dma/mp/.

These requirements include:

- Completing a **paper** UB04 claim form
- Listing sterilization charges in the “Non-Covered” Column
- Including a statement in the “Remarks Field” indicating charges for sterilization were entered in the “Non-Covered” column
- **Printing out the form**
- Uploading the printed form and submitting it – along with electronic claim submission – to NCTracks.

Electronic Sterilization Claims for Non-Covered Sterilization Services

Inpatient delivery claims which include non-covered sterilization services not related to “Undocumented Aliens” should be submitted electronically. The claim will be denied with EOB 00041 (Federal Sterilization Consent Form Required). After receiving a denial, providers should submit a paper adjustment request form with supporting documentation. The adjustment request should include a UB claim form listing sterilization charges in the “Non-Covered” column **and** a statement in the “Remarks Field” indicating non-covered charges are related to sterilization. Adjustment instructions and documentation requirements can be found on the NCTracks Provider Portal.

These procedures are based on Clinical Coverage Policy 1E-3, *Sterilization Procedures*, located on DMA's Clinical Coverage Policy web page at www.ncdhhs.gov/dma/mp/.

Note: Failure to complete both the "Non-Covered" column and the "Remarks Field" will result in denial.

Optical Providers

Request Begin Date on Prior Approvals for Visual Aids

When entering PA requests in the NCTracks Provider Portal, the 'Request Begin Date' should be the current date (i.e., the day the request is being submitted) **and** the request should be entered under the correct Health Plan on the current date. PA requests are being received from providers with a backdated or future Request Begin Dates. This can result in non-payment of dispensing fees.

The Request Begin Date is the first line on the "Detail" tab of the NCTracks Provider Portal submission for visual aid PA requests.

In addition, providers should **not** enter Procedure Codes when submitting PA requests for visual aids. Entering procedure codes will result in only partial payment for dispensing fees.

Errors in Submitting Requests for Visual Aids

Providers should enter information accurately when submitting PA requests for visual aids in the NCTracks Provider Portal. The majority of these requests are auto-approved and transmitted to Nash Optical the same day. If a request has been submitted in error, or with errors entered, a provider may **not** void the request. Many providers call the CSC Call Center and submit tickets to correct these errors. Unfortunately, in many cases, the glasses have been fabricated.

If an error has been made when submitting a Visual Aids PA request:

1. Call Nash Optical at 1-888-388-1353 to stop the order;
2. Call the CSC Call Center at 1-800-688-6696 and request an escalated ticket to void the PA request, which will be forwarded to the PA functional area;
3. Watch for the incorrect request to be placed in 'void' status on your PA Request Status in the NCTracks Provider Portal; and,
4. Resubmit the request correctly

CSC, 1-800-688-6696

Attention: All Providers**NCTracks Tip: Getting Help in the Secure NCTracks Provider Portal**

The following help features are available on the NCTracks Secure Provider Portal:

- Page-Level Help: Page-specific assistance and guidance
- Data/Section Group Help: Explains what is being requested in a particular *section* of a page
- Tooltip Help: Hover your mouse over an underlined word to understand its definition

These Help features, and others, are available on every page of the secure NCTracks portal.

For a complete explanation of all available help options in the secure NCTracks provider portal, read *Features of NCTracks Portal Help System* on the Fact Sheet page at

<https://www.nctracks.nc.gov/content/public/providers/provider-user-guides-and-training/fact-sheets.html>.

CSC, 1-800-688-6696

Attention: All Providers**Procedure Code Update to Add Nurse Practitioner and Physician Assistant Taxonomies**

The N.C. Division of Medical Assistance (DMA) continues to identify procedure codes for which Nurse Practitioners (NP) and Physician Assistants (PA) have been unable to receive reimbursement. Some of the CPT codes that have been identified are listed below. System changes have been made and NP and PAs should resubmit claims that were filed in a timely manner for dates of service on or after July 1, 2013.

As other procedure codes are identified, system changes will be made and providers will be notified in future Medicaid Bulletins.

