



September 2014 Medicaid Bulletin

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Attention: All Providers**HIPAA Fax and Mail Protections/DMA Addresses****HIPAA Safeguards**

Providers must use reasonable safeguards when faxing or mailing items containing Protected Health Information (PHI) as defined under the Health Insurance Portability and Accountability Act (HIPAA). Guidance from the U.S. Office of Civil Rights (OCR) about faxing or mailing protected information can be found at www.ncdhhs.gov/dma/hipaa/Mail-Fax-Checklist.pdf.

For additional HIPAA information, visit the Division of Medical Assistance (DMA) HIPAA Web page at www.ncdhhs.gov/dma/hipaa/ or call 919-855-4230.

Addressing DMA Mail**For items sent via US Postal System:**

Staff member name
Division of Medical Assistance
Section Name
2501 Mail Service Center
Raleigh, NC 27699-2501

For items sent via FedEx or UPS:

Packages sent via FedEx or UPS should be sent directly the physical address below. Include the staff and section information indicated:

Staff member name and phone number
Division of Medical Assistance
Section
1985 Umstead Drive
Raleigh, NC 27603

Providers with questions should contact the DMA mailroom or DMA's HIPAA section.

DMA HIPAA Privacy, 919-855-4230
DMA Mailroom, 919-855-4160

Attention: All Providers**Maintaining the Security and Accessibility of Records after Expiration or Termination of Provider Agreement**

N.C. Medicaid and N.C. Health Choice (NCHC) providers must maintain custody of records and documentation related to Medicaid and NCHC service provision and reimbursement a minimum of six years after the expiration or termination of the Provider Participation Agreement. This provision is specified in [10A NCAC 22F.0107](#) and the N.C. Department of Health and Human Services (DHHS) [Provider Administrative Participation Agreement](#) (Section 7), which is part of the Medicaid and NCHC provider enrollment application.

Providers are required to maintain clinical service records, billing and reimbursement records, and records to support staff qualifications and credentials (personnel records). **This includes documentation required to meet federal, state, Medicaid and NCHC billing guidelines.**

Clinical service records include:

- Diagnostic testing results (x-rays, lab tests, psychological assessments, etc.)
- Records from other providers used in the development of care plans
- Nurses' notes or progress notes
- Service orders that authorize treatment
- Treatment service or treatment plans
- Beneficiary demographic information (for billing and reimbursement records)

Failure to protect consumer or staff privacy by safeguarding records and ensuring confidentiality of protected health information is a violation of the [Health Insurance Portability and Accountability Act \(HIPAA\)](#) and [NCGS § 108A-80](#), and may be a violation of the [North Carolina Identity Theft Protection Act](#). Violations will be reported to the Consumer Protection Section of the N.C. Attorney General's Office, the Medicaid Investigations Unit of the N.C. Attorney General's Office and/or the U.S. DHHS Office of Civil Rights.

The following sanctions, penalties, and fees may be imposed for HIPAA violations:

- Mandatory investigation and penalties for noncompliance due to willful neglect
- Willful neglect may result in a fine ranging from \$50,000 to \$1.5 million (\$10,000 up to \$250,000 if corrected within 30 days)

- Enforcement by the State Attorney General along with provisions to obtain further damages on behalf of the residents of North Carolina in monetary penalties, plus attorney fees and costs as provided for by the Health Information Technology for Economic and Clinical Health (HITECH) Act.

A provider's obligation to maintain records is independent of ongoing participation in the N.C. Medicaid or NCHC programs and extends beyond the expiration or termination of those agreements or contracts (see [10A NCAC 22F.0107](#) and Section 8 of the [DHHS Provider Administrative Participation Agreement](#)). Provider records may be subject to post-payment audits or investigations after a health facility closes.

Failure to retain required documentation of services provided may result in recoupment of payments made for those services, termination or suspension of the provider from participation with the N.C. Medicaid or NCHC programs, and/or referral to the U.S. DHHS Office of Inspector General for exclusion or suspension from federal and state healthcare programs.

If a new provider assumes the functions of a closing entity, maintenance of records for the applicable beneficiaries may be transferred to the new provider, if the new provider agrees to accept custody of such records in writing and a copy of this agreement is provided to N.C. Division of Medical Assistance (DMA) upon request.

When custody of records is not transferred, the expiring/terminating providers should send copies of transitional documentation to the provider who will be serving their beneficiaries for continuity of care. Beneficiary authorization should be obtained as necessary. Copies of records may be provided to the beneficiary directly for coordination of care.

DMA must be notified of changes in provider enrollment status, including changes in ownership and voluntary withdrawal from participation in the N.C. Medicaid and NCHC programs, as explained in the NCTracks manual titled *How to Select a Billing Agent and Other Claims Submission Options in NCTracks* on the [Provider User Guides and Training page](#). Providers who anticipate closure are required to develop and implement a records retention and disposition plan. The plan must indicate:

- How the records will be stored;
- The name of the designated records custodian;
- Where the records will be located;
- The process to fulfill requests for records;
- How beneficiaries will retrieve necessary contact information and the process to request their records;
- Retention periods and the records destruction process to be used when the retention period has expired; and

- Affirmations that there are no outstanding litigation, claim, audit or other official actions pending.

The plan should be on file with the records custodian.

Program Integrity
DMA, 919-814-0122

Attention: All Providers

NCTracks Tip of the Month: Understanding the Acronyms

An NCTracks Glossary of Terms Web page has been added to the NCTracks Provider Portal to help providers understand the terminology and acronyms associated with NCTracks and N.C. Department of Health and Human Services (DHHS) programs supported by it. The glossary also helps providers with correspondence and communication associated with NCTracks. The glossary is in alphabetical order, but providers can also find terms by using the Search box in the upper right corner of the Web page.

