October 2013 Medicaid Bulletin

In This Issue ……Page

In This Issue ……Page

Providers are responsible for informing their billing agency of information in this bulletin.
CPT codes, descriptors, and other data only are copyright 2011 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.

Attention: All Providers

NCTracks Common Issues

Medicaid providers using NCTracks have expressed a number of common questions and issues, a few of which are outlined in this article. In addition, an "Issues List" is posted to the NCTracks provider portal at https://www.nctracks.nc.gov/content/public/providers/nctracks-status-page.html, reflecting the most pervasive issues affecting providers and is updated regularly.

Internet Explorer 10 is not currently supported

The Internet browser, Internet Explorer 10, is **not** currently supported by NCTracks. Supported browsers include Internet Explorer 8 and 9 and Firefox. Check the System Requirements link at the bottom of every Web page for a complete description of supported browsers.

Providers will be notified when Internet Explorer 10 has been tested and certified with NCTracks. In the meantime, those using Internet Explorer 10, may find that buttons on some provider portal screens are not visible or do not function properly. Providers can download and install Firefox at http://www.mozilla.org/firefox at no cost to access the full functionality of NCTracks.

Prior Approval Status

Not sure what the status of your Prior Approval means? Check out the Frequently Asked Questions (FAQs) on the Prior Approval page of the provider portal at https://www.nctracks.nc.gov/content/public/providers/prior-approval/faqs-for-pa.html for a complete list of status codes and definitions for Prior Approval requests.

Clarification: Affiliation Edit and Claim Denials

One of the requirements associated with the implementation of NCTracks is that attending/rendering providers must be affiliated with the billing providers who are submitting claims on their behalf. The Edit associated with this requirement is # 07025. **Providers who have denied claims with Edit 07025 on their Remittance Advice may have thought Edit 07025 was the cause of the denial, but it is not.** If the claim denied, there was another cause of the denial.

The disposition of Edit 07025 has been set to "pay and report" since NCTracks went live on July 1. The "pay and report" disposition means that claims where the attending/rendering provider is not affiliated with the billing provider will not deny, but the Edit and EOB will post on the provider's Remittance Advice.

The intent is to alert providers to situations in which the affiliation relationship does not exist, so the attending/rendering provider can initiate a Manage Change Request. The text

of the EOB reads, *"THE RENDERING PROVIDER IS NOT AFFILIATED WITH YOUR PROVIDER GROUP. CONTACT THE RENDERING PROVIDER AND ASK THEM TO COMPLETE A MANAGED CHANGE REQUEST ADDING YOUR PROVIDER GROUP NPI ON THE AFFILIATED PROVIDER PAGE WITHIN THE NEXT FOUR WEEKS TO PREVENT CLAIMS BEING DENIED."*

Note: The Manage Change Request to establish or change a provider affiliation must be initiated by the Office Administrator of the attending/rendering provider. The group or hospital that is the billing provider cannot alter affiliations in NCTracks.

Providers are encouraged to correct any affiliation issues right away. The state will provide 45-days notice to providers before the disposition of this edit is changed to "deny." Once the disposition is changed, a claim failing this edit will suspend for four weeks. If the affiliation relationship is not established within that time period, the claim will be denied.

Announcements

Providers are encouraged to watch for new Announcements posted regularly to the NCTracks Provider Portal at https://www.nctracks.nc.gov/content/public/providers.html.

CSC, 1-800-688-6696

Attention: All Providers

Staying Current with ICD-10

October 2014 will be here before you know it. One way you can stay on top of developments related to ICD-10 is to bookmark the ICD-10 Web page on the OMMISS Website at http://ncmmis.ncdhhs.gov/icd10.asp and join the ICD-10 listserv by providing your name and email address at the bottom of the page. The listserv is used to distribute articles, fact sheets, and other important information regarding the implementation of ICD-10.

Another way to keep posted on ICD-10 is to subscribe to the ICD-10 RSS News Feed in NCTracks. To do so, log into the NCTracks secure Provider Portal by clicking on the icon in the upper right corner of the page at https://www.nctracks.nc.gov/content/public/providers.html. Once logged in, click on the link for "Subscription Preferences" in the upper right of the page, then add "ICD-10 News" to your Selected News Sources. An "ICD-10 News" box will appear beside (or below) your Inbox every time you log into the portal. Updates will be made weekly – just click on the links to learn more about ICD-10.

