April 2014 Medicaid Bulletin

Attention: All Providers

NCTracks Updates

New Frequently Asked Questions (FAQs) and Forms about Updating Office Administrator Information

Two Frequently Asked Questions (FAQs) were added – and an existing FAQ was updated – on the FAQ page devoted to NCTracks User Setup & Maintenance at https://www.nctracks.nc.gov/content/public/providers/faq-main-page/faqs-for-NCTracks-User-Setup-Maintenance.html. Each of these FAQs addresses changing a provider organization's Officer Administrator information. The FAQs are:

- I have forgotten my Office Administrator password and I am unable to answer my security question to reset my password. What do I do?
- The Office Administrator is no longer available and I am unable to access the NCTracks provider record - Individual Providers
- The Office Administrator is no longer available and I am unable to access the NCTracks provider record - Organization Providers

All of these FAQs have forms associated with them, which are linked from the FAQ. The forms also can be found on the NCTracks Provider Policies, Manuals and Guidelines page at https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html.

Ambulance Provider Fact Sheet

A fact sheet for ambulance providers has been posted to the Fact Sheet page of the NCTracks Provider User Guides and Training page at https://nctracks.nc.gov/content/public/providers/provider-user-guides-and-training.html.

The fact sheet helps ambulance providers use NCTracks to bill for services rendered to Medicaid recipients. It includes guidelines for which claim and bill types to use, a list of HCPCS and revenue codes, a table of condition codes and other information. The fact sheet can be read online, printed, or downloaded to a computer.

Revised Medicaid Resolution Inquiry Form

The Medicaid Resolution Inquiry Form, which is used to submit requests for time limit overrides, has been updated to clarify when it can be used and what supporting documents are required. The updated form can be found under the heading "Provider Forms" on the NCTracks Provider Policies, Manuals and Guidelines page at https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html.

Include National Provider Identifiers (NPIs) With Fax and Email to NCTracks

When sending documents to NCTracks, it is strongly advised that providers use a "turnaround" cover sheet whenever possible. This is the most effective way of ensuring that supporting documentation is linked to the submitted request. Turnaround cover sheets are available at the end of submitting prior approval requests and enrollment applications through the NCTracks provider portal. Print the turnaround cover sheet and include it when emailing, faxing, or mailing supporting documentation to NCTracks.

If a turnaround cover sheet is not available, remember to include **all** provider National Provider Identifiers (NPIs) on any fax cover sheets or first page of any documentation being faxed. Be sure to include NPIs in the subject line of emails sent to NCTracks (or in the body of the email) and on any attachments.

An example would be supporting documentation related to Enrollment or Manage Change Request applications. The NPI is needed to link the documents to the correct provider record. Failure to include the NPI can result in the document being misrouted and cause delays in processing the request. **Those who have recently sent documents to NCTracks without NPIs are encouraged to resend the documents with the NPIs.**

Note: The confirmation sheet generated when Prior Approval requests are submitted through NCTracks is **not** the same as a turnaround document. The confirmation sheet does **not** contain the barcode which automatically links supporting documentation to the request. To get a turnaround document when submitting a Prior Approval request, indicate that attachments being submitted via email, mail, or fax before submitting the Prior Approval request online. Those who receive a letter requesting additional information regarding Prior Approval requests will receive a bar-coded turnaround document to submit with the additional information.

NCTracks Call Center Ticket Numbers

When contacting the NCTracks Call Center (1-800-688-6696), providers should request a contact ticket number. The contact ticket number helps providers, the Call Center and the NC Division of Medical Assistance (DMA) keep track of the call, allowing for smoother service and potentially leading to a faster resolution.

Contact ticket numbers begin with the letter "I" and are followed by numbers. Providers should retain all contact ticket numbers in their records until the problem indicated in the contact is resolved.

NCTracks ICD-10 Web Page

The NCTracks ICD-10 Web page at
https://www.nctracks.nc.gov/content/public/providers/ICD10.html on the Provider Portal is an important resource as the state moves toward implementation of ICD-10 on October

1, 2014. Providers are encouraged to check frequently for new announcements, FAQs, additional resources and the latest edition of the ramp-up articles.

Newsletter Archive on Provider Communications Page of NCTracks Website

A new Provider Communications page has been added to the NCTracks Provider Portal at https://www.nctracks.nc.gov/content/public/providers/provider-communications.html. The Web page includes provider announcements, updates and an archive of the provider newsletter, *NCTracks Connections*. The archive is a chronological listing of provider newsletters that were sent to providers through the email listserv. The archive already includes regular newsletters sent during 2014. NCTracks will be posting newsletters published since July 1, 2013 during the next few weeks.