The Glossary of Terms can be accessed from the “Frequently Asked Questions” tab on left-hand side of the Provider Portal Home Page, as well as the “Quick Links” section on the right-hand side. The direct URL is <https://www.nctracks.nc.gov/content/public/providers/faq-main-page/nctracks-glossary-of-terms.html>.

CSC, 1-800-688-6696

Attention: All Providers**S**peech/Language and Occupational Therapy Providers

When submitting a claim for either Medicaid or N.C. Health Choice (NCHC), the N.C. Division of Medical Assistance (DMA) recognizes CPT code 92526, “treatment of swallowing dysfunction and/or oral function for feeding,” as defined in the *AMA Professional Edition Current Procedural Terminology 2014*.

For that reason, treatment should **not** be billed with CPT Code 92526 unless there are documented findings which address the following deficits consistent with a dysphagia diagnosis:

- Coughing and/or choking while eating or drinking;
- Coughing, choking or drooling with swallowing;
- Wet-sounding voice;
- Changes in breathing when eating or drinking;
- Frequent respiratory infections;
- Known or suspected aspiration pneumonia;
- Masses on the tongue, pharynx or larynx;
- Muscle weakness, or myopathy, involving the pharynx;
- Neurologic disorders likely to affect swallowing;
- Medical issues that affect feeding, swallowing, and nutrition; or
- Oral function impairment or deficit that interferes with feeding.

These findings must be indicated through:

- Video fluoroscopic swallowing exam (VFSE), also sometimes called a modified barium swallow exam (MBS);
- Fiberoptic endoscopic evaluation of swallowing (FEES); or
- Clinical feeding and swallowing evaluation.

Do **not** submit a Medicaid claim using CPT code 92526 for treatment to decrease food aversions, increase food repertoire and expand tolerance to different textures of foods which pertain to nutritional feeding disorders and feeding development unless at least one of the deficits above is documented. Failure to comply with these guidelines may result in a post payment review audit and/or recoupment.

Outpatient Specialized Therapies
DMA, 919-855-4308

Attention: All Providers**NCTracks Updates: General****Claims Denying Appropriately for Edit 349**

Providers have reported claim denials for Edit 00349 (“SERV DENIED FOR PCPB OR PCPC”) with EOB 06702 (“SERVICE COVERED BY PIEDMONT CARDINAL HEALTH PLAN”). **These claims have been denied appropriately.**

Edit 00349 uses procedure, diagnosis and provider information to determine if services billed are mental health/substance abuse services which should be billed to the Local Management Entity (LME).

If providers receive edit EOB 06702 on their Remittance Advice (RA) it means the service was billed to NCTracks when it should have been billed to the LME.

- Claims which denied for EOB 06702 should be submitted to the LME for payment.
- LME contact information can be found on the N.C. Division of Medical Assistance (DMA) LME Web page at: www.ncdhhs.gov/dma/lme/LME-Contact-Info.html.

Reminder - Taxonomy Codes Required on Medicare Crossover Claims

Taxonomy codes are required on crossover claims submitted to NCTracks, even if they are not required by the Medicare intermediary.

Medicare intermediaries will include taxonomy codes in crossover claims to NCTracks if the information is submitted with the Medicare claim. The taxonomy codes used on Medicare crossover claims should reflect what is on the provider's record in NCTracks. Claims will be denied in NCTracks if the proper taxonomy code is not used.

Providers who have had Medicare crossover claims denied because they did not include the proper taxonomy codes will need to correct and resubmit the claims to NCTracks with the missing Medicare payment information.

Providers unsure of which taxonomy codes to use should read the user guide, “How to View and Update Taxonomy,” on the Provider User Guides and Training page at <https://www.nctracks.nc.gov/content/public/providers/provider-user-guides-and-training.html>. Providers can verify their taxonomy codes using the NCTracks Status & Management page in the secure provider portal.

Updating TPL Information for Beneficiaries Whose Primary Insurance Does Not Cover Nursing Care

If a beneficiary is in a nursing home, but the beneficiary's primary insurance on file does not cover skilled nursing facility (SNF) care, the SNF claims may be denied with EOB 00094. The description of EOB 00094 may be misleading. NCTracks does not recognize occurrence code 24 in this situation.

If the beneficiary has a valid policy, but it does not cover SNF care, the provider may update this information by faxing the following information to DMA Third Party Recovery at 919-715-7133:

- NPI
- Beneficiary ID
- Beneficiary Name
- Admission Date

The fax should specify that the beneficiary has a valid third party insurance policy, but it does not cover SNF care. DMA Third Party Recovery can update this information in NCTracks. This is done once per beneficiary policy. The provider can then resubmit the denied claim.

Common Billing Error on Sterilization Claims – Missing FP Modifier

NCTracks has observed high numbers of claim denials for sterilization due to the use of incorrect modifiers. Clinical Coverage Policies can be found on DMA's Clinical Policy Web page at www.ncdhhs.gov/dma/mp/.

Note: The following state policy guidance regarding modifiers on sterilization claims:

- **Clinical Coverage Policy**
1E-3 Sterilization Procedures
Amended Date: July 1, 2013

Modifiers and Billing Guidance:

All providers, except ambulatory surgical centers, must append modifier FP to the procedure code when billing for sterilization procedures. Other modifiers must be used, as applicable.

- **Clinical Coverage Policy**
1L-1 Anesthesia Services
Amended Date: March 1, 2012

Modifiers and Billing Guidance:

The following guidelines apply to billing anesthesia services for sterilization procedures:

1. CPT anesthesia procedure codes used for a sterilization procedure must be billed with ICD-9-CM diagnosis code V25.2 and modifier FP appended to the code.
2. The CPT anesthesia procedure codes that may be used for sterilization are 00840, 00851, and 00921.
3. Anesthesia reimbursement for a sterilization procedure is now a flat fee when billed in conjunction with labor and delivery.

