



May 2014 Medicaid Bulletin

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Attention: All Providers

NCTracks Updates

EPSDT Policy Update

Note: Behavioral Health and Waiver services are not impacted by this change. Local Management Entities - Managed Care Organizations (LME-MCO) and Value Options continue to review and authorize prior approvals for these service areas.

Effective with dates of service on or after **April 1, 2014**, Computer Sciences Corporation (CSC) assumed responsibility for processing prior approval (PA) requests for beneficiaries under 21 years of age who received services through Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)* program in the following service areas:

- Dental
- Orthodontic
- Durable Medical Equipment (DME) including Orthotics and Prosthetics
- Medical/Surgical
- Visual Aids/Optical
- Hearing Aid
- Pharmacy

EPSDT prior approval requests were previously processed by the N.C. Division of Medical Assistance (DMA). PA requests with dates of service prior to April 1, 2014 are being processed by DMA.

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

1. CSC will process EPSDT PA requests for services needed that **exceed clinical coverage policy limits** in the programs listed above. Providers must use the **NCTracks Provider Portal** to request PA for services that exceed the clinical policy limits.
2. CSC will process all EPSDT PA requests for *Non-Covered Services* for recipients younger than 21 years of age in the above listed programs. 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. Do not submit the form by itself. **For example, if the non-covered service needed is a DME service, follow the normal process for**

requesting a DME Prior Approval and include the completed Non-Covered Services Form along with supporting documentation.

Note: The previous DMA version of this form is no longer available.

* Federal Medicaid law at 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act] requires state Medicaid programs to provide Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for recipients 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].

Resubmit Select Denied Sterilization Consent Forms If Signed/Dated Prior to July 1, 2013

The state has authorized providers to resubmit sterilization consent forms that have been permanently denied for **illegible signatures** and/or an **initial used for the first name of the recipient, interpreter, witness, or physician**, if the Recipient/Witness signature date is **prior to July 1, 2013**.

Providers will need to print their full name under their signature, then resubmit the consent form by mailing it to CSC, P.O. Box 30968, Raleigh, NC 27622.

Requesting Retroactive Approval for Long Term Care (LTC)

A new *How to Request Retroactive Approval for LTC*, is now available. The guide explains both:

- How to submit a request for Long Term Care (LTC) Retroactive approval on the initial Prior Approval (PA) request
- How to submit a request when there is an approved Long Term Care PA in NCTracks and the provider needs PA approval for retroactive dates

The new guide can be found on the Provider User Guides and Training page of the NCTracks Provider Portal at

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

Update on Pregnancy Medical Home Claims

All Pregnancy Medical Home claims need to include the modifier “AF” with the procedure code submitted, regardless of the dates of service. The “AF” modifier will enable the provider to be paid at the rate previously received in the legacy system.

NCTracks supports all three types of Pregnancy Medical Home claims that receive higher reimbursement, including the pregnancy risk screening, delivery and postpartum plan.

Providers who previously filed Pregnancy Medical Home claims that were denied or pended for Edit 353 (rate not found) need to re-submit the claims using the “AF” modifier.

Dental Providers - Use the Correct PA Form

Some dental and orthodontic providers have been submitting PA requests on the DMA 372-118 form (*NC DMA Request for Prior Approval*). This form is for medical providers. Since NCTracks launched on July 1, 2013, there has been no change for dental or orthodontic providers submitting PA requests by mail or fax. **Dental and orthodontic providers are still required to use the 2006 American Dental Association (ADA) form.**

If a dental or orthodontic PA request is sent to NCTracks using the DMA 372-118 form for medical providers, the PA will be routed to medical PA review. This will delay the review of the PA.

Providers should use the Web portal to submit PAs and additional information rather than mailing or faxing. However, if submitting a paper form, be sure to submit dental and orthodontic paper PA on the 2006 ADA form.

Update Re: FAQs and Forms to Update Office Administrator

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>.