837 Companion Guides Updated for Encounter Processing

Note: This item is included to DMA providers for information only. There are no new requirements for DMA providers.

The 837 Companion Guides have been updated for encounter processing, which was implemented on February 1, 2014. The guide is primarily of interest to the Local Management Entities/Managed Care Organizations (LMEs/MCOs) working with the N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. The latest version of the companion guides can be found on the Trading Partner Information page of the NCTracks Provider Portal at https://www.nctracks.nc.gov/content/public/providers/provider-trading-partners.html.

CSC, 1-800-688-6696

Attention: All Providers and N.C. Health Choice Providers

Flu Vaccine: Update to March 2014 article

The new CPT code, 90685 "Influenza Virus Vaccine, Quadrivalent, Split Virus, Preservative Free, When Administered To Children 6-35 Months Of Age, For Intramuscular Use," was added as a billable code for N.C. Medicaid beneficiaries effective October 1, 2013. This code is covered at a $0.00 rate as it is available to these patients through the Vaccine For Children (VFC) program. See below for reimbursement guidelines for administration of all flu vaccine.

Each year, scientists try to match the viruses in the influenza vaccine to those most likely to cause flu that year. This season's influenza vaccine is comprised of the following three strains:

- A/California/7/2009 (H1N1) pdm09-like virus
- A/Victoria/361/2011 (H3N2)-like virus
- B/Massachusetts/2/2012-like virus

A new quadrivalent flu vaccine also includes the following strain:

- B/Brisbane/60/2008–like virus

For further details on the 2013-2014 influenza vaccine, see the Advisory Committee on Immunization Practices (ACIP) recommendations published in the Sept. 20, 2013, Centers for Disease Control's *Morbidity and Mortality Weekly Report* at www.cdc.gov/mmwr/preview/mmwrhtml/rr6207a1.htm.

N.C. Medicaid does not expect that providers will be vaccinating beneficiaries with the 2013-2014 influenza seasons' vaccine after date of service June 30, 2014.

N.C. Immunization Program/Vaccines for Children (NCIP/VFC)

The N.C. Immunization Branch distributes all required childhood vaccines to local health departments, hospitals and private providers under N.C. Immunization Program/Vaccines for Children (NCIP/VFC) guidelines. According to NCIP coverage criteria, the NCIP/VFC influenza vaccine is available at no charge for children 6 months through 18 years of age who are eligible for the VFC program during the 2013-2014 influenza season. This includes Medicaid-covered children through 18 years of age. The current NCIP coverage criteria and definitions of VFC categories can be found at www.immunize.nc.gov/providers/coveragecriteria.htm.

Children eligible for the VFC program also include American Indian and Alaska Native (AI/AN) N.C. Health Choice (NCHC) beneficiaries. These beneficiaries are identified as MIC-A and MIC-S on their NCHC Identification Cards. However, the NCIP/VFC program allows beneficiaries/parents to declare their VFC eligibility status.

When an NCHC beneficiary self-declares their status as AI or AN, the provider should administer VFC vaccine. The provider must report the CPT vaccine code with $0.00 but may bill NCHC for the administration costs.

All other NCHC beneficiaries are considered insured, and must be administered privately purchased vaccines. Refer to the June 2012 general Medicaid article, *Billing for Immunizations for American Indian and Alaska Native N.C. Health Choice Recipients* at www.ncdhhs.gov/dma/bulletin/0612bulletin.htm#AI for further details.

For NCIP/VFC vaccines, providers will only report the vaccine code but may bill for the administration fee for Medicaid and eligible AI/AN NCHC beneficiaries. Providers wishing to immunize children who are **not** VFC-eligible – including all NCHC children who are not AI/AN, and adult patients who do not meet the eligibility criteria for NCIP influenza vaccine – must purchase the vaccine for those groups. New federal restrictions **prevent** NCIP/VFC vaccines from being expanded universally.

Billing/Reporting Influenza Vaccines for Medicaid Beneficiaries

The following tables indicate the vaccine codes that can be either reported (with $0.00 billed) or billed (with the usual and customary charge) for influenza vaccine, depending on the age of the beneficiaries and the formulation of the vaccine. The tables also indicate the administration codes that can be billed, depending on the age of the beneficiaries.