Important - Default Effective Dates When Updating Provider Record

When updating a provider record in NCTracks, the Manage Change Request (MCR) will assign a default effective date reflecting the current date of the request. NCTracks will edit subsequent transactions against the effective dates in the provider record. For example, if a provider bills for a service rendered on a date that is prior to the effective date of the relevant taxonomy code, the claim will be denied.

Some effective dates can be changed from the default date. MCR effective dates can be manually changed from the default date. For example, adding or reinstating health plans, service locations, or taxonomy codes, can be manually changed by entering a date. However, the manually entered date cannot precede the enrollment date for the provider, nor can the date be 365 days older than the date associated with the relevant credential or license. Manually changing the effective date must occur when the MCR is submitted.

If an MCR is submitted with the wrong effective date(s), the provider will need to contact the NCTracks Call Center at 1-800-688-6696 and request a ticket be entered to change the effective date. This process may take several weeks because it requires multiple levels of approval. Consequently, providers are encouraged to verify the effective dates of any changes to the provider record prior to submitting the MCR.

Other effective dates cannot be manually changed from the default date. For example, the effective date for affiliation of an individual provider to a group or hospital will default to the current date and it cannot be changed. Therefore, it is important that affiliations be designated on the provider record prior to rendering the service.

Note: The affiliation edit is currently set to “Pay and Report,” but at some point the state will likely change the disposition of this edit to “Deny.”

CSC, 1-800-688-6696

Attention: All Providers**NCTracks Update: Prior Approval****Importance of Address on Prior Approval Requests**

The address and National Provider Identifier (NPI) submitted on prior approval (PA) requests determine where correspondence is sent.

Approval letters are sent electronically only to the **requesting provider's** Message Center Inbox via the NCTracks secure provider portal. No paper copy (fax or U.S. mail) is sent. The electronic approval letters are sent only to the requesting provider; no letter is sent to the beneficiary.

In contrast, letters requesting additional information are sent by U.S. mail to the **requesting provider** listed on the PA request. Requests for additional information are only sent to the requesting provider - no letter is sent to the beneficiary.

Adverse decision letters (denials, reductions, or modified approvals) are sent via U.S. mail to the **requesting provider** listed on the PA request and the **beneficiary**. The provider letter is sent via regular U.S. mail and the beneficiary letter is sent via certified mail.

Optical Providers: Voided Requests for Visual Aids Due to Early Submission

Providers are reminded that beneficiaries under the age of 21 are eligible for visual aids once a year, based on the date of their last approval. In some cases, requests that are submitted earlier than 365 days from the last approval are automatically voided by NCTracks. Providers are notified why the request was denied.

Providers should check the beneficiary's record to ensure at least a year has passed since the last visual aide request. If a beneficiary's history is unavailable, providers may retrieve the last approval date by contacting the NCTracks Call Center at 1-888-688-6696.

PA Requests for Dental and Orthodontic Providers

NCTracks has the capability for x-rays and photographs to be uploaded with PA requests. Providers are encouraged to upload supporting documentation with their PA requests, as this allows for faster processing.

If a PA request is placed in a "Pend AI 1" status (requesting additional information), providers may upload additional documentation to that existing PA request.

Do **not** upload additional documentation to a PA request that has been denied.

Do not send images which are embedded in Word documents, as they do not display properly in the software used for document review. Submit supporting documentation in one of the following formats:

- .doc - use for text documents only (no embedded images)
- .pdf - use for text or images (x-rays or photographs)
- .jpg - use for images only
- .tif - use for images only

For more information, a provider user guide titled “How to Enter a Dental or Orthodontic Prior Approval in NCTracks” is available on the N.C. Provider User Guides and Training page at <https://www.nctracks.nc.gov/content/public/providers/provider-user-guides-and-training.html>.

Note: If a provider’s software does not allow for the beneficiary’s name and date of service for the image to be displayed on the file, add this information in the “Documentation of Medical Necessity” field in the provider portal.

CSC, 1-800-688-6696

Attention: All Providers**P**rovider Refund Requests**New Adjustments and Refunds Page on Provider Portal**

A Claims Web page is now available on the NCTracks Provider Portal to give providers a single location to find key information regarding claims submission and processing in NCTracks. The Web page is linked to another page dedicated specifically to Secondary Claims.

An additional page, specifically for Adjustments and Refunds, is now available. It contains information about submission and processing of claims adjustments and refunds in NCTracks, including User Guides, Forms, Frequently Asked Questions, and Quick Links.

Click on the “Claims” tab located on the left side of the Provider Portal Home Page to access the new Adjustments and Refunds Web page. It can also be accessed directly at <https://www.nctracks.nc.gov/content/public/providers/claims/adjustments-and-refunds.html>. More information will be added to these pages as it becomes available.

The original links have **not** been removed, in case providers are accustomed to finding claims information in its previous location.

New Form for Provider Refund Requests

In an effort to provide consistency in provider refund requests, a “Provider Refund Form” has been posted on the NCTracks Provider Policies, Manuals and Guidelines page at <https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>.

Refunds may be submitted to NCTracks for a variety of reasons, including billing errors, overpayments, and claims reprocessing resulting in accounts receivable. Rather than waiting for an automated recoupment, providers may choose to submit a refund to NCTracks. When submitting a refund, keep in mind:

1. Refunds are specific to a payor.

Payors supported by NCTracks include Medicaid, N.C. Health Choice (NCHC), N.C. Division of Mental Health, Developmental Disabilities and Substance Abuse Services, N.C. Office of Rural Health and Community Care, and the Division of Public Health (DPH). Providers who need to make refund payments to multiple payors (e.g., DMH and DPH) must submit separate forms and separate payments for each payor. If a single payment is received for multiple payors, it will be returned to the provider. It is also important that the form and payment be mailed to the correct address. Addresses for each payor can be found on the Provider Refund Form.