CSC, 1-800-688-6696

Attention: All Providers

NCTracks User Guides Available

A new Web page has been created on the NCTracks Provider Portal for User Guides, Fact Sheets, and Provider Training information. The User Guides are organized by category and contain useful step-by-step instructions with screen shots for many topics of interest. The list of User Guides currently available includes:

- How to Complete the Re-Credentialing/Re-verification process in NCTracks
- How to Add or Update Electronic Funds Transfer (EFT) Information in NCTracks
- How to Change the Physical Address in NCTracks
- How to Enter Your EIN
- How to select a Billing Agent and Other Claims Submission Options in NCTracks
- How to View and Update Taxonomy
- How to Add Billing and Rendering Provider Taxonomy Information to a Claim - Edit 07011
- How to Resolve the Claims Reject Edit 00431 for Community Alternatives Program (CAP) Providers

The URL is https://www.nctracks.nc.gov/content/public/providers/provider-user-guides-and-training.html. Providers are encouraged to visit this Web page frequently for new User Guides and updated information. Providers are also encouraged to continue to take advantage of Provider Training opportunities available through SkillPort on the secure Provider Portal.

Note: NCTracks has moved some documents from their previous locations to consolidate multiple pages into a single source of information for providers who need assistance with using NCTracks.

CSC, 1-800-688-6696

Attention: All Providers

Receiving Email Alerts Through NCTracks

Note to Providers: This version of the article was originally published in September 2013.

Providers can subscribe for 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 these issues:

- Taxonomy
- Electronic Funds Transfer
- Prior Approval
- Training/Informational Opportunities
- Common Billing Errors
- Extended NCTracks Call Center Hours.

To receive email alerts and other communications from NCTracks, visit this page https://www.nctracks.nc.gov/content/public/providers/provider-announcements.html. Then click on the "Sign up for NCTracks Communications" link under "Quick Links."

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 (NCHC) email alerts and NCTracks communications.

CSC, 1-800-688-6696

Attention: All Providers

NCTracks Contact Information

NCTracks has replaced the legacy Medicaid Management Information System (MMIS) for processing Medicaid claims and enrollments. The NCTracks system consolidates several claims processing platforms into a single solution for multiple divisions within the N.C. Department of Health and Human Services (DHHS). These divisions are:

- Division of Medical Assistance (DMA);
- Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS);
- Division of Public Health (DPH); and,
- Office of Rural Health and Community Care (ORHCC)

CSC is the state contractor for NCTracks and assumed many of the telephone numbers and post office boxes previously used by legacy vendors. The following list outlines how best to contact CSC for various topic areas.

Internet Communications:

General:

The **NCTracks Website** address is www.nctracks.nc.gov/. There is a "Contact Us" link at the bottom of every Web page.

Information on Provider Enrollment:

Enrollment functionality previously associated with the CSC Enrollment, Verification and Credentialing (EVC) Website is now available through the new NCTracks Provider Portal, at www.nctracks.nc.gov. For more information, see www.nctracks.nc.gov/provider/providerEnrollment/index.jsp.

Email Correspondence:

Emails related to NCTracks should be directed to NCTracksProvider@nctracks.com.

Medicaid Email Alerts:

Refer to the article titled "Receiving Email Alerts Through NCTracks" on page 3 of this bulletin to learn more about receiving email alerts regarding important Medicaid information between monthly cycles of the general Medicaid Provider Bulletin.

Telephone Numbers:

NCTracks Automated Voice Response System: 1-800-723-4337

NCTracks Call Center

- Main Call Center Number: 1-800-688-6696
- Prior Approval Unit (Medical and Dental): 1-800-688-6696
- Prior Approval Unit (Pharmacy): 1-866-246-8505
- Provider Enrollment: 1-800-688-6696
- Trading Partner Agreements: 1-800-688-6696

NCTracks Fax Numbers:

- Main Fax Number: 919-851-4014
- Pharmacy Prior Approval: 866-246-8507
- Non-Pharmacy Prior Approval: 919-816-3139
- CA Overrides: 919-816-4420

Mailing Information:

General Correspondence:
CSC
P.O. Box 300009
Raleigh, NC 27622-8009

Prior Approval Requests:
CSC
P.O. Box 31188
Raleigh, NC 27622-1188

Provider Enrollment Supplemental Information:
CSC
Provider EVC Unit
P. O. Box 300020
Raleigh, NC 27622-8020

Courier Deliveries – UPS or Federal Express:
CSC
[Name of CSC Employee or Department]
Suite 102
2610 Wycliff Road
Raleigh, NC 27607-3073

It is highly recommended that overpayments be handled by submitting a replacement claim to NCTracks, which will result in the fastest application of refunds. However, if a refund check is sent, it should be mailed to one of the following addresses:

Refunds to Medicaid
Misc. Medicaid Payments
PO Box 602885
Charlotte, NC 28260-2885

Overnight Address for Medicaid Refunds
Misc. Medicaid Payments
Lockbox Services (602885)
1525 West W.T. Harris Blvd. - 2C2
Charlotte, NC 28262

Refunds to Public Health
Misc. DPH Payments
PO Box 602879
Charlotte, NC 28260-2879

Overnight Address for DPH Refunds
Misc. DPH Payments
Lockbox Services (602879)
1525 West W.T. Harris Blvd. - 2C2
Charlotte, NC 28262

All claims are expected to be submitted electronically through NCTracks. However, if paper versions of claims are permitted under State policy, they should be mailed to:

CSC
P.O. Box 30968
Raleigh, NC 27622-0968

NCTracks Call Center Hours of Operation:

General:

Monday through Friday: 8:00 a.m. to 5:00 p.m.