Note: The information in the following tables is **not** detailed billing guidance. Specific information on billing all immunization administration codes for NCHC beneficiaries can be found in the July 2013 NC Medicaid Special Bulletin, *Health Check Billing Guide 2013* at: www.ncdhhs.gov/dma/healthcheck/HC-Billing_Guide_2013.pdf

Table 1: Influenza Billing Codes for Medicaid Beneficiaries Less Than 19 Years of Age Who Receive VFC Vaccine

Vaccine CPT Code to Report	CPT Code Description
90655	Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use
90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
90657	Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use
90658	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use
90672	Quadrivalent Influenza virus vaccine, live, for intranasal use (FluMist)
90685	Influenza virus vaccine, quadravalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use
90686	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
90471EP	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **1 vaccine** (single or combination vaccine/toxoid)
+90472EP (add-on code)	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **each additional vaccine** (single and combination vaccine/toxoid) (List separately in addition to code for primary procedure). **Note**: Providers *may* bill more than one unit of 90472EP as appropriate.
90473EP	Immunization administration by intranasal or oral route; **1 vaccine** (single or combination vaccine/toxoid). **Note:** Billing CPT code 90474 for a second administration of an intranasal/oral vaccine is *not* applicable at this time.
+90474EP (add-on code)	Immunization administration by intranasal or oral route; **each additional vaccine** (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure). **Note:** Billing CPT code 90474 for a second administration of an intranasal/oral vaccine is *not* applicable at this time.

Table 2: Influenza Billing Codes for Medicaid Beneficiaries 19 and 20 Years of Age

Use the following codes to bill Medicaid for an influenza vaccine purchased and administered to beneficiaries **19 through 20 years of age.**

Note: For the 2013-2014 flu season, the NCIP will **not** provide Live Attenuated Influenza Vaccine (LAIV) (CPT code 90672 FluMist) for adults *ages 19 and over*.

Vaccine CPT Code to Bill	**CPT Code Description**
90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
90658	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use
90672	Quadrivalent Influenza virus vaccine, live, for intranasal use (FluMist)
90686	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
90471EP	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **1 vaccine** (single or combination vaccine/toxoid)
+90472EP (add-on code)	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **each additional vaccine** (single and combination vaccine/toxoid) (List separately in addition to code for primary procedure
90473EP	Immunization administration by intranasal or oral route; **1 vaccine** (single or combination vaccine/toxoid). **Note:** Billing CPT code 90474 for a second administration of an intranasal/oral vaccine is *not* applicable at this time.
+90474EP (add-on code)	Immunization administration by intranasal or oral route; **each additional vaccine** (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure). **Note:** Billing CPT code 90474 for a second administration of an intranasal/oral vaccine is *not* applicable at this time.

Note: The influenza vaccine is one of four vaccines for which Medicaid <u>will</u> reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). These providers may bill the appropriate CPT code for the vaccine used (90656, 90658, *90686* or 90672) along with the appropriate administration code (90471 through 90474). For beneficiaries 6 months through *18 years of age*, if the

vaccine was provided through the NCIP, the center/clinic may bill only for the administration costs under the C suffix provider number.

Table 3: Influenza Billing Codes for Medicaid Beneficiaries 21 Years of Age and Older

Use the following codes to **bill** Medicaid for an **injectable** influenza vaccine **purchased** and administered to beneficiaries *19 years of age and older*.

Note: For the 2013-2014 flu season, the NCIP will not provide LAIV (CPT code 90672, FluMist) for adults. Medicaid does NOT reimburse for purchased LAIV for beneficiaries 21 years of age and older.

Vaccine CPT Code Bill	CPT Code Description
90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
90658	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use
90686	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **1 vaccine** (single or combination vaccine/toxoid)
+90472 (add-on code)	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **each additional vaccine** (single and combination vaccine/toxoid) (List separately in addition to primary procedure)

For beneficiaries 21 years of age or older receiving an influenza vaccine, an evaluation and management (E/M) code **cannot** be reimbursed to any provider on the same day that injection administration fee codes (e.g., 90471 or 90471 and +90472) are reimbursed, unless the provider bills an E/M code for a separately identifiable service by appending modifier 25 to the E/M code.

Billing/Reporting Influenza Vaccines to Medicaid for NCHC Beneficiaries

The following table indicates the vaccine codes that can be either reported (with $0.00) or billed (with the usual and customary charge) for influenza vaccine, depending on a NCHC beneficiary's VFC eligibility and the formulation of the vaccine. The table also indicates the administration codes that may be billed.