Note: The fax number for submitting Office Administrator Change Forms has changed to 1-855-710-1965. The form and FAQs have been updated with the new number.

CSC, 1-800-688-6696

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 included 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: All Providers

Update: NC Medicaid Provider Enrollment, Screening and Training

Special Risk-Based Screening

Federal and state regulations which require certain providers to undergo supplemental screenings based on their risk category for fraud, waste and abuse have been updated.

Historical Requirements

Beginning October 1, 2012, the N.C. Division of Medical Assistance (DMA) implemented Federal regulations [42 CFR 455.410](#) and [455.450](#). These regulations – which are still in effect – establish three categories for N.C. Medicaid and N.C. Health Choice (NCHC) provider types in order to assess their risk of fraud, waste, and abuse.

- Low,
- Moderate
- High.

It further requires that DMA conduct onsite screenings of all **newly enrolling, re-enrolling or re-validating providers** who fall into the “moderate” or “high” risk categories.

N.C. General Statutes 2011-399 §108C-3 further define provider types which fall into each category. It requires DMA to screen all initial provider applications, including applications for new practice locations, and all revalidation requests. A full text of state regulations related to enrollment onsite screenings can be found at www.ncga.state.nc.us/sessions/2011/bills/senate/pdf/s496v5.pdf.

PCG Post-Enrollment Visits

Additionally, Federal Code of Regulations at [42 C.F.R. 455.432](#) grants state Medicaid agencies the authority to conduct **POST**-enrollment site visits. Public Consulting Group (PCG) will continue to conduct site visits on behalf of DMA, **including visits to recently enrolled providers who are considered moderate- or high-risk but have not yet completed screening requirements.**

PCG will schedule and announce ALL pre- and post-enrollment related site visits.

In order to be successful, providers who are enrolled and delivering Medicaid services but have not completed the onsite visit requirements are strongly encouraged to familiarize themselves with the following information prior to being contacted by PCG:

- www.ncga.state.nc.us/sessions/2011/bills/senate/pdf/s496v5.pdf
- [42 C.F.R. 455.432](http://42.C.F.R.455.432)
- <https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>
- <https://www.nctracks.nc.gov/content/public/providers/provider-enrollment/terms-and-conditions.html>

Amended Regulations – Dentists and Orthodontists

N.C. Session Law 2013-378 amended G.S. 108C-3.

The most significant change in this session law as it relates to enrollment screening requirements is the removal of Dentists and Orthodontists from the moderate-risk category and placing them in the limited risk category. A full text of the amended state regulations related to onsite screenings can be found at:

<http://www.ncga.state.nc.us/Sessions/2013/Bills/House/PDF/H399v10.pdf>

More Information

More information about enrollment and screening can be found at:

- www.ncdhhs.gov/dma/provenroll/; and,
- <https://www.nctracks.nc.gov/content/public/providers/provider-enrollment.html>.

Provider Relations
DMA, 919-855-4050

Attention: All Providers

Procedure Code Update: Laminoplasty

Effective June 1, 2014 Medicaid will cover:

- **Procedure Code 63050:** Laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral segments; and
- **Procedure Code 63051:** Laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral segments with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices (e.g., wire, suture, mini-plates), when performed.

These procedures will require prior approval which can be submitted through NCTracks.

Clinical Policy,
DMA, 919-855-4318

Attention: Behavioral Health Providers

DSM-5 Implementation

The Fifth Edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* was released in May 2013. The N.C. Department of Health and Human Services (DHHS) will fully implement DSM-5 coding requirement **effective August 1, 2014**.

Thus, DSM-5 codes will be required for all dates of services beginning August 1, 2014 and going forward.