Pharmacy Prior Approval:

Monday through Friday: 7:00 a.m. to 11:00 p.m.
Saturday and Sunday: 7:00 a.m. to 6:00 p.m.

Non Pharmacy Prior Approval:

Monday through Friday: 7:00 a.m. to 7:00 p.m.
Saturday and Sunday: 8:00 a.m. to 5:00 p.m.

CSC Holiday Schedule

CSC will observe the following holidays from October through December 2013:

Holiday	Days Observed
Thanksgiving Day	Thursday, November 28, 2013
Day after Thanksgiving	Friday, November 29, 2013
CSC-Designated Holiday	Tuesday, December 24, 2013
Christmas Day	Wednesday, December 25, 2013

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 Division of Medical Assistance (DMA) Website at www.ncdhhs.gov/dma/mp/:

- *1A-39, Routine Costs in Clinical Trial Services for Life Threatening Conditions (9/1/13)*

These policies supersede previously published policies and procedures.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

NC Medicaid EHR Incentive Program: October 2013 Payment Update

Stage 2 Meaningful Use (MU) and Eligible Hospitals (EH)

Stage 2 MU for EHs becomes effective October 1, 2013. EHs that have completed two successful years of Stage 1 MU attestation may begin their fiscal quarter MU reporting period on October 1, 2013. Starting January 1, 2014, those EHs can attest to Stage 2 MU in the N.C. Medicaid Incentive Payment System (NC-MIPS) after attestation with Medicare.

Note: EHs attesting to MU must first attest with the Centers for Medicare & Medicaid Services (CMS) and may attest with N.C. Medicaid through NC-MIPS the next day.

Meaningful Use in Program Year 2014

All Eligible Providers (EPs) and EHs attesting to MU in Program Year 2014 need to register their intent to engage in ongoing electronic reporting to relevant public health systems for Stage 1 and Stage 2 MU with the N.C. Division of Public Health within 60 days of starting their MU reporting period. EPs and EHs are **not** required to meet MU; however, there are significant subsidy options available for those who become full participants on the NC Health Information Exchange (NC HIE). These subsidies could cover part or all of the cost of connecting and reporting relevant Stage 2 MU measures.

For more information, contact Jayson Caracciolo of Community Care of North Carolina at 919-926-3901 or jcaracciolo@n3cn.org.

For more information about Stage 2 MU, see the article titled "*NC Medicaid EHR Incentive Program – September 2013 Update*" in the *September 2013 Medicaid Bulletin.*

One-time 90-day or Fiscal Quarter MU Reporting Period in 2014 ONLY

To allow EPs and EHs to upgrade their systems to the required 2014 certification standards, federal regulations allow a one-time 90-day (for EPs) or fiscal quarter (for EHs) MU reporting period for all Electronic Health Record (EHR) Incentive Program participants in Program Year 2014 – regardless of their participation year. All other EPs and EHs on track to attest for a 365-day MU reporting period in Program Year 2014 will instead report a 90-day (for EPs) or fiscal quarter (for EHs) MU reporting period, and begin with a 365-day MU reporting period in Program Year 2015.

New Provider Tool

To simplify the process of signing up providers who are new to a practice, the NC EHR Incentive Program has created a straightforward tool to help each EP chart the necessary steps. The chart is located at www.ncdhhs.gov/dma/ehr/EHR_Flowchart_0913.pdf

N.C. Medicaid EHR Incentive Program
DMA, 919-814-0180

Attention: All Providers

NCFAST Implementation Update

NCFAST (North Carolina Families Accessing Services through Technology) is a new computerized eligibility and case management system for several economic benefit programs in North Carolina – including N.C. Medicaid, N.C. Health Choice (NCHC), Work First Cash Assistance, Special Assistance, and Food and Nutrition Services.

N.C. Medicaid and NCHC applications are currently being taken in NCFAST for individuals who have not previously received assistance. The rollout of the new system began in mid-August with the pilot counties of Carteret, Chatham, Johnston, and Orange. All 100 North Carolina counties are expected to take N.C. Medicaid and NCHC applications through NCFAST by October 1, 2013.

Beneficiaries who had eligibility entered into the Eligibility Information System (EIS) prior to the NCFAST rollout will continue to have their information housed in EIS until full conversion is completed. Conversion of ongoing cases into NCFAST will occur through a phased approach beginning in January 2014.

N.C. Medicaid and NCHC eligibility information from both systems – EIS and NCFAST – will be transmitted to NCTracks to ensure current eligibility is recorded for all beneficiaries.