Table 4: Influenza Billing Codes for NCHC Beneficiaries 6 through 18 Years of Age Who Receive VFC Vaccine (MIC-A and MIC-S Eligibility Categories or Beneficiaries in Other Categories who Self Declare AI/AN Status) or Purchased Vaccine (All Other NCHC Eligibility Categories)

Vaccine CPT Code to Report/Bill	CPT Code Description
90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
90658	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use
90672	Quadrivalent Influenza virus vaccine, live, for intranasal use (FluMist)
90686	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **1 vaccine** (single or combination vaccine/toxoid)
+90472 (add-on code)	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **each additional vaccine** (single and combination vaccine/toxoid) (List separately in addition to code for primary procedure). **Note**: Providers *may* bill more than one unit of 90472 as appropriate.
90473	Immunization administration by intranasal or oral route; **1 vaccine** (single or combination vaccine/toxoid). **Note:** Billing CPT code 90474 for a second administration of an intranasal/oral vaccine is *not* applicable at this time.
+90474 (add-on code)	Immunization administration by intranasal or oral route; **each additional vaccine** (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure). **Note:** Billing CPT code 90474 for a second administration of an intranasal/oral vaccine is *not* applicable at this time.

Note: The EP modifier should NOT be billed on NCHC claims.

For FQHCs and RHCs *participating in the NCIP*, for AI/AN NCHC beneficiaries 6 through 18 years of age, if the vaccine was obtained through NCIP/VFC, the clinic

may bill only for the administration costs under the C suffix provider number. The vaccine CPT code must be reported and $0.00 should be billed.

For influenza vaccine and administration fee rates, refer to the Physician's Drug Program fee schedule on the fee schedule page of the N.C. Division of Medical Assistance Website at www.ncdhhs.gov/dma/fee/fee.htm.

CSC, 1-800-688-6696

Attention: All Providers

NC Medicaid EHR Incentive Program: April 2014 Updates

Electronic Health Record (EHR) Incentive Payments for Program Year 2013

Those attesting for program year 2013 are not required to update their patient volume (PV) reporting period. However, there will be **significant delays** in processing PV for reporting periods containing dates on or after July 1, 2013.

To expedite payment, eligible providers may change their PV reporting period to any consecutive 90-day period:

   A) In calendar year 2012; or
   B) As early as 12 months prior to the attestation date and ending no later than June 30, 2013.

To update a PV reporting period, visit N.C. Medicaid Incentive Payment System (NC-MIPS), withdraw the previous attestation and re-attest.

EHR Program Year 2013 Attestation Tail Period

Note: The last day to submit a Program Year 2013 attestation is April 30, 2014.

For additional program updates, visit the N.C. Division of Medical Assistance EHR Web page at www.ncdhhs.gov/dma/provider/ehr.htm.

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

Attention: All Providers

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Policy Update

Beginning on April 1, 2014, NCTracks will process all prior approval requests for services coverable under the scope of Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)* benefit for beneficiaries under 21 years of age. Before to this date, prior approval requests for many EPSDT coverable services were being processed by the N.C. Division of Medical Assistance.

The EPSDT Policy Instructions Update, revised January 11, 2010, and found at www.ncdhhs.gov/dma/epsdt/epsdtpolicyinstructions.pdf remains the same, except for the following:

1. NCTracks will process EPSDT prior approval requests for services needed that **exceed clinical coverage policy limits**. Providers must use the **NCTracks Prior Approval Web Portal** (https://www.nctracks.nc.gov/content/public/providers/prior-approval.html) to request services that exceed clinical policy limits.

2. NCTracks will process all EPSDT prior approval requests for *Non-Covered Services* for beneficiaries under 21 years of age. Providers must use the "**Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years Old**" found at https://www.nctracks.nc.gov/content/public/providers/prior-approval.html.

   This Non-Covered Services form must be submitted/uploaded along with supporting documentation via **NCTracks**. **Note:** The previous DMA version of this form is no longer available.

About EPSDT

Federal Medicaid law at 42 U.S.C.§ 1396d(r) [1905(r) of the Social Security Act] requires state Medicaid programs to provide EPSDT for beneficiaries under 21 years of age. Within the scope of EPSDT benefits under the federal Medicaid law, states are required to cover any service that is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition identified by screening," whether or not the service is covered under the North Carolina State Medicaid Plan. The services covered under EPSDT are limited to those within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d (a) [1905(a) of the Social Security Act].