2. Refunds are specific to an National Provider Identifier (NPI)

Providers who have refunds attributed to multiple National Provider Identifiers (NPIs), must submit separate forms and separate payments for each NPI. If a single payment is received for multiple NPIs, it will be returned to the provider.

3. Incomplete Forms

Complete all fields on the form, according to the instructions provided. Incomplete forms will delay processing.

CSC, 1-800-688-6696

Attention: All Providers

Clinical Coverage Policies

The following new or amended combined N.C. Medicaid and N.C. Health Choice (NCHC) clinical coverage policies are available on the N.C. Division of Medical Assistance (DMA) Website at www.ncdhhs.gov/dma/mp/:

- 1B-1, Botulinum Toxin Treatment: Type A (Botox) and Type B (Myobloc) (8/15/14)
- 1S-2, HIV Tropism Assay (8/15/14)
- 7, Hearing Aid Services (8/15/14)
- 10A, Outpatient Specialized Therapies (8/15/14)

These policies supersede previously published policies and procedures.

Clinical Policy and Programs

DMA, 919-855-4260

Attention: All Providers**Re-verification is Required for All N.C. Medicaid and N.C. Health Choice Providers a Minimum of Every Three Years**

The N.C. Division of Medical Assistance (DMA) is federally mandated to ensure that all provider information is accurate and current in NCTracks. It is the state's policy to re-verify providers and provider group information a minimum of every three years.

NCTracks electronically generates and distributes re-verification invitations to all enrolled providers 75 days prior to the three-year anniversary of either their enrollment date or the date of their last renewal contract. Within 30 days of receiving the invitation letter, providers must verify their provider information and submit any additional information requested via the online re-verification application.

Providers that do not take action within the specified time frame will experience an interruption in claims payment and risk eventual termination from the N.C. Medicaid and N.C. Health Choice programs. As a reminder, termination from the programs requires providers to re-enroll and pay any applicable fees. No claims will be paid during the time that providers are not enrolled in the programs.

Providers should look for re-verification invitations. Additional information regarding re-verification can be found on DMA's Provider Enrollment Web page at www.ncdhhs.gov/dma/provenroll/. Questions should be directed to the NCTracks Call Center at **800-688-6696** or by e-mail at NCTracksprovider@nctracks.com.

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

Attention: ‘Be Smart’ Family Planning Service Providers

‘Be Smart’ Program Transitioning to an Amendment to the State Plan Covered Services

An application has been submitted to the Centers for Medicare & Medicaid Services (CMS) for the “Be Smart” Family Planning Waiver (FPW) program to transition from a waiver program to an amendment to the Medicaid State Plan. If approved, the new program will be implemented effective October 1, 2014 and will be called the “Be Smart” Family Planning Program. The name will be changed to reflect that the program will no longer be a waiver or demonstration, but the “Be Smart” moniker will be maintained to minimize confusion for providers, beneficiaries and other stakeholders.

The State Eligibility Option for Family Planning Services – or State Plan Amendment (SPA) – was an option available to North Carolina under the Affordable Care Act (ACA) to cover family planning services previously available under the FPW. The new program will expand the array of covered family planning services for beneficiaries.

The program’s goals are: to reduce unintended pregnancies, improve the well-being of children and families, and support beneficiaries in planning the timing and spacing of their children, should they decide to have children.

Under the Waiver, eligible low-income women ages 19-55 and men ages 19-60 received family planning services and supplies. The “Be Smart” program, in operation since October 1, 2005, will continue to cover basic family planning services and supplies: annual exams and physicals, most FDA-approved birth control supplies, screenings and treatment for sexually transmitted infections, screening for HIV and sterilizations for both women and men. The proposed changes to the “Be Smart” Family Planning Program are as follows:

- Expands coverage to include the same family planning services and supplies that other full-coverage regular 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.
- Imposes limited restrictions based on age, and covering family planning services and supplies for all beneficiaries who meet the State’s income and other eligibility guidelines except for sterilization procedures.
- Covers medically necessary contraceptive method follow-up, screening and treatment for sexually transmitted infections (STI) and screening for HIV, which can be included in the six inter-periodic annual visits. Under the Waiver, screening and treatment for STIs and screening for HIV were 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.
- Covers non-emergency medical transportation to and from family planning appointments.

If the “Be Smart” Family Planning Program is approved by CMS, a Family Planning Services policy will be published to reflect these changes. In addition to information given to beneficiaries upon enrollment, the state relies on providers to educate beneficiaries on the services and the appropriate use of those services covered under the new family planning program.

Examples of items **not** covered under the new program include:

- Emergency rooms or departments
- Ambulance
- Inpatient hospital
- Complicated women’s health care problems, such as endometriosis
- Non-family planning issues, including psychological and psychiatric services, infertility services, hysterectomies, abortions, AIDS and cancer treatment, dental and optical services, chiropractic or services required to manage or treat a chronic medical condition, such as asthma, diabetes or hypertension
- Other health care problems discovered during a screening, such as breast lumps.

Eligible beneficiaries for the new family planning program, which does not require co-pays, must have incomes no greater than 195% of the federal poverty level. For additional information about the “Be Smart” Family Planning Program, visit the N.C. Division of Medical Assistance (DMA) Web site at www.ncdhhs.gov/dma/services/familyplanning.htm.

