December 2015 Medicaid Bulletin

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Attention: All Providers*

Update on Enrollment Criteria for Ordering, Prescribing and Referring Providers

Notice to Providers: This article updates the August 2014 Medicaid Bulletin article *Providers Not Enrolled in Medicaid.* This update also appeared in the November 2015 Medicaid Bulletin.

All providers who render services to beneficiaries must be enrolled in N.C. Medicaid or N.C. Health Choice (NCHC). In addition, 42 CFR 455.410 requires that all Ordering, Prescribing and Referring (OPR) physicians – as well as other professionals providing services under the N.C. Medicaid, NCHC or their respective waiver programs – be enrolled as participating providers. This includes anyone who orders, refers, or prescribes services or items (such as pharmaceuticals) to N.C. Medicaid and NCHC beneficiaries, and seeks reimbursement.

Any physician or non-physician practitioners who render services, or write orders, prescriptions or referrals, must be enrolled in N.C. Medicaid or NCHC and their **individual** NPI (**not organizational** NPI) must be included on the claim.

Beginning Feb. 1, 2016, failure of an OPR provider to enroll in N.C. Medicaid or NCHC will result in a 90-day claim suspension. The billing provider will receive a denial with an EOB stating that the OPR provider is not enrolled.

Institutional, clinical and professional claims will suspend for 90 days if **any** of the NPIs on the claim are found to be providers who are not enrolled in N.C. Medicaid or NCHC. Providers should ensure that all rendering, ordering, prescribing and referring providers of the services for which they submit Medicaid or NCHC claims are enrolled in those programs.

As a reminder, effective July 1, 2015, all Institutional (UB-04/837-I) claims for Psychiatric Residential Treatment Facility (PRTF) services must include the name and NPI of the beneficiary's attending psychiatrist and billing provider for reimbursement. If the attending psychiatrist's NPI is not entered on the claim, the claim will deny with EOB Code 03101, "THE TAXONOMY CODE FOR THE ATTENDING PROVIDER IS MISSING OR INVALID." For more information, refer to the April 2015 Medicaid Bulletin.

If services are furnished to beneficiaries in another state, the out-of-state providers are required to enroll with N.C. Medicaid or NCHC. Enrollment in another state's Medicaid program does **not** exempt a rendering or OPR provider from enrolling with N.C. Medicaid or NCHC. More information for OPR professionals can be found on the N.C. Division of Medical Assistance (DMA) Provider Enrollment web page.

Providers with questions about the NCTracks online enrollment application can contact the CSC Call Center at 1-800-688-6696 (phone); 919-851-4014 (fax) or NCTracksprovider@nctracks.com (email).

* This also includes providers directly contracted with the LME/MCOs.

Provider Relations
DMA, 919-855-4050

Attention: All Providers

Clinical Coverage Policies

The following new or amended combined N.C. Medicaid and N.C. Health Choice clinical coverage policies are available on the N.C. Division of Medical Assistance (DMA) Clinical Coverage Policy web page.

- 3L, State Plan Personal Care Services (PCS) (11/01/15)
- 5A, Durable Medical Equipment (11/01/15)
- 8A-1, ACT-Stand-Alone Service Definition (11/01/15)
- 1E-7, Family Planning Services (11/15/15)

These policies supersede previously published policies and procedures.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

NCTracks Updates

2016 Checkwrite Schedules Posted

The 2016 checkwrite schedules for both the Division of Medical Assistance (DMA) and the combined Division of Mental Health/Division of Public Health/Office of Rural Health and Community Care (DMH/DPH/ORHCC) have been posted to the NCTracks website. They can be found under the Quick Links on the right side of the NCTracks Provider Portal home page.

Reminder of NCTracks Re-credentialing Process

Notice to Providers: This is a reminder and update to the announcement posted on the NCTracks Provider Portal on Aug. 24, 2015.

The Centers for Medicare & Medicaid Services (CMS) requires that all Medicaid providers be re-credentialed (also known as "re-verification") at least every five years. DMA is reviewing the status of enrolled providers to ensure compliance.

When re-credentialing is due, a notice will be posted to providers' Message Center Inbox on the secure NCTracks Provider Portal. Due dates are specific to each provider, so all providers will **not** receive notices at the same time.

Providers have 45 days after notification to complete the process. Session Law 2011-145 Section 10.31(f)(3) requires that providers pay a $100 enrollment fee for Medicaid re-credentialing.