10080	11100	11752	11981	17106	17111	20500	20552
20610	22632	23600	24530	24560	24576	27501	27560
27810	27824	32655	33405	33430	33464	33472	36558
36571	36581	36582	36589	36561	36590	36870	38220
43644	47525	49422	51705	51741	51798	54056	56501
58300	58301	59025	63030	63047	67700	70450	72069
72070	72110	72120	72202	73000	73080	73550	75820
75978	75984	76645	76700	80048	80061	80069	80154
80299	81002	81003	81025	82043	82075	82145	82205
82486	82520	83540	83735	83789	83805	83840	83925
83992	84153	84460	84479	85018	85610	85652	86376
86756	87184	87480	87510	87660	87880	88164	99202
99203	99204	99205	99212	99213	99214	99215	99219
99243	99251	99252	99253	99254	99255	99285	99354
99385	99395	G0202	G0434	J3420	J3480	J7030	J7321
J7323	J7325	Q0111					

CSC, 1-800-688-6696

Attention: All Providers

Revised Allergy Testing Policy

The revised Clinical Coverage Policy 1N-1, *Allergy Testing*, is being posted February 1, 2015. The following unit limitations are included in this version.

Allergy Testing Limits

Codes	Testing Limitations
95004	75 units per year
95017	30 units per date of service
95018	30 units per date of service
95024	20 units per year
95027	20 units per year
95028	20 units per year
95044	36 units per year
95070	1 unit per date of service
95071	1 unit per date of service
95076	1 unit per date of service
95079	8 units per date of service

Questions should be directed to CSC at 1-800-688-6696.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers**L**ock-In Program Updates

The Beneficiary Lock-In Program operates in accordance with federal and state laws to prevent overutilization of Medicaid benefits. Beneficiaries identified for the lock-in program will be restricted to a single prescriber and pharmacy in order to obtain opioid analgesics, benzodiazepines, and certain anxiolytics covered through the Medicaid Outpatient Pharmacy Program. Criteria for inclusion in this program is at www.ncdhhs.gov/dma/mp/9pharmacy.pdf.

The first beneficiaries were identified through NCTracks in December, 2014 and received notification letters in January, 2015. These beneficiaries will be locked into one prescriber and pharmacy for all benzodiazepine and opioid medications for a one-year period beginning March 1, 2015. **Providers with whom the patient will be locked-in will be notified in February.**

Providers who have questions should call CSC at 1-866-246-8505

Outpatient Pharmacy Services
DMA, 919-855-4300

Attention: All Providers**C**rinone® 8% Available Through Prior Authorization (PA) for Cervical Insufficiency (Short Cervix)

Effective **November 1, 2014**, the N.C. Division of Medical Assistance (DMA) will allow Crinone® 8% to be prescribed with prior authorization (PA) for Cervical Insufficiency (Short Cervix).

PA criteria can be found at <https://www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html>; PA forms can be found at <https://www.nctracks.nc.gov/content/public/providers/pharmacy/forms.html>. Completed PA forms may be faxed to 1-855-710-1969 or submitted through the NCTracks provider portal.

Outpatient Pharmacy Services
DMA, 919-855-4300

Attention: Nurse Practitioners, Physician Assistants and Physicians**Antihemophilic factor (recombinant), porcine sequence (Obizur®), HCPCS code J7199: Billing Guidelines**

Effective with date of service December 1, 2014, the N.C. Medicaid program covers antihemophilic factor (recombinant), porcine sequence (Obizur®), for use in the Physician's Drug Program (PDP) when billed with HCPCS code J7199 Hemophilia clotting factor, Not otherwise classified. Obizur® is currently commercially available in 500 unit vials.

Antihemophilic factor (recombinant), porcine sequence (Obizur®) is indicated for the treatment of bleeding episodes in adults with acquired hemophilia A.

The recommended dosage for antihemophilic factor (recombinant), porcine sequence (Obizur®) is an initial dose of 200 units per kg. Titrate dose and frequency of administration based on factor VIII recovery levels and individual clinical response.