‘Be Smart’ Family Planning Program
DMA, 919-855-4260

Attention: Home Care, Adult Care Home and Family Care Home Providers, and Supervised Living Homes Billing PCS Services

Personal Care Services (PCS) Program Highlights

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

Payment Adjustments

PCS providers will receive a letter stating the estimated total payment adjustment amount prior to the September 9, 2014 check write. All amounts owed to the N.C. Division of Medical Assistance (DMA) that are not satisfied within 30 days from the Systematic Payment Adjustment Begin Date will incur penalty and interest.

Systematic Payment Adjustments will begin with the September 9 check write and will continue through April 2015 beginning with claims with Dates of Service from October 1, 2013 through May 22, 2014.

Month of Service	Date of Service Begin Date	Date of Service End Date	Systematic Payment Adjustment Begin date
October 2013	October 1, 2013	October 31, 2013	September 9, 2014
November 2013	November 1, 2013	November 30, 2013	October 7, 2014
December 2013	December 1, 2013	December 31, 2013	November 12, 2014
January 2014	January 1, 2014	January 31, 2014	December 9, 2014
February 2014	February 1, 2014	February 28, 2014	January 2015 ¹
March 2014	March 1, 2014	March 31, 2014	February 2015

¹Check-write calendar for calendar year 2015 is not available. Dates for 2015 adjustments will be confirmed once available.

Providers can pay the balance owed to DMA at any point in the adjustment process by sending a check to the lockbox address listed below. Please note that you can only have one check per NPI/Payer otherwise those funds will not be able to be posted correctly. Payments will be posted to your accounts more quickly by including the accounts receivable page from the remittance advice statement with the payment.

Miscellaneous Medicaid Payments
 PO Box 602885
 Charlotte, NC 28260-2885

Additional information regarding the PCS Payment Adjustment is available on the PCS Web page at www.ncdhhs.gov/dma/pcs/pas.html.

Requesting Personal Care Services (PCS)

The section of Liberty Healthcare Corporation-NC's May 2014 presentation about how to submit a *DMA-3051 Request for Services* form is now available online. The online presentation can be found on the Liberty Healthcare Corporation-NC Website at www.nc-pcs.com/pdfs/DMA-3051-Training-5-16-14.pdf and on the N.C. Division of Medical Assistance (DMA) PCS web page at www.ncdhhs.gov/dma/pas/pas.html under the heading "Trainings."

QiReport - PCS Provider Interface – Mandatory Registration

Registration on the QiReport Provider Interface is now REQUIRED for all PCS providers. The PCS QiReport Provider Interface is a Web-based information system to support PCS Independent Assessments. The interface collects, stores, and communicates beneficiary information including decision notices, change of status assessment requests, discharge reports and the independent assessments required to develop plans of care. To register, complete the QiReport Registration form, which is available on DMA's PCS Web page under "Forms" and at www.qireport.net. Completed registration forms must be sent to VieBridge, Inc. QiReport Support:

By Fax: 919-301-0765

By Mail:

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

On-line Plan of Care

[DMA plans to implement the PCS On-line Plan of Care \(POC\)](#) in Fall 2014. Providers must use QiReport to gain electronic access to the independent assessments necessary to develop of the beneficiaries' On-Line POC. Updates and training sessions about the On-Line POC process will be announced on DMA's PCS Web page.

PCS Provider Regional Trainings

Fall 2014 regional training sessions for PCS providers will begin in October 2014. These trainings will be announced on DMA's PCS Web page. Those with questions or suggestions for training topics can contact DMA at 919-855-4340 or Liberty Healthcare Corporation-NC at 1-855-740-1400.

Facility, Home, and Community Based Services
DMA, 855-4340

Attention: All Providers**New Clinical Criteria for Medications**

Effective September 1, 2014, N.C. Medicaid and N.C. Health Choice (NCHC) requires prior authorization on the following medications: Zubsolv, Juxtapid, Sovaldi, and Olysio. New quantity limits are in place for Epi-Pen, and updates to Botox, Xolair, Kalydeco, Narcotic Analgesics, Triptans, and sedative hypnotics are also in place.

Clinical criteria can be found on the NCTracks “Prior Approval Drugs and Criteria” Web page at <https://www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html>.

Outpatient Pharmacy
DMA, 919-855-4300

Attention: All Providers**Coverage of Synagis for the 2014/2015 Season**

The N.C. Medicaid outpatient pharmacy benefit will cover Synagis for the upcoming Respiratory Syncytial Virus (RSV) season based on the updated guidance from the American Academy of Pediatrics (AAP) Committee on Infectious Diseases, and the Bronchiolitis Guidelines Committee. The AAP guidance was published online on July 28, 2014 at <http://pediatrics.aappublications.org/content/134/2/415.full.html>. It replaces the guidance found in the *2012 Red Book*.

The updated guidelines narrow the criteria for evidence-based use of Synagis. Providers are encouraged to review the new AAP guidance prior to the start of the RSV season. Complete procedures for making a prior authorization (PA) request for coverage of Synagis for the upcoming season are forthcoming. The only method to submit a PA request during the coverage period is through www.documentforsafety.org. The Web-based program will process PA information in accordance with the updated criteria. The start date to submit requests will be announced in a future Medicaid Bulletin.

Outpatient Pharmacy
DMA, 919-855-4300

Attention: All Providers**Influenza Vaccine and Reimbursement Guidelines for 2014-2015 for Medicaid and N.C. Health Choice (NCHC)**

Composition of the influenza vaccines for the 2014-2015 influenza season includes:

- A) Trivalent vaccines composed of the following virus strains;
- An A/California/7/2009 (H1N1)pdm09-like virus;
 - An A/Texas/50/2012 (H3N2)-like virus;
 - A B/Massachusetts/2/2012-like virus.
- B) Quadrivalent vaccines contain two A and two B strains, the above three strains and B/Brisbane/60/2008-like virus.