It is crucial that all providers who receive notices promptly begin the re-credentialing process. All N.C. Medicaid and N.C. Health Choice (NCHC) providers are **required** to re-credential every five years as part of the N.C. Division of Health and Human Services (DHHS) Provider Administrative Participation Agreement. **The process is not optional**.

Providers who do not complete the process on time will receive a letter notifying them that they are suspended from participation in the Medicaid program. The suspension letter is posted to their Message Center Inbox on the secure NCTracks Provider Portal and mailed to the provider in an envelope marked "Important" in red letters.

Provider have 30 days following notification of suspension to complete the re-credentialing process. Providers who do not complete the process within that time frame will be terminated from the Medicaid program.

Note: Re-credentialing does not apply to any time-limited enrolled providers such as out-of-state (OOS) providers. OOS providers must continue to complete the enrollment process every 365 days.

To assist providers with this process, a new Provider Re-Credentialing/Re-verification web page is available on the NCTracks provider portal. Providers are encouraged to consult the new web page for information regarding the online process, as well as links to associated provider announcements, user guides and frequently asked questions.

Billing Update for Procedure Code T1999

As of Nov. 1, 2015, procedure code T1999 (Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified) has new service limitations. The following rules are applied to any T1999 dollars used since the beginning of the current State Fiscal Year (SFY) on July 1, 2015:

- No prior approval (PA) is required for total dollars used up to $250.00

- A PA is required for total dollars used from $250.01 to $1,500.00
    - For recipients under age 21, a PA is required for total dollars used from $250.01 to the amount specified on the PA

- Claims with total dollars exceeding $1,500.00 will be denied
    - For recipients under age 21, claims with total dollars exceeding the maximum amount identified on the PA will be denied
    - Early and Periodic Screening, Diagnosis and Treatment (EPSDT) recipients under age 21 may exceed the $1,500.00 limit if there is a validated need

- For recipients over age 21, no more than $1,500.00 per recipient per SFY may be billed, with or without PA.

The provider taxonomy codes listed below are subject to these restrictions when billing procedure code T1999:

- 251E00000X Home Health
- 261QF0400X FQHC Clinic
- 261QR1300X Rural Health Clinic
- 251J00000X Nursing Care
- 251B00000X Case Management
- 253Z00000X In Home Supportive Care
- 385H00000X Respite Care
- 333300000X Emergency Response System Company
- 332B00000X DME and Medical Supplies
- 332U00000X Home Delivered Meals

PA requests are only accepted via the NCTracks secure Provider Portal. PA requests are not accepted via fax, phone or mail. Providers can verify service limit amounts via the Automated Voice Response System (AVRS), the NCTracks secure Provider Portal and X12 270/271 transactions.

For additional information, refer to DMA Clinical Coverage Policy (CCP) 3A, *Home Health Services* on the DMA clinical coverage policy web page. Also refer to *Updated Bill Type for Home Health Provider* in the October 2015 Medicaid Special Bulletin.

Note: T1999 services are measured in dollars while Home Health Aide or Skilled Nurse services continue to be measured in visits.

Service Limits Available in Eligibility Verification Response

As of Nov. 1, 2015, NCTracks furnishes used and available service limit amounts for services received in the current fiscal year via the:

- Eligibility verification response for the AVRS,
- NCTracks secure Provider Portal, and,
- 270/271 X12 transaction for services used in the current fiscal year.

This enhancement allows providers to access the service limit amounts for the following services:

- Skilled Nursing visits,
- Home Health Aide visits
- Procedure code T1999 (Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified).

Note: If an eligibility verification response does not return service limit data, it indicates that within the current SFY (July 1-June 30), services with limits have not been used or claims with services limits have not been paid at the time of the inquiry.