For Medicaid Billing

- The ICD-9-CM diagnosis code required for billing antihemophilic factor (recombinant), porcine sequence (Obizur®) is 286.52 Acquired hemophilia.
- Providers must bill Obizur® with HCPCS code J7199 Hemophilia clotting factor, Not otherwise classified.
- Providers must indicate the number of HCPCS units.
- One Medicaid unit of coverage for Obizur® is 1 IU. The maximum reimbursement rate per 1 IU is \$5.5710. One 500 unit vial contains 500 billable units.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Obizur® 500 unit vials are 00944-5001-01, 00944-5001-05, and 00944-5001-10.
- The NDC units for antihemophilic factor (recombinant), porcine sequence (Obizur®) should be reported as "UN1."
- For additional instructions, refer to the January 2012, Special Bulletin, *National Drug Code Implementation Update*, on DMA's website at www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf.
- Providers shall bill their usual and customary charge for non-340-B drugs.
- PDP reimburses for drugs billed for N.C. Medicaid and N.C. Health Choice (NCHC) beneficiaries by 340-B participating providers who have registered with the Office of Pharmacy Affairs (OPA) at <http://opanet.hrsa.gov/opa/Default.aspx>. Providers billing for 340-B drugs shall bill the cost that is reflective of their acquisition cost. Providers shall indicate that a drug was purchased under a 340-B purchasing agreement by appending the "UD" modifier on the drug detail.
- The fee schedule for the PDP is available on DMA's "Fee Schedule" web page at <http://www.ncdhhs.gov/dma/fee>.

CSC, 1-800-688-6696

Attention: Outpatient Behavioral Health Providers

Associate-level Licensed Providers: Direct Enrollment

By **June 30, 2015**, associate-level licensed providers of Medicaid outpatient behavioral health services must directly enroll with Medicaid. These providers must also apply and enroll through the Local Management Entity-Managed Care Organization (LME-MCO) with which they want to contract.

Effective July 1, 2015, if associate-level licensed providers plan to provide services to Medicaid beneficiaries age 0 to 3, N.C. Health Choice (NCHC) beneficiaries, or legal aliens, the providers must enroll with the N.C. Division of Medical Assistance (DMA) by contacting CSC. Associate-level licensed providers will need to be enrolled with both DMA (through CSC) and the LME-MCO if they wish to provide services to multiple populations.

Associate-level licensed providers enrolling with DMA (through CSC) or an LME-MCO will enroll under the taxonomy code of their respective profession. For example, an associate-level licensed clinical social worker will enroll under the taxonomy code for a licensed clinical social worker.

For claims submitted through NCTracks, the rate for associate-level licensed providers is the same as the rate for their fully licensed counterparts. However, LME-MCOs have the ability to set their own rates for services. Therefore, associate-level licensed providers should contact the LME-MCO for information regarding rates.

Associate-level licensed providers will need to obtain their own National Provider Identifier (NPI) number. To apply for an NPI number, see the instructions on the following website <https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.instructions>

Associate-level licensed providers may contact CSC with questions regarding enrollment with DMA. **CSC may be contacted at:**

CSC, Provider Enrollment Unit
P. O. Box 300020
Raleigh, NC, 27622-8020
Phone: 1-800-688-6696

Associate-level licensed providers should contact their LME-MCO regarding contracting with them.

Supervision

All associate-level licensed providers are required to be supervised by an individual approved by their licensing board. This supervision is critical to ensuring quality of services for beneficiaries being served by associate-level licensed providers. Each associate-level licensed provider is

required to ensure that they meet the supervision requirements set forth by their respective licensing board.

The links to the rules pertaining to the respective board's supervision requirements found in the North Carolina Administrative Code (NCAC) are as follows.