For further details on the 2014-2015 influenza vaccine, visit the Centers for Disease Control (CDC) Website site at www.cdc.gov/mmwr/preview/mmwrhtml/mm6332a3.htm.

N.C. Division of Medical Assistance (DMA) does not expect that providers will be vaccinating beneficiaries with the 2014-2015 influenza seasons' vaccine after date of service June 30, 2015, when the injectable vaccine expires.

North Carolina Immunization Program/Vaccines for Children (NCIP/VFC)

Under North Carolina Immunization Program/Vaccines for Children (NCIP/VFC) guidelines, the N.C. Division of Public Health (DPH) Immunization Branch distributes all required childhood vaccines to local health departments, Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), hospitals, and private providers.

For the 2014-2015 influenza season, NCIP/VFC influenza vaccine – all quadrivalent – is available at no charge to providers for children 6 months through 18 years of age who are eligible for the Vaccines for Children (VFC) program, according to the N.C. Immunization Program (NCIP) coverage criteria. The current NCIP coverage criteria and definitions of VFC categories can be found on DPH's Immunization Branch Web page at www.immunize.nc.gov/providers/coveragecriteria.htm.

Eligible VFC children include NCHC beneficiaries who are American Indian and Alaska Native (AI/AN). These beneficiaries can be identified as AI/AN in one of two ways:

1. They are either identified as MIC-A and MIC-S on their NCHC Identification Cards, or

2. Beneficiaries/parents may self-declare their VFC eligibility status in accordance with NCIP/VFC program policy.

When NCHC beneficiaries self-declare their status as AI/AN, and the provider administers the state-supplied vaccine, the provider must report the CPT vaccine code with \$0.00 and may bill NCHC for the administration costs only. For further details, 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.

All other NCHC beneficiaries are considered **insured (not VFC eligible)**, and must be administered privately purchased vaccines.

For VFC/NCIP vaccines administered to VFC eligible children, providers shall only report the vaccine code. Providers may bill the DMA for the administration fee for Medicaid and eligible AI/AN Health Choice beneficiaries.

Providers must purchase vaccines for children who are **not** VFC-eligible (including all NCHC children who are not AI/AN) and adult patients. For Medicaid-eligible beneficiaries 19 and older, purchased vaccine and administration costs may be billed to Medicaid, according to the guidelines stated in Tables 2 and 3 below. In order to determine who is eligible for NCIP influenza and other vaccines, visit DPH's Immunization Branch Web page at www.immunize.nc.gov/providers/coveragecriteria.htm.

Billing/Reporting Influenza Vaccines for Medicaid Beneficiaries

The following tables indicate the vaccine codes that may 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 may be billed, depending on the age of the beneficiaries and the vaccine(s) administered to them.

Note: The information in the following tables is **not** detailed billing guidance. Specific information on billing all immunization administration codes for **Health Check beneficiaries** can be found in the *Health Check Billing Guide* located at www.ncdhhs.gov/dma/healthcheck/.

Table 1

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

Vaccine CPT Codes to Report

Vaccine CPT Code to Report	CPT Code Description
90685	Quadrivalent inactivated influenza vaccine (IIV4), Preservative-free administered to children 6-35 months of age, for intramuscular use
90686	Quadrivalent inactivated influenza vaccine (IIV4), administered to individuals 3 through 18 years of age, for intramuscular use
90687	Quadrivalent inactivated influenza vaccine (IIV4), Preservative-containing administered to individuals 6-35 months of age, for intramuscular use
90688	Quadrivalent inactivated influenza vaccine (IIV4), Preservative-containing, when administered to individuals 3 through 18 years of age , for intramuscular use
90672	Quadrivalent live attenuated influenza vaccine (LAIV4), Preservative-free.

Administrative CPT Codes to Bill

Administration CPT Code(s) to Bill	CPT Code Description
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 <i>may</i> 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 <i>not</i> 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 <i>not</i> 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: The VFC/NCIP provides influenza products for recipients 6 months through 18 years of age **only**. The VFC/NCIP will **NOT** provide influenza vaccine for recipients 19 years of age and older.

Vaccine CPT Codes to Report

Vaccine CPT Code to Report	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	Quadrivalent inactivated influenza vaccine (IIV4 administered to individuals 3 years and older, for intramuscular use
90688	Quadrivalent inactivated influenza vaccine (IIV4), Preservative-containing, when administered to individuals 3 years of age and older, for intramuscular use
90672	Influenza virus vaccine, live, for intranasal use. Preservative-free.

Administrative CPT Codes to Report

Administration CPT Code(s) to Bill	CPT Code Description
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 <i>not</i> applicable at this time.

Administration CPT Code(s) to Bill	CPT Code Description
+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 <i>not</i> applicable at this time.

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 **21 years of age and older**.

Note: The VFC/NCIP provided influenza products for VFC-age (6 months through 18 years of age) beneficiaries **only**. The VFC/NCIP will **NOT** provide influenza vaccine for beneficiaries 19 years of age and older.

Medicaid does NOT reimburse for purchased Live Attenuated Influenza Vaccine (LAIV) for those beneficiaries 21 years of age and older.