Important: Accumulation of service amounts

Also beginning Nov. 1, 2015, NCTracks posts a "pay and report" edit to the paper Remittance Advice (RA) every time a service subject to limitations is paid. The edits posted are the same ones previously used to indicate only that the service limit has been exceeded. The edits will now post whenever a service subject to limitations is adjudicated – whether paid or denied. To determine whether the edit has posted as "pay and report" or a denial, the provider will need to check the paid amount for that claim line item. The edits affected are:

- Edit 44890 - EXCDS LMT FOR MANDATORY SRV FY (EOB 09825 - EXCEEDS LEGISLATIVE LIMITS FOR PROVIDER VISITS FOR FISCAL YEAR)

- Edit 44900 - EXCDS LMT FOR OPTIONAL SRV FY (EOB 09825 - EXCEEDS LEGISLATIVE LIMITS FOR PROVIDER VISITS FOR FISCAL YEAR)

- Edit 55100 - HHPA REQD T1999 > $250 IN SFY (EOB 55100 - HOME HEALTH PA REQUIRED FOR T1999 WITH ACCUMULATED SERVICES GREATER THAN $250 WITHIN THE SFY. PLEASE REQUEST HOME HEALTH PA.)

- Edit 55110 - SVCS FOR T1999 > $1500 IN SFY (EOB 55110 - EXCEEDS $1500 MAXIMUM LIMITATION ALLOWED PER STATE FISCAL YEAR)

- Edit 54810 - FISCAL YEAR LIMIT (EOB 02476 - SERVICE DENIED. EXCEEDS THE LIMITATION OF UNITS ALLOWED PER STATE FISCAL YEAR)

- Edit 53150 - UNIT LIMITATION EXCEEDED FOR SFY (EOB 02476 - SERVICE DENIED. EXCEEDS THE LIMITATION OF UNITS ALLOWED PER STATE FISCAL YEAR)

271 Health Care Eligibility Benefit Response: A number of segments in the 271 Health Care Eligibility Benefit Response, Loop 2110C, are used for service limits. Trading Partners should refer to the *270/271 Health Care Eligibility Benefit Inquiry and Response* Companion Guide on the Trading Partner Information page of the NCTracks Provider Portal for additional information on service limits.

Note: T1999 services are measured in dollars while Home Health Aide or Skilled Nurse services continue to be measured in visits.

New Features for Durable Medical Equipment and Home Health PA

For PA requests for Durable Medical Equipment (DME) and Home Health services, a signed and completed certificate of medical necessity (CMN) is required. Historically, it was submitted using the paper CMN available on the NCTracks website or by having the prescribing provider sign the system-generated document when a PA request is submitted via the secure Provider Portal.

Beginning Nov. 1, 2015, providers requesting DME and Home Health services can route through NCTracks a PA request to the recipient's prescribing provider for review. The prescribing provider can approve and electronically sign the request using their PIN, then submit to NCTracks for review. If the prescribing provider does not agree with the service request, the record can be returned to the requesting provider to review and correct as applicable.

Per DMA policy, a prescribing provider is defined as a physician, physician assistant or nurse practitioner. A new NCTracks user role – Prescribing Provider – has been developed for this group to access the routed records. The Office Administrator (OA) for the NPI must assign the appropriate authorized users the new "Prescribing Provider" user role so they can access records routed for review.

The paper CMN remains available, but the online routing of the request can expedite the submission of PA requests for DME and Home Health providers.

Important Note: Until a signed PA request is successfully submitted to NCTracks, it is not visible to the Call Center or the DMA. Call Center Agents and DMA have no information about records that are being routed between requesting and prescribing providers. The two provider groups (prescribing and service providers) must communicate with each other if there are any questions on the status of these PA records.

Additional Options to Describe Living Arrangements and Skin Conditions

Providers also have the new option of "N/A" for describing the recipient's living arrangement/support system and skin condition. This addition is being made to the Request for Prior Approval CMN/PA Form (DMA 372-131) and the PA entry pages in the secure Provider Portal. This information is required as part of the PA request process. An attestation statement is also being added below the signature section on the form. The updated form has been posted to the NCTracks Prior Approval web page.

Training Available

Training for Office Administrators (OAs) regarding the assignment of user roles in NCTracks is available in Skillport, the NCTracks Learning Management System. In addition, there will be an instructor-led course and job aid developed to assist providers with taking advantage of this new functionality. More information regarding provider training will be posted on the NCTracks Provider Portal as soon as it is available.

New Information Required on Provider Record for Agents, Managing Employees, and Owners

IntelliCorp Records, Inc. serves as the state-approved vendor for the criminal background searches performed during NCTracks provider enrollment, verification and credentialing activities. IntelliCorp has informed CSC of changes required to perform future background checks on individuals named in the NCTracks provider records.

As of Nov. 1, 2015, modifications were made to the NCTracks provider application process to ensure the physical residential address, email address, and phone number are included for each Agent, Managing Employee, and Owner.