Medicaid Eligibility
DMA, 919-855-4000

Attention: All Providers

Medicaid Credit Balance Reporting

All providers participating in the N.C. Medicaid Program are required to submit a quarterly **Medicaid Credit Balance Report** to the N.C. Division of Medical Assistance (DMA) Third-Party Recovery Section identifying balances due to Medicaid. Providers must report any **outstanding** credits owed to Medicaid that have not been reported previously on a Medicaid Credit Balance Report. Hospital and nursing facility providers are required to submit a report every calendar quarter even if there are no credit balances.

The report must be submitted no later than 30 days following the end of the calendar quarter (March 31, June 30, September 30, and December 31).

The Medicaid Credit Balance Report is used to monitor and recover "credit balances" owed to the Medicaid Program. A credit balance results from an improper or excess payment made to a provider. For example, refunds must be made to Medicaid if a provider is paid twice for the same service (e.g., by Medicaid and a medical insurance policy, by Medicare and Medicaid, by Medicaid and a liability insurance policy), if the patient liability was not reported in the billing process, or if computer or billing errors occur.

For the purpose of completing the report, a Medicaid Credit Balance is the amount determined to be refundable to the Medicaid Program. When a provider receives an improper or excess payment for a claim, it is reflected in the provider's accounting records (patient accounts receivable) as a "credit." However, credit balances include money due to Medicaid regardless of its classification in a provider's accounting records. If a provider maintains a credit balance account for a stipulated period (e.g., 90 days) and then transfers the account or writes it off to a holding account, this does not relieve the provider of liability to the Medicaid Program. Providers must exercise reasonable diligence in reconciling invoice records with credit balances to determine whether overpayments exist.

The Medicaid Credit Balance Report requires specific information for each credit balance on a claim-by-claim basis. The reporting form provides space for 15 claims, but it may be reproduced as many times as necessary to accommodate all the credit balances being reported. Specific instructions for completing the report are on page two of the reporting form.

Providers **should not** submit the credit balance report form in lieu of submitting the claims for adjustment. Neither the DMA Third-Party Liability Section nor the CSC Third-Party Liability Department will complete the adjustments for providers. All adjustments should be completed using the NCTracks Provider Portal prior to CSC or DMA receiving the reports. Instructions on how to submit an adjustment claim can be found on the NCTracks Provider Portal under the "Provider Policies." If the

adjustment does not process successfully, and you need assistance, call the CSC Call Center at 1-800-688-6693 and ask for the CSC Third-Party Liability Department.

Submit **only** the completed Medicaid Credit Balance Report to the Third-Party Liability Section of DMA and send a copy to the fiscal agent. Submitting the credit balance report to the Third-Party Liability Section and to the fiscal agent (CSC) is for verification purposes only. Providers are responsible for completing their own adjustments.

Completing the Medicaid Credit Balance Report

- Send the original completed **Medicaid Credit Balance Report** to DMA and a copy of the report to CSC.
- Check the box stating "I have submitted the appropriate claims to NCTracks."
- Check "I have attached a Refund Check for the Fiscal Agent to Process" at the bottom of the Medicaid Credit Balance Report.
- Enclose a copy of the Medicaid Credit Balance Report associated with the refund.
- Refund checks must accompany the credit balance reports.

The submission of a refund check is not the preferred method of handling credit balance overpayments. However, in the event you must submit a refund check; send the credit balance refund check(s) to:

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

Make the check payable to "DHHS Medicaid."

The information on the form must be accurate in order for the Fiscal Agent to process the refund.

Program Integrity, Third-Party Liability Section
DMA, 919-814-0223

Attention: All Providers

Prepayment Review of Provider Claims for Prior Authorized Services

Session Law 2011-399 § 108C-7. Prepayment Claims Review, states:

> (c) For any claims in which the Department has given prior authorization, prepayment review shall not include review of the medical necessity for the approved services.

In accordance with **§ 108C-7,** when a provider assigned to prepayment review submits claims for services rendered, the prepayment review contract staff does not review the medical necessity of a prior authorized service. However, the prepayment review contractor will review the documentation for services billed, including prior authorized services, to determine if the documentation is compliant with policy. An example is obtaining staff credentials to verify that a service has been rendered by an appropriately credentialed person, as required by Medicaid policy.

Program Integrity
919-814-0000

Attention: Behavioral Health Providers and LME/MCOs

Correct LME-MCO Phone Numbers, Prior Authorizations for NCHC and Ages 0-2, and Submitting ValueOptions Authorization Requests

LME-MCO Administrative Contact Numbers

Several N.C. Medicaid beneficiaries have received Medicaid ID Cards with the incorrect Local Management Entity-Managed Care Organization (LME-MCO) administrative contact telephone numbers on them. The telephone numbers appear on the back of the Medicaid ID Card.

Providers who have received telephone calls regarding incorrect telephone numbers should inform beneficiaries of the correct administrative telephone numbers, which are provided below. Medicaid beneficiaries can use the correct toll-free telephone numbers to access information about available services in their area and information regarding their Medicaid participation. Providers can also use these numbers to access information about requests for behavioral health service authorizations for Medicaid beneficiaries.