Marriage and Family Licensure Board

www.ncmft.org/images/uploads/other_pdfs/chapter_31_rules.pdf

Substance Abuse Professional Practice Board

<http://reports.oah.state.nc.us/ncac/title%2021%20-%20occupational%20licensing%20boards%20and%20commissions/chapter%2068%20-%20substance%20abuse%20professional%20practice%20board/21%20ncac%2068%20.0204.pdf>

North Carolina Board of Licensed Professional Counselors

http://ncblpc.org/Laws_and_Codes/Title_21_Chapter_53.pdf

North Carolina Social Work Certification and Licensure Board

<http://ncswboard.org/page/administrative-code#.0210>

“Incident to” Billing

As outlined in Section 6.2 of Clinical Coverage Policy 8C, *Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers*, associate-level licensed providers are allowed to bill:

- “Incident-to” their supervising physician, or,
- Through the LME-MCO until the associate-level licensed provider is able to directly enroll with the LME-MCO.

When associate-level licensed provider are able to direct enroll, DMA will discontinue this “incident to” policy. To view the policy visit the DMA Clinical Coverage Policy web page at www.ncdhhs.gov/dma/mp/.

Note: The “incident to” policy change will not impact providers receiving other state-funded reimbursement as the Division of Mental Health/Developmental Disabilities and Substance Abuse Servicers (DMH/DD/SAS) does not support “incident to” billing.

Until they have completed direct enrollment or June 30, 2015, whichever comes first, associate-level licensed providers will be able to continue billing “incident to:”

- Their supervising physician for Medicaid, or,
- HCPCS codes through a willing LME-MCO for Medicaid and/or state-funded behavioral health outpatient services.

Effective July 1, 2015:

1. DMA will change the outpatient Clinical Coverage Policy 8C and remove the section on “incident to” billing for associate-level licensed providers, as well as remove the section allowing associate licensed level providers to bill HCPCS codes (H0001, H0004 + modifiers, H0005 and H0031) through the LME-MCO.
2. It would be considered fraud for an associate-level professional to continue billing “incident to” a physician.

Associate-level licensed providers are not permitted to bill “incident to” the NPI number of any other professional.

Contact Kathy Nichols at: Katherine.Nichols@dhhs.nc.gov for questions.

Behavioral Health Policy Section
DMA, 919-855-4290

Attention State Plan Personal Care Services (PCS) Beneficiaries, Providers, and Physicians

New DMA-3051 Physicians Referral Form is Now Available

Effective February 2, 2015, beneficiaries requesting Personal Care Services (PCS) must use the *DMA 3051 - Request for Independent Assessment for Personal Care Services (PCS) Attestation of Medical Need (2/2/2015)*. This form is a *revision* of the currently used *DMA 3051-Request for Services form (12/1/2013)*.

DMA-3051 Request for Services forms (12/1/2013) cannot be processed if submitted on or after February 2, 2015. A link is provided below with instructions for requesting services and submitting the revised 3051 Referral Form. Use the contacts listed below should you have questions.

New forms, instructions, and training materials are available here:

- www.ncdhhs.gov/dma/pcs/pas.html
- www.nc-pcs.com/training/

Those with questions regarding the new form you may contact the N.C. Division of Medical Assistance PCS or Liberty Healthcare Corporation-NC

Liberty Healthcare Corporation

1-919-322-5944

1-855-740-1400

NC-IAsupport@libertyhealth.com

The Division of Medical Assistance - PCS

919-855-4360

PCS_Program_Questions@dhhs.nc.gov

Facility, Home, and Community Based Services

DMA, 919-855-4340

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 substantively 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
February 2015	2/05/15	2/10/15	2/11/15
	2/12/15	2/18/15	2/19/15
	2/19/15	2/24/15	2/25/15
	2/26/15	3/03/15	3/04/15
March 2015	3/05/15	3/10/15	3/11/15
	3/12/15	3/17/15	3/18/15
	3/19/15	3/24/15	3/25/15
	3/26/15	3/31/15	4/01/15

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
Director of Clinical
Division of Medical Assistance
Department of Health and Human Services

Paul Guthery
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CSC