Note: NCTracks currently captures the physical residential address of Owners that are listed on the application; this modification requires the email address and phone numbers of Owners as well.

How will this information be added?

- Providers can add this information by completing a full **Manage Change Request** (MCR) at any time.

Note: Anyone who submits an MCR for **any** reason will be required to complete this information if it is missing from the provider record.

- Those providers who are required to complete re-credentialing will be prompted to complete an MCR prior to completing the re-credentialing application if the information is missing from the provider record.

  Note: For more information on re-credentialing, refer to the October 28 NCTracks announcement and the new Provider Re-credentialing/re-verification web page on the NCTracks Provider Portal.

- All new provider **enrollments or re-enrollments** that list an Owner, Agent or Managing Employee will be required to provide this information.

NCTracks provider enrollment, verification and credentialing activities cannot be completed without a background check on Owners, Agents and Managing Employees.

New NCHC Claim Edit for Non-covered Diagnosis Codes

Beginning Nov. 1, 2015, claims for N.C. Health Choice (NCHC), also known as State Children's Health Insurance Program (SCHIP), billed with non-covered diagnosis codes (ICD-9 or ICD-10), are being denied as result of a new edit. Edit/EOB 01814 - CLAIM DENIED FOR NON COVERED DIAGNOSIS FOR NCHC RECIPIENT. This edit affects NCHC original and adjusted claims when any non-covered diagnosis code is billed. When a claim is billed with a combination of covered and non-covered diagnosis codes, it will deny regardless of the diagnosis pointers at the detail line.

This new edit was implemented based on date of processing, not date of service. Claims with a date of service prior to Nov. 1, 2015, processed on or after Nov. 1, 2015, are subject to the edit. Claims with non-covered diagnosis codes that paid prior to Nov. 1, 2015, and are adjusted on or after Nov. 1, 2015, are subject to the new edit, which will cause the adjustment to deny.
This update reflects N.C. Session Law 2011-145. There is no reprocessing scheduled due to this new edit. The new edit is not applicable to encounter claims.

Enhancements to Hearing Aid PA Requests

As of Nov. 1, 2015, there were several enhancements to the NCTracks Provider Portal entry of PA requests for Hearing Aid services. Among the enhancements, some fields that were previously optional are required going forth. The specific changes are:

1. In the Hearing Aid Service section, the requested service is a required field. If the PA request is not for a new hearing aid, hearing aid replacement or hearing aid repair, "Other" should be selected for the requested service.

2. When "New Hearing Aid" is selected in the Hearing Aid Service section, all fields for manufacturer details and cost are required – Manufacturer, Name/Model No., Invoice

Cost, Type and Style. Previously, only the Invoice Cost and Style were required fields. Medical clearance, audiogram and evaluation are still required for new hearing aids.

3. When "Hearing Aid Replacement" is selected, all fields related to manufacturer details and cost are required. (These are the same fields required for a new hearing aid.) Previously, the user did not need to enter any additional data for this selection.

4. When "Hearing Aid Repair" is selected, the data fields of Invoice Cost, Description and Documentation of Medical Necessity are required. Previously, the user did not need to enter any additional data for this selection.

5. The question "Has patient previously been provided with this service?" is required and does not have a default response. The previous default answer was "no."

6. A new text field at the bottom of the Hearing Aid Service section labeled "Notes to Prior Approval Reviewer" has been added.

In addition, there are more selections in the drop-down fields during PA entry and the selections have been updated to more accurately describe the services available. The list of options for hearing aid service type has been modified to provide more specific information regarding repair versus replacement, laterality (right, left or both), and warranty versus non-warranty.

A job aid regarding these enhancements is available in the Reference Documents folder of SkillPort, the NCTracks Learning Management System, and also on the Provider User Guides and Training page of the Provider Portal. Providers are encouraged to review this document to become familiar with the changes in the hearing aid PA entry screens.

Changes to Ongoing Payment of QMB Crossover and Secondary Claims on Nov. 1, 2015

As noted in the July 15, 2015, announcement, DMA conducted a comprehensive review of changes made to its processing of Medicare crossover and secondary claims for services rendered to Qualified Medicare Beneficiaries (QMBs). It was determined that the changes implemented March 1, 2015, were not aligned with CMS' evolving guidance to state Medicaid plans.