LME-MCO	CORRECT TOLL FREE NUMBER
Alliance Behavioral Health	1-800-510-9132
Cardinal Innovations Healthcare Solutions	1-800-939-5911
CenterPoint Human Services	1-888-581-9988
CoastalCare	1-855-250-1539
East Carolina Behavioral Health (ECBH)	1-877-685-2415
MeckLINK	1-877-700-3001
Partners Behavioral Health Management	1-888-235-4673
Sandhills Center	1-800-256-2452
Smoky Mountain Center	1-800-849-6127
Western Highlands Network	1-800-951-3792

Prior Authorization N.C. Health Choice (NCHC) and ages 0-2

Note: All prior authorizations for services for NCHC and ages 0-2 will continue to be obtained through ValueOptions. If you have any questions regarding these types of authorizations, call ValueOptions at 1-888-510-1150.

Submitting ValueOptions Authorization Requests

Reminder: As of October 1, 2011, providers must submit authorization requests electronically through the Provider Connect Web portal. Any authorization requests NOT submitted electronically will be returned as "Unable to Process."

Additional information is available in the ValueOption Website:
www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm

Behavioral Health Section
DMA, 919-855-4290

Attention: 'Be Smart' Family Planning Service Providers

Placement of the Annual Exam Date On Claim Forms

The N.C. Division of Medical Assistance (DMA) recognizes that providers of services to "Be Smart" beneficiaries have questions about submitting claims for the initial Annual Exam Date (AED).

DMA requires that the AED be placed in the "initial treatment date" area on the claim form for the initial annual exam and accompanying laboratory procedures, except pregnancy tests. Providers who placed the AED in the incorrect location on claim forms for Family Planning Waiver services received denials for provided services.

Claims previously 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 Program
DMA, 919-855-4260

Attention: Be Smart' Family Planning Service Providers

'Be Smart' Program Converting to an Amendment to the State Plan

On June 7, 2013, the Centers for Medicare & Medicaid Services (CMS) approved North Carolina's conversion of the "Be Smart" Family Planning **Waiver** (FPW) program from a waiver program to an amendment to the Medicaid State Plan. The new program, effective November 1, 2013, will be called the "Be Smart" Family Planning **Program**. The name was changed to reflect that the program is no longer a waiver or demonstration, however, the "Be Smart" name was maintained to minimize confusion for current providers, beneficiaries and other stakeholders.

The State Eligibility Option for Family Planning Services – or State Plan Amendment (SPA) – was an option available to the State under the Affordable Care Act (ACA) to cover family planning services previously available under FPW while also expanding the array of covered family planning services.

The program's goals are: to reduce unintended pregnancies, improve the well-being of children and families, and support beneficiaries in planning the spacing of their 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 CMS-approved changes to be added to the new "Be Smart" Family Planning Program are:

- Expanding 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.

- Imposing no eligibility restrictions based on age, and covering family planning services and supplies for all beneficiaries who meet the State's income and other eligibility guidelines.

- Covering 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.

- Covering non-emergency medical transportation to and from family planning appointments.

An N.C. Medicaid Special Bulletin for the "Be Smart" Family Planning Program will be published to reflect changes in the new family planning program. 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.

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

- Emergency room or department
- Ambulance
- 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 or services required to manage or treat a medical condition, such as 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 an income of no greater than 185% of the federal poverty level.

A Family Planning Services clinical policy will be posted on the DMA website in the coming months. Additional information about the "Be Smart" Family Planning Program can also be obtained at: www.ncdhhs.gov/dma/services/familyplanning.htm.

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

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

Clarification on Carolina ACCESS Referrals

When a Carolina ACCESS (CA) referral is entered into NCTracks, a confirmation number is received. This confirmation number should not be placed on the claim. The NCTracks confirmation number verifies that a CA referral is in the NCTracks portal.

However, State policy currently allows providers to use the National Provider Identifier (NPI) of the beneficiary's assigned Carolina ACCESS Primary Care Provider (PCP) on the claim, in place of entering a Carolina ACCESS referral in NCTracks. When the NPI of the PCP is used for a Carolina ACCESS referral, it is placed in the electronic loop that corresponds with 17b on a professional claim.

Providers will be notified when it becomes mandatory to enter all CA referrals through NCTracks.

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

Attention: Dental Providers

Dentists/Orthodontists are no Longer Subject to Pre-Enrollment Site Visits

N.C. State Law 2013-378 amended General Statute 108C-3, moving "dentists and orthodontists" from the "Moderate" to the "Low/Limited" risk categories. Provider types which fall into the moderate and high-risk categories are subject to a pre-enrollment site visit in order to enroll or re-enroll in the N.C. Medicaid or N.C. Health Choice (NCHC) programs.

This change is effective October 1, 2013. Dentists and orthodontists enrolling or re-enrolling after that date do not have to undertake a pre-enrollment site visit in order to participate in the N.C. Medicaid or NCHC programs.