Vaccine CPT Code to Report

Vaccine CPT Code to Report	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	Quadrivalent inactivated influenza vaccine (IIV4) administered to individuals 3 years and older, for intramuscular use
90688	Quadrivalent inactivated influenza vaccine (IIV4), Preservative-containing, when administered to individuals 3 years of age and older, for intramuscular use

Administration CPT Code(s) to Bill

Administration CPT Code(s) to Bill	CPT Code Description
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 for NCHC Beneficiaries

The following table indicates the vaccine codes that may be either reported (with \$0.00) or billed (with the usual and customary charge) for influenza vaccine, depending on an NCHC beneficiary’s VFC eligibility (that is, if the beneficiary is AI/AN) 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 Years 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

Vaccine CPT Code to Report	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	Quadrivalent inactivated influenza vaccine (IIV4), administered to individuals 3 years and older, for intramuscular use
90688	Quadrivalent inactivated influenza vaccine (IIV4), Preservative-containing, when administered to individuals 3 years of age and older, for intramuscular use

Vaccine CPT Code to Report	CPT Code Description
90672	Quadrivalent live attenuated influenza vaccine (LAIV4), Preservative-free

Administrative CPT Code(s) to Bill

Administration CPT Code(s) to Bill	CPT Code Description
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 <i>may</i> 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 <i>not</i> 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 <i>not</i> applicable at this time.

Notes:

- The EP modifier should **not** be billed on NCHC claims.
- There is no co-pay for office visits and wellness checks.

Immunization Billing for Medicaid and NCHC Beneficiaries from FQHCs and RHCs:

For beneficiaries 0 through 20 years of age:

If vaccines are provided through the NCIP/VFC, the center/clinic shall report the CPT vaccine codes (with \$0.00 billed) under Physician Services NPI and may bill for the administration codes (CPT procedure codes 90471EP through 90474EP). This billing is appropriate when only vaccines are provided at the visit, or if vaccines were provided in conjunction with a wellness check. If a core visit was billed, CPT vaccine codes shall be reported (with \$0.00 billed) under Physician Services NPI and an administration code shall not be billed.

If **purchased vaccines (non-VFC eligible)** were administered, the center/clinic may bill the CPT vaccine codes (with their usual and customary charge) under the Physician Services NPI for the vaccines administered and may bill for the administration codes (with the usual and customary charge). This billing is appropriate if only vaccines were given at the visit or if vaccines were given in conjunction with a wellness check. If a core visit was billed, CPT vaccine codes shall be reported (with \$0.00 billed) under the Physician Services NPI provider number and the administration codes shall not be billed. For detailed billing guidance, refer to the *Health Check Billing Guide* located at www.ncdhhs.gov/dma/healthcheck/.

Note: When billing for NCHC beneficiaries, refer to the detailed billing guidance above including Table 4 and the Core Visit policy in DMA's Provider Library Web page at www.ncdhhs.gov/dma/provider/library.htm.

For beneficiaries 21 years of age and older:

When purchased vaccines are administered, CPT vaccine codes may be billed (with the usual and customary charge) and administration codes may be billed (with the usual and customary charge) under the Physician Services NPI. This is applicable when vaccine administration was the only service provided that visit. When a core visit is billed, the CPT vaccine code shall be reported (with \$0.00 billed) under the Physician Services NPI and an immunization administration code may not be billed.

For influenza vaccine and administration fee rates, refer to the Physician's Drug Program fee schedule on DMA's Fee Schedule Web page at www.ncdhhs.gov/dma/fee/.

CSC, 1-800-688-6696

Attention: Nurse Practitioners, Physicians Assistants and Physicians

Vedolizumab (Entyvio™), HCPCS code J3590: Billing Guidelines

Effective with date of service June 1, 2014, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover vedolizumab injection (Entyvio™) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3590 (unclassified biologics). Entyvio™ is commercially available in 300 mg/20 mL single-use vials.

Vedolizumab (Entyvio™) is indicated for Adult Ulcerative Colitis and Adult Crohn's Disease.

The recommended dosage for vedolizumab (Entyvio™) is 300 mg infused intravenously over approximately 30 minutes at zero, two and six weeks, then every eight weeks thereafter.

For Medicaid and NCHC Billing

- The ICD-9-CM diagnosis codes required for billing vedolizumab (Entyvio™) are 555 (Regional enteritis) or 556 (Ulcerative colitis).
- Providers must bill Entyvio™ with HCPCS code J3590 (unclassified biologics).
- Providers must indicate the number of HCPCS units.
- One Medicaid unit of coverage for Entyvio™ is 1 mg. The maximum reimbursement rate per mg is \$17.3484. One 300 mg/20 mL vial contains 300 billable units.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Entyvio™ 300 mg/20 mL vials is 64764-0300-20.
- The NDC units for vedolizumab (Entyvio™) should be reported as "UN1".
- If the drug was purchased under the 340-B drug pricing program, place a "UD" modifier in the modifier field for that drug detail.
- Refer to the January 2012, Special Bulletin, *National Drug Code Implementation Update*, on DMA's Provider Bulletin Web page at www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf, for additional instructions.
- Providers shall bill their usual and customary charge.
- The new fee schedule for the PDP is available on DMA's Fee Schedule Web page at www.ncdhhs.gov/dma/fee/.

CSC, 1-800-688-6696

Attention: Nurse Practitioners, Physicians Assistants and Physicians

Ramucirumab (Cyramza™), HCPCS code J9999: Billing Guidelines

Effective with date of service May 1, 2014, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover ramucirumab (Cyramza™) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J9999 (Not otherwise classified, antineoplastic drugs). Cyramza™ is commercially available in 100 mg/10 mL and 500 mg/50 mL vials.

Ramucirumab (Cyramza™) is indicated for advanced gastric cancer or gastro-esophageal junction adenocarcinoma, as a single-agent after prior fluoropyrimidine- or platinum-containing chemotherapy.