The August 1, 2014 implementation gives clinical professionals additional time to learn the right diagnostic codes for service authorization requests. This change will apply to both Division of Mental Health/Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) and Division of Medical Assistance (DMA) behavioral health services covered by the Local Management Entities-Managed Care Organizations (LME - MCOs), as well as behavioral health services authorized by Value Options and paid by NCTracks for N. C. Health Choice beneficiaries and Medicaid beneficiaries 3 years old or younger.

Behavioral Health Services
DMA, 919-855-4290

Attention: 'Be Smart' Family Planning Waiver Providers

Update: The 'Be Smart' Waiver Conversion to a State Plan Amendment has been Delayed

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. The "Be Smart" Family Planning Waiver has been extended through September 30, 2014. The State Plan Amendment will be submitted to and approved by CMS prior to that date. **Despite the delay, the Family Planning Waiver will continue to operate with no interruption in service to its beneficiaries.**

More information about the "Be Smart" Family Planning Program can be found in the *April 2014 Medicaid Bulletin* at www.ncdhhs.gov/dma/bulletin/0414bulletin.htm#spa and on DMA's Family Planning web page at www.ncdhhs.gov/dma/services/familyplanning.htm.

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

Attention: Federally Qualified Health Center and Rural Health Center Providers

Place of Service Billing for Core Services

Core services provided by a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC) should be billed with “**POS code 50 (Federally Qualified Health Center)**” for the FQHC and “**POS code 72 (Rural Health Center)**” for the RHC. Effective with date of service July 1, 2014, system changes will be made that will allow only POS code 50 (for FQHC) and POS code 72 (for RHC) to be submitted on the claim for payment of core services.

CSC, 1-800-688-6696

Attention: Hospitals and OB/GYN Providers

Presumptive Eligibility

State approved medical providers may screen patients for eligibility in Medicaid for Pregnant Women (MPW). When presumptively eligible, a woman may receive prenatal ambulatory services until the end of the month following the date of her Medicaid application. This allows beneficiaries adequate time to apply for Medicaid at the Department of Social Services (DSS) or online at www.ePASS.nc.gov.

If the pregnant woman fails to apply for Medicaid or Work First within this time period, she is eligible for limited Medicaid services until the last calendar day of the month following the month she is determined presumptively eligible. For example, if the woman receives medical services under presumptive eligibility in April, she has until May 31 to apply for Medicaid. If the pregnant woman applies for Medicaid within this time frame, she remains presumptively eligible for Medicaid until the county DSS office makes a determination on her application.

During the presumptive eligibility period, Medicaid will cover **only** ambulatory prenatal services provided by a Medicaid enrolled provider. This includes prescriptions.

Resubmitting Denied Claims

If pregnancy-related claims are submitted before a (i) beneficiary applies or (ii) determination has been made by the county DSS office, the claims will deny with

Edit/Explanation of Benefit (EOB) Code 00268/00139. The provider can submit a paper claim *with* a copy of the Remittance Status displaying the denial code to:

DMA Claims Analysis – 19
2501 Mail Service Center
Raleigh, NC 27699-2501

The DMA Claims Analysis Unit will research the eligibility files for DSS approval. If approval is found, the Claims Analyst will special batch the claim and override presumptive denial. If no approval is found, the claim will be returned to the provider with an explanation.

Undocumented Individuals

Undocumented individuals requesting Medicaid coverage for medical emergencies must meet categorical and financial eligibility requirements, including state residency. In addition, the medical services rendered must meet the federal definition of “emergency services.” The definition of an emergency medical service includes vaginal or C-section delivery. Undocumented individuals are only authorized for Medicaid services for the actual days they receive an emergency medical service. For all other emergency services, including miscarriages and other pregnancy terminations, the N.C. Division of Medical Assistance (DMA) determines the eligibility coverage.

Note: Sterilizations do not meet the definition of “emergency services” and are **not reimbursed** for undocumented individuals.