Dental providers may disregard any notices received from PCG related **to pre-enrollment site visits**.

Background

Beginning October 1, 2012, the N.C. Division of Medical Assistance (DMA) implemented Federal regulations 42 CFR 455.410 and 455.450 – requiring all participating providers to be screened according to their categorical risk level. These screenings will take place both upon initial enrollment and re-enrollment.

42 CFR 455.450 establishes the following three categorical risk levels for N.C. Medicaid and N.C. Health Choice (NCHC) providers to assess the risk of fraud, waste, and abuse:

- Low/Limited
- Moderate
- High

Provider types and specialties that fall into the moderate- and high-risk categories are subject to a pre-enrollment site visit, unless a screening and site visit has been successfully completed by Medicare or another state agency within the previous 12 months. State statute defines the provider types which fall into each category.

Provider Services
DMA, 919-855-4050

Attention: Hospice Providers

Prior Approval Requirement Process Changes

Effective with Date of Service (DOS) December 1, 2012, hospice providers are required to submit prior approval requests using form DMA-3212 to the N.C. Division of Medical Assistance (DMA) for beneficiaries entering the fifth or subsequent benefit periods.

NCTracks does not currently contain the capabilities necessary to perform this process. Therefore, effective October 1, 2013, hospice providers must fax the Hospice Prior Approval Request Form (DMA-3212) for beneficiaries entering the fifth or subsequent benefit periods to N.C. DMA, Attn: Hospice Consultant at 919-715-9025.

The hospice consultant will review the Hospice Prior Approval Requests and enter the approval or denial into the NCTracks system until NCTracks is able to perform this function.

Prior approval is requested by hospice provider for beneficiaries entering the fifth or subsequent benefit periods as follows:

1. The provider completes the **N.C. Medicaid Hospice Prior Approval Authorization Form (DMA-3212)** which can be found at one of the following locations:

    - www.ncdhhs.gov/dma/provider/forms.htm
    - www.ncdhhs.gov/dma/services/hospice.htm
    - http://info.dhhs.state.nc.us/olm/forms/

2. The provider attaches the following required documents to the completed form:

    - Signed Election Statement
    - Physician Certification/Recertification
    - Hospice Plan of Care
    - Supporting Documentation (e.g., medical history, prognosis)

3. The completed N.C. Medicaid Hospice Prior Approval Authorization Form (DMA-3212) and attached required documents must be submitted **NO LATER THAN 10 DAYS** prior to the expiration of the current benefit period.

4. The hospice consultant will review the Hospice Prior Approval Requests and enter the approval or denial into the NCTracks system.

Clinical Policy and Programs
DMA, 919-855-4380

Attention: Pharmacists, Prescribers and Physicians

Prior Approval Request for Synagis for Respiratory Syncytial Virus (RSV) Season 2013/2014

The clinical criteria used by N.C. Medicaid for the 2013/2014 RSV season are consistent with published guidelines in the *Red Book: 2012 Report of the Committee on Infectious Diseases, 29th Edition*. **Prior approval (PA) is required for Medicaid coverage of Synagis during the upcoming RSV season.** The coverage season is November 1, 2013 through March 31, 2014. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) criteria are considered for Synagis requests.

Submit all PA requests for coverage of Synagis for the upcoming season electronically at www.documentforsafety.org. The online Synagis Program will accept requests starting October 15, 2013. This Web-based tool is designed to capture all information for a PA request. When the system offers an opportunity to upload supporting documents, the most recent progress note documenting the patient's pulmonary or cardiac status is required when a specialist is involved in the care. The electronic system can automatically approve a request based on the criteria submitted and it allows a provider to self-monitor the status of a request pending medical review.

For approved requests, each Synagis dose will be individually authorized to promote efficient product distribution. After the initial approval, providers must submit a "next dose request" to obtain an authorization for each subsequent dose up to the approved number of doses. If an infant received one or more Synagis doses prior to hospital discharge, the provider should indicate as part of the request the most recent date a dose was administered – and the number of doses administered by the provider should be adjusted accordingly. Providers should ensure the previously obtained supply of Synagis was administered before submitting a "next dose request."

It is important for a Synagis distributor to have the appropriate single-dose authorization on hand and a paid claim prior to shipping Synagis. An individual-dose authorization is required for each paid Synagis claim. The claim should not exceed the quantity indicated on the authorization. A Synagis claim will deny if a dose request was not done by the provider.

Maximum of Five Doses

Up to five doses can be authorized during the season for chronic lung disease (CLD) and hemodynamically significant congenital heart disease (HSCHD) for infants and children less than 24 months of age.

CLD

The diagnosis causing the long-term respiratory problems must be specific. Treatment – such as supplemental oxygen, bronchodilator, and diuretic or chronic corticosteroid therapy – in the six months before the start of the season is required.