For Medicaid and NCHC Billing

- The ICD-9-CM diagnosis code required for billing ramucirumab (Cyramza™) is 151 (Malignant neoplasm of stomach).
- Providers must bill Cyramza™ with HCPCS code J9999 (Not otherwise classified, antineoplastic drugs).
- Providers must indicate the number of HCPCS units.
- One Medicaid unit of coverage for Cyramza™ is 1 mg. The maximum reimbursement rate per mg is \$11.016. One 100 mg/10 mL vial contains 100 billable units.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Cyramza™ 100 mg/10 mL and 500 mg/50 mL vials are 00002-7669-01 and 00002-7678-01.
- The NDC units for ramucirumab (Cyramza™) should be reported as "UN1".
- If the drug was purchased under the 340-B drug pricing program, place a "UD" modifier in the modifier field for that drug detail.
- Refer to the January 2012, Special Bulletin, *National Drug Code Implementation Update*, on DMA's Provider Bulletin Web page at www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf, for additional instructions.
- Providers shall bill their usual and customary charge.
- The fee schedule for the PDP is available on DMA's Fee Schedule Web page at www.ncdhhs.gov/dma/fee/.

CSC, 1-800-688-6696

Attention: Nurse Practitioners, Physicians Assistants and Physicians

Coagulation factor IX (recombinant), Fc Fusion Protein (Alprolix™), HCPCS code J7199: Billing Guidelines

Effective with date of service May 1, 2014, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover coagulation factor IX (recombinant), Fc Fusion Protein (Alprolix™) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J7199 (Hemophilia clotting factor, not otherwise classified). Alprolix™ is currently commercially available in 500 IU, 1000 IU, 2000 IU and 3000 IU vials.

Coagulation factor IX (recombinant), Fc Fusion Protein (Alprolix™) is indicated for the treatment of hemophilia B, including routine prophylaxis.

The recommended dosage for coagulation factor IX (recombinant), Fc Fusion Protein (Alprolix™) is initially 30 - 60 IU/dL for minor or moderate bleeding; repeat every 48 hours as needed. For major bleeding, the recommended dosage is 80 - 100 IU/dL; consider repeating after 6 - 10 hours, then every 24 hours for three days, then every 48 hours until healing achieved. For routine prophylaxis, the recommended dosage is 50 IU/kg once weekly or 100 IU/kg once every 10 days. Adjust dosing regimen based on individual response.

For Medicaid and NCHC Billing

- The ICD-9-CM diagnosis code required for billing coagulation factor IX (recombinant), Fc Fusion Protein (Alprolix™) is 286.1 (Coagulation factor IX disorder).
- Providers must bill Alprolix™ with HCPCS code J7199 (Hemophilia clotting factor, not otherwise classified).
- Providers must indicate the number of HCPCS units.
- One Medicaid unit of coverage for Alprolix™ is 1 IU. The maximum reimbursement rate per unit is \$3.078. One 500 IU vial contains 500 billable units.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Alprolix™ 500 IU, 1000 IU, 2000 IU, and 3000 IU vials are 64406-0911-01, 64406-0922-01, 64406-0933-01, and 64406-0944-01, respectively.
- The NDC units for coagulation factor IX (recombinant), Fc Fusion Protein (Alprolix™) should be reported as "UN1".
- If the drug was purchased under the 340-B drug pricing program, place a "UD" modifier in the modifier field for that drug detail.

- Refer to the January 2012, Special Bulletin, *National Drug Code Implementation Update*, on DMA's Provider Bulletin Web Page at www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf, for additional instructions.
- Providers shall bill their usual and customary charge.
- The fee schedule for the PDP is available on DMA's Fee Schedule Web page at www.ncdhhs.gov/dma/fee/.

CSC, 1-800-688-6696

Attention: Physicians**Affordable Care Act: Enhanced Payments Update**

State Plan Amendment (SPA) 14-016 was recently approved by The Centers for Medicare & Medicaid Services (CMS). SPA 14-016 changes the deadline date **from June 30, 2013 to June 30, 2014** for eligible primary care physicians to submit an attestation via the self-attestation portal and receive enhanced payments under the Affordable Care Act (ACA) for dates of service retro-active to **January 1, 2013**.

Eligible physicians that submitted an attestation via the self-attestation portal on, or after, July 1, 2013 but no later than June 30, 2014 may receive the enhanced payment for claims billing for E&M codes with dates of service on, or after, January 1, 2013, and will be notified prior to the reprocessing of these claims.

Physician self-attestations continue to be received and reviewed for eligibility on a weekly basis. The self-attestation portal is located on DMA's ACA Primary Care Rate Increase Web page at www.ncdhhs.gov/dma/provider/ACA_Home.html. Physicians receiving an error message are encouraged to select the "Webmaster" link to report the error. 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.

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

The pseudo Medicare Fee Schedule for both 2013 and 2014 is located on DMA's Fee Schedule Web page at www.ncdhhs.gov/dma/fee/. The Medicare ACA rates decreased for 2014 due to the reduction in the Relative Value Units (RVUs). The conversion factors for the 2013 and 2014 have remained the same.

DMA continually revises the information available on DMA's ACA Primary Care Rate Increase Web Page, including the Frequently Asked Questions (FAQ) link. Information also is available on the NCTracks Website (www.nctracks.nc.gov) and through NCTracks email updates.

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
September	9/4/14	9/9/14	9/10/14
	9/11/14	9/16/14	9/17/14
	9/18/14	9/23/14	9/24/14
	9/25/14	9/30/14	10/1/14
October	10/2/14	10/7/14	10/8/14
	10/9/14	10/15/14	10/16/14
	10/16/14	10/21/14	10/22/14
	10/23/14	10/28/14	10/29/14
	10/30/14	11/4/14	11/5/14

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

Sandra Terrell, MS, RN
Acting Chief Operating Officer
Division of Medical Assistance
Department of Health and Human Services

Paul Guthery
Executive Account Director
CSC