Claims Analysis Unit
DMA, 919-855-4045

Attention: Pharmacists and Prescribers

Nc Medicaid and N.C. Health Choice Preferred Drug List Changes

Effective with an estimated date of service of **May 17, 2014**, the N.C. Division of Medical Assistance (DMA) will make changes to the N.C. Medicaid and N.C. Health Choice Preferred Drug List (PDL). Below are highlights of some of the changes that will occur:

- The prior authorization criteria will be removed from the second generation anti-convulsant class
- The use of only Spiriva® in the COPD class will be required before moving to a non-preferred agent
- Adderall XR and Adderall generics will be removed from the PDL entirely. Prior authorization will be required for these generic products.
- New classes are being added:
 - CARDIOVASCULAR, Sympatholytics and Combinations
 - ENDOCRINOLOGY, Sodium Glucose Co-Transporter 2 (SGLT2)
 - OPHTHALMIC, Antibiotics-Steroid Combinations
 - OTIC, Anti-Infectives and Anesthetics
 - TOPICALS, Antibiotics-Vaginal; and,
 - MISCELLANEOUS, Estrogen Agent Combinations and Estrogen Agent Oral/Transdermal

In addition to the changes above, the preferred brands with non-preferred generic equivalents will be updated and are listed in the chart below:

Brand Name	Generic Name
Accolate	Zafirlukast
Adderall	Amphetamine Salt Combo
Adderall XR	Amphetamine Salt Combo ER
Alphagan P	Brimonidine
Aricept ODT	Donepezil ODT
Astelin/Astepro	Azelastine Hydrochloride
Benzaclin	Clindamycin/Benzoyl Peroxide
Cardizem LA	Matzim LA
Catapress-TTS	Clonidine Patches

Brand Name	Generic Name
Derma-Smoothe-FS	Fluocinolone 0.01% Oil
Differin	Adapalene
Diovan HCT	Valsartan Hydrochlorothiazide
Dovonex Cream	Calcipotriene 0.005% Cream
Diastat / Diastat Accudial	Diazepam Rectal & Rectal Device
Exelon	Rivastigmine
Gabitril	Tiagabine
Kadian ER	Morphine Sulfate ER
Gris-Peg	Griseofulvin Ultramicrosize
Lovenox	Enoxaparin
Marinol	Dronabinol
Metrogel Vaginal	Metronidazole Gel Vaginal
Opana ER	Oxymorphone ER
Pulmicort 0.25mg/2ml, 0.5mg/2ml	Budesonide 0.25mg/2ml, 0.5mg/2ml
Retin-A Micro	Tretinoin Microsphere
Singulair Granules	Montelukast Granules
Tobradex Suspension	Tobramycin/Dexamethasone Susp
Toprol XL	Metoprolol Succinate
Travatan	Travoprost
Trilipix	Fenofibric Acid
Uroxatral	Alfuzosin
Vancocin	Vancomycin
Zovirax Ointment	Acyclovir Ointment

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

Attention: Pharmacists and Prescribers

Makena Will Be Available June 1, 2014 Via Point of Sale

Makena is still available through the Physicians Drug Program (PDP) at a rate of \$2.87 per milligram. In addition, the N.C. Division of Medical Assistance (DMA) also covers the compounded product, 17P, through the PDP program. The compounding product may be unavailable soon and, in order to prevent any barrier in obtaining the product, DMA has chosen to allow Makena to be dispensed at point-of-sale (POS) **starting June 1, 2014**. DMA may impose a prior authorization requirement in the near future.

Makena may have limited distribution. Visit the manufacturer (Ther-Rx Corp.) Website at www.ther-rx.com/, or call the company at 1-877-567-7676, to learn more about obtaining Makena through the PDP program or through POS.

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

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
May	5/01/2014	5/06/2014	5/07/2014
	5/08/2014	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	6/03/2014	6/04/2014
June	6/05/2014	6/10/2014	6/11/2014
	6/12/2014	6/17/2014	6/18/2014
	6/19/2014	6/24/2014	6/25/2014

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.

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)