HSCHD

Infants not at increased risk from RSV who generally should **not** receive immunoprophylaxis include those with hemodynamically insignificant heart disease, such as secundum atrial septal defect, small ventricular septal defect (VSD), pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, patent ductus arteriosus (PDA), lesions adequately corrected by surgery unless the infant continues on medication for CHF, or mild cardiomyopathy not requiring medication.

Congenital abnormalities of the airway or neuromuscular disease

Infants born on or after November 2, 2012 with compromised handling of respiratory secretions secondary to congenital abnormalities of the airway or neuromuscular disease may be eligible for prophylaxis during the first year of life. The diagnosis to justify severe neuromuscular disease or congenital airway abnormalities must be specific.

Prematurity

In addition to the conditions listed above, a premature infant (prematurity must be counted to the exact day) may qualify for five doses as follows:

- Born at an Estimated Gestational Age (EGA) of ≤28 weeks 6 days and Date of Birth (DOB) is on or after November 2, 2012
- Born at an EGA of 29 weeks 0 days to 31 weeks 6 days and DOB is on or after May 2, 2013

Five-Dose Exceptions

Coverage of Synagis for CLD and HSCHD will terminate when the beneficiary exceeds 24 months of age **and** has received a minimum of three doses during the season. Coverage of Synagis for congenital abnormalities of the airways and severe neuromuscular disease that compromises handling of respiratory secretions will terminate when the beneficiary exceeds 12 months of age **and** has received a minimum of three doses during the season.

Maximum of Three Doses; Last Dose Administered at Three Months of Age (90 Days of Life)

Infants meeting clinical criteria as follows may be approved for up to three doses of Synagis during the season:

Born at an ***EGA*** of 32 weeks 0 days to 34 weeks 6 days and DOB on or after August 2, 2013, with at least one of the two following defined risk factors:

1. Attends child care [defined as a home or facility where care is provided for any number of infants or young toddlers (toddler age is up to the third birthday)]. The name of the day care facility must be submitted with the request.
2. Has a sibling younger than five years of age living permanently in the same household. Multiple births do not qualify as fulfilling this risk factor.

Generally, the following diagnoses do not singularly justify medical necessity for Synagis prophylaxis:

- Positive RSV episode during the current season
- Repeated pneumonia
- Sickle cell
- Multiple birth with approved sibling
- Apnea or respiratory failure of newborn

Submitting a Request to Exceed Policy

For doses exceeding policy or for Synagis administration outside the defined coverage period, the provider should use the *Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age* to request Synagis. The form is available on N.C. Division of Medical Assistance Website at www.ncdhhs.gov/dma/epsdt/. A medical necessity review will be done under EPSDT (see www.ncdhhs.gov/dma/epsdt/index.htm). If the information provided justifies medical need, the request will be approved.

Pharmacy Distributor Information

Synagis claims processing will begin on October 29, 2013, to allow sufficient time for pharmacies to provide Synagis by November 1, 2013. Payment of Synagis claims with date of service prior to October 29, 2013 and after March 31, 2014, will not be allowed. Point of sale claims should not be submitted by the pharmacy distributor prior to the first billable date of service for the season. Pharmacy providers should always indicate an accurate days' supply when submitting claims through NCTracks. Claims for Synagis doses that include multiple vial strengths must be submitted as a single compound-drug claim. Synagis doses that require multiple vial strengths that are submitted as individual claims will be subject to recoupment by DMA Program Integrity. Physicians and pharmacy providers are subject to audits of beneficiary records by DMA Program Integrity.

Providers will fax each single-dose authorization to the pharmacy distributor of choice. Single-dose vial authorizations, up to the maximum number of doses approved for the beneficiary, will be issued by Medicaid. Ensure the appropriate authorization is received before submitting a claim to Medicaid. The authorizations should be maintained in accordance with required recordkeeping time frames.

Provider Information

Providers without Internet access should contact the Medicaid Outpatient Pharmacy Program at 919-855-4300 to facilitate submission of a PA request for Synagis. More information about the Synagis program is found at www.documentforsafety.org.

Technical Support

Technical support can assist with provider registration, user name and password issues, beneficiary searches, and other registry functions. Technical support is available Monday to Friday from 8 a.m. to 5 p.m. by calling 1-855-272-6576 (local: 919-657-8843).

Outpatient Pharmacy
DMA, 919-855-4300

Attention: Personal Care Services (PCS) Providers

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) program.

Independent Assessment Entity Transition

DMA Clinical Coverage Policy 3L for PCS requires the following documentation for prior authorization:

1) An Activities of Daily Living assessment completed by an independent entity for all Medicaid beneficiaries; and,
2) A pre-admission screening for serious mental illness completed by an independent entity for Medicaid beneficiaries residing in adult care homes.