For example, if the non-covered service needed is a Durable Medical Equipment (DME) service, follow the normal process for requesting a DME prior approval and include the completed Non-Covered Services Form along with supporting documentation.

EPSDT,
DMA, 919-986 9777

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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/. 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 such topics as:

- Common Billing Errors
- Enhanced Payments under the Affordable Care Act
- HIPAA/ICD-10
- Medicare Crossover Claims
- Prior Approval
- Updating and Amending Applications
- Using Skillport

To receive email alerts and other communications from NCTracks, visit https://www.nctracks.nc.gov/content/public/providers/provider-communications.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: 'Be Smart' Family Planning Waiver Providers

Update: The 'Be Smart' Waiver Applies for Conversion to a State Plan Amendment

The N.C. Division of Medical Assistance (DMA) has submitted a request to the Centers for Medicare & Medicaid Services (CMS) to convert the "Be Smart" Family Planning Waiver program to an amendment to the Medicaid State Plan. **If approved by CMS, the new program will be effective May 1, 2014 and will be called the "Be Smart" Family Planning Program.**

It is expected that the SPA will be approved; if not, the waiver will continue.

The name will be changed to reflect that the program will no longer be a waiver (demonstration) program. The "Be Smart" name will be maintained to minimize confusion for current providers, beneficiaries and stakeholders.

The State Eligibility Option for Family Planning Services (or State Plan Amendment - SPA) is an option available to the state under the Affordable Care Act. Building on the success of the waiver, North Carolina is taking advantage of this opportunity to enhance and expand the state's current family planning program.

Under the waiver, in operation since October 2005, eligible low-income women aged 19-55 and men aged 19-60 have been receiving family planning services and supplies. This has resulted in achieving the program's goals of reducing unintended pregnancies, improving the well-being of children and families, and enabling beneficiaries to plan for the spacing of pregnancies.

The "Be Smart" program will continue to cover basic family planning services and supplies: annual exams and physicals, most FDA-approved birth control, screenings and treatment for sexually transmitted infections, screening for HIV and sterilizations for both women and men.

If approved, changes to the "Be Smart" program will include:

- Expanded coverage to include the same family planning services and supplies that general (full-coverage) Medicaid beneficiaries receive. The program will continue to cover one annual exam or physical per year and up to six inter-periodic visits per year.

- Removal of eligibility restrictions based on age. It will cover family planning services and supplies to all individuals who meet the state's income and other eligibility guidelines.

- Expanded coverage, screening and treatment for sexually transmitted infections (STI) and screening for HIV, for up to six inter-periodic visits per year. Under the Waiver, screening and treatment for STIs and screening for HIV was limited to one visit and one course of treatment per year, all of which were required to be performed in conjunction with, or pursuant to, the annual exam.

- Coverage of non-emergency medical transportation to and from family planning appointments. This service was not previously covered under the Waiver.

Examples of services **not** covered under the new program are:

- Emergency room visits
- Ambulance services
- Inpatient hospital services
- Treatment for complicated women's health care problems, such as endometriosis
- Non-family planning services, including psychological and psychiatric services, infertility services, hysterectomies, abortions, AIDS and cancer treatment, dental and optical services, chiropractic services, or services required to manage or treat a medical condition, such as diabetes or hypertension; and
- Other health care problems discovered during a screening, such as breast lumps.

Eligible beneficiaries of the new family planning program will have an income of no greater than 185% of the federal poverty level. There will be no co-payments.
More information about the proposed "Be Smart" Family Planning Program can be found on DMA's Family Planning Web page at
www.ncdhhs.gov/dma/services/familyplanning.htm.

If the new program is approved by CMS, a Special Medicaid Bulletin, new clinical policies and other information related to the program will be posted on the DMA Website.

Note: In addition to the information given to beneficiaries upon enrollment, the state relies on providers to educate beneficiaries on the appropriate use of services covered under the new family planning program.

'Be Smart' Family Planning
DMA, 919-855-4260

Attention: 'Be Smart' Family Planning Waiver Providers

Placement of the Annual Exam Date on FPW Claim Forms

The N.C. Division of Medical Assistance (DMA) requires that Family Planning Waiver (FPW) service providers place the initial Annual Exam Date (AED) in the "initial treatment date" area on the claim form. This applies to annual examinations and laboratory procedures. The AED is not required on the claim form for pregnancy tests and periodic visits. Several FPW providers have been placing the AED in the incorrect location on claim forms, resulting in claims being denied.