Effective October 1, 2013, Liberty Healthcare, NC is the PCS independent assessment agent for the N.C. Division of Medical Assistance (DMA), replacing the Carolinas Center for Medical Excellence (CCME). Liberty Healthcare, NC's contact information is as follows:

Address: Liberty Healthcare NC, PCS Program
5540 Centerview Drive, Suite 114, Raleigh, NC 27606
Call Center Phone: 855-740-1400 or 919-322-5944
Fax: 484-434-1571
Independent Assessment Email: ncfax@libertyhealth.com

Those with questions regarding the transition of the independent assessment entity can call 919-855-4340 or email PCS_Program_Questions@dhhs.nc.gov.

PCS Request for Services Form

Effective October 1, 2013, current PCS referral/request forms will be consolidated into the **DMA 3051 Personal Care Services (PCS) Request for Services Form.** This form will take the place of the new referral forms, Change of Status forms, and the Change of Provider forms. All PCS providers, irrespective of setting, will use the **DMA 3051 PCS Request for Services Form.** To access the form, visit www.ncdhhs.gov/dma/pcs/pas.html and click "Forms."

With the implementation of DMA 3051, **the following forms have been terminated effective October 31, 2013:**

- DMA 3041 New Referral Request Form – Home Care Agency
- DMA 3068 New Referral Request Form – Licensed Residential Facility
- DMA 3042 Change of Status Request Form – Home Care Agency

- DMA 3069 Change of Status Request Form – Licensed Residential Facility
- DMA 3043 Change of Provider Request Form – Home Care Agency
- DMA 3070 Change of Provider Request Form – Licensed Residential Facility

Those with additional questions regarding these forms can call the PCS Program at 919-855-4340 or email PCS_Program_Questions@dhhs.nc.gov.

New 2013 Session Law: Additional Safeguards for Medicaid PCS

A Medicaid beneficiary who meets the eligibility criteria of S.L. 2013-306, s. 10.9F.(c) is eligible for **up to 50 additional hours** of Medicaid PCS per month for a total of **up to 130 hours** per month in accordance with an assessment and a plan of care. The effective date of the new provision is dependent upon The Centers for Medicaid and Medicare Services (CMS) approval of the State Plan Amendment.

Bridge funding for .5600A and .5600C Group Homes

In accordance to Session Law 2013-360, Section 12A.2A, the N.C. General Assembly has appropriated $4.6 million in non-recurring funds to provide supplemental short-term assistance for beneficiaries living in group homes. The N.C. Department of Health and Human Services (DHHS) will allocate funds through the Local Management Entities/Managed Care Organizations (LME/MCOs), which shall distribute monthly payments as directed in Session Law 2013-360.

For additional information on Bridge funding for Group Homes, view the press release at www.ncdhhs.gov/mhddsas/updates/.

Upcoming Training

Visit the PCS Webpage at www.ncdhhs.gov/dma/pcs/pas.html and click on "Trainings" to view posted trainings on the DMA 3051 PCS Request for Services Form, as well as QiReport Registration and Utilization. Additional plans for provider trainings and Webinars will be announced on the PCS Webpage. Those with questions regarding trainings can call 919-855-4340 or email PCS_Program_Questions@dhhs.nc.gov.

Personal Care Services (PCS) Program Contacts

To contact the state's PCS program, call 919-855-4340 or email PCS_Program_Questions@dhhs.nc.gov. For PCS updates and to access important links visit the PCS Webpage www.ncdhhs.gov/dma/pcs/pas.html.

Home and Community Care
DMA, 919-855-4340

Employment Opportunities with the N.C. Division of Medical Assistance (DMA)

Employment opportunities with DMA are advertised on the Office of State Personnel's Website at www.osp.state.nc.us/jobs/. To view the vacancy postings for DMA, click on "Agency," then click on "Department of Health and Human Services." If you identify a position for which you are both interested and qualified, complete a state application form online and submit it. If you need additional information regarding a posted vacancy, call the contact person at the telephone number given in the vacancy posting. General information about employment with North Carolina State Government is also available online at www.osp.state.nc.us/jobs/general.htm

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 the address listed below.

Richard K. Davis
Division of Medical Assistance
Clinical Policy Section
2501 Mail Service Center
Raleigh NC 27699-2501

The initial comment period for each proposed policy is 45 days. An additional 15-day comment period will follow if a proposed policy is revised as a result of the initial comment period. If the adoption of a new or amended medical coverage policy is necessitated by an act of the General Assembly or a change in federal law, then the 45 and 15-day time periods shall instead be 30 and 10-day time periods.

2013 Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
October	10/04/13	10/08/13	10/09/13
	10/11/13	10/15/13	10/16/13
	10/18/13	10/22/13	10/23/13
	10/25/13	10/29/13	10/30/13
November	11/01/13	11/05/13	11/06/13
	11/08/13	11/13/13	11/14/13
	11/15/13	11/19/13	11/20/13
	11/22/13	11/26/13	11/27/13
	11/29/13	12/03/13	12/04/13

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

Rick Galasso
Executive Account Director
Computer Sciences Corp. (CSC)