All claims submitted and denied for a lack of the AED on the claim form should be corrected and resubmitted through NCTracks. Questions should be directed to CSC at 1-800-688-6696.

'Be Smart' Family Planning
DMA, 919-855-4260

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

Clarification on Carolina ACCESS Referrals

Note: This article expands on an article which was published in October 2013.

State policy allows specialists to use the National Provider Identifier (NPI) of the beneficiary's Carolina ACCESS Primary Care Provider (PCP) as the "referring provider" on a claim. When the NPI of the PCP is used for a Carolina ACCESS referral claim, it is placed in an electronic loop that corresponds with 17b on a professional claim. This is the preferred way for specialists to file a claim in NCTracks.

The alternative is for a PCP to enter a referral to a specialist in NCTracks. This method is not required at this time. Specialists and PCPs will be notified when it becomes mandatory for PCPs to enter all Carolina ACCESS referrals through NCTracks. In the meantime, specialists should continue to use the NPI of the beneficiary's Carolina ACCESS PCP under "referring provider" on the claim.

PCPs and specialists with questions regarding Carolina ACCESS referrals may contact their Regional Consultant. Contact information for each Regional Consultant is available at www.ncdhhs.gov/dma/ca/MCC_0212.pdf.

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

Attention: Physicians

Affordable Care Act: Enhanced Payments

N.C. Division of Medical Assistance (DMA) continues to research and review attestation results to ensure that all eligible providers who have attested for Affordable Care Act (ACA) Primary Care Enhanced Payments are correctly identified in NCTracks.

Stage 1 of the reprocessing of physician claims with dates of service on or after July 1, 2013 took place during the check writes of March 11 and March 18, 2014. DMA is now preparing for Stage 2 of the reprocessing of physician claims.

Stage 2 of the reprocessing of claims will consist of those claims that were handled by HP Enterprise Systems (HPES) from January 1, 2013 to June 30, 2013.This stage will involve releasing enhanced payments to providers **already identified** in NCTracks as eligible for the retroactive payment. Physicians will be notified prior to the reprocessing of these claims.

As part of a quality control effort, DMA is reviewing all attestation submissions to ensure that physicians correctly identified as a family practice, or general internal medicine, or pediatrician, including the sub-specialties for each discipline as defined by Section 1202 of the Affordable Care Act. Secondly, DMA is verifying that the date associated with the attestation is correct.

Weekly provider attestations continue to be received and reviewed for eligibility. The Self-Attestation Portal is located on the DMA Website at www.ncdhhs.gov/dma/provider/ACA_Home.html. Providers receiving an error message when entering information into the attestation portal are encouraged to select the "Webmaster" link to report the issue. The Webmaster link also can be found on the last page of DMA's Affordable Care Act (ACA) Webinar at www.ncdhhs.gov/dma/provider/ACA_Payments_030514.ppt, which was held on March 5, 2014.

The pseudo Medicare Fee Schedule for both 2013 and 2014 is located on the DMA Website at www.ncdhhs.gov/dma/fee/. Providers will notice that the Medicare ACA rates decreased for 2014, this is due to the reduction in the Relative Value Units (RVUs). The conversion factors for the 2013 and 2014 have remained the same.

To keep providers informed, DMA continually revises the information available on the Self-Attestation Portal of the DMA Website, including the Frequently Asked Questions

(FAQ) link. Information also is available on the NCTracks Website
(www.nctracks.nc.gov) and through the NCTracks email blasts.

Questions or concerns regarding the attestation process should be directed to DMA
Provider Relations.

DMA Provider Relations
919-855-4050

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.

2014 Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
April	04/03/14	04/08/14	04/09/14
	04/10/14	04/15/14	04/16/14
	04/17/14	04/22/14	04/23/14
	04/24/14	04/29/14	04/30/14
May	5/1/2014	5/6/2014	5/7/2014
	5/8/2014	5/13/2014	5/14/2014
	5/15/2014	5/20/2014	5/21/2014
	5/22/2014	5/28/2014	5/29/2014
	5/29/2014	6/3/2014	6/4/2014

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   **Paul Guthery**
Acting Director   **Executive Account Director**
Division of Medical Assistance   **Computer Sciences Corp. (CSC)**
Department of Health and Human Services