This change is applicable to beneficiaries with the following Category of Eligibility codes: MQBQN, MAAQN, MAAQY, MABQN, MABQY, MADQN, MADQY, SAAQN, SAAQY, SADQN and SADQY.

To align the processing of Medicare crossover and secondary claims for services rendered to QMB recipients with CMS guidance, DMA has been taking a series of steps. The next step in this process was to implement the ongoing payment methodology for QMB crossover and secondary claims.

"Lesser of" Logic

As of Nov. 1, 2015, the "lesser of" logic is applied to services covered by both Medicare and Medicaid that are rendered to QMB recipients. Specifically, payment for Medicare-covered services that are also covered in the Medicaid state plan are paid at the lesser of the Medicare cost-share (which is the sum of co-insurance, deductible and copay) or the difference between the amount paid by Medicare and the amount paid by the Medicaid state plan rate (if any). Refer to the Medicare Crossover Update dated October 7, 2013, for additional information.

For services not covered under the N.C. Medicaid plan, DMA pays the Medicare cost share amount. This applies to crossovers and secondary filed claims (Part C) for Q class recipients. This methodology results in the provider receiving the Medicare or Medicaid allowable and the QMB recipient not being responsible for any additional monies for services covered by Medicaid or Medicare.

The final step to be taken in this process is to address the previously paid QMB crossover and secondary claims for services not covered under the N.C. Medicaid plan, where the provider should have received the Medicare cost share amount. The date for reprocessing of these claims has not yet been determined. More information will be posted on the NCTracks Provider Portal as soon as it is available.

Crossover Claims to Deny If Medicare Denies

As of Nov. 1, 2015, if Medicare has denied a line on a crossover claim, NCTracks also denies the line with Edit/EOB 01760 - MISSING MEDICARE LINE OTHER PAYER INFORMATION. If the claim was denied by Medicare due to billing issues, the provider should submit a corrected claim to Medicare. Otherwise, refer to the User Guide "How to Indicate Other Payer Details on a Claim in NCTracks and Batch Submissions" on the Provider User Guides and Training page of the Provider Portal for information on the process for billing secondary claims to NCTracks.

Reminder - Change in Delivery of Nursing Facility Rate Letter and Patient Roster

Notice to Providers: This announcement was previously posted in the article *Change in Delivery of Nursing Facility Rate Letter and Patient Roster* in the November 2015 Medicaid Bulletin.

Effective Jan. 1, 2016, nursing facility providers will receive their nursing facility rate letters and Final Point in Time Reports (patient rosters) from CSC through the secure NCTracks Provider Portal. Previously, DMA mailed this information to providers.

The nursing facility rate letter and patient roster will be posted to the provider's Message Center Inbox each quarter. This approach provides quick accessibility to review, download, and print letters and patient rosters. This is the same method used to retrieve the paper remittance advice (RA). The letters and rosters will remain available for up to eight quarters.

Nursing facility providers may see a slight difference in the format of the information, but the content will be the same. Access is restricted to those people who have permission to view the corresponding NPI on the secure NCTracks Provider Portal. To obtain permission, contact the Office Administrator for the NPI.

Training information will be made available for nursing facility providers shortly. An announcement will be posted on the NCTracks Provider Portal.

CSC, 1-800-688-6696

Attention: All Providers

Outpatient Specialized Therapies Providers

The ICD-10-CM diagnosis codes Z51.89 (encounter for other specified aftercare) and Z48.89 (encounter for other specified surgical aftercare) are causing the denial of claims for Medicaid and N.C. Health Choice (NCHC) beneficiaries. For correct claim adjudication, do **not** use the ICD-10-CM diagnosis codes Z51.89 or Z48.89. **The most specific ICD-10-CM diagnosis code that adequately describes the reason for therapeutic aftercare should be submitted on the claim.**

Outpatient Specialized Therapies
DMA, 919-855-4260

Attention: All Providers

Change in Coverage for Sodium Chloride Nebulizers

Effective Sept. 17, 2015, previously covered National Drug Codes (NDCs) for Sodium Chloride Inhalation Solution (3 percent, 7 percent and 0.9 percent) are no longer rebate eligible and, therefore, are not covered by the N.C. Medicaid Outpatient Pharmacy Program. Sodium Chloride 0.9 percent is covered by Clinical Coverage Policy 5A, *Durable Medical Equipment and Supplies*, Section 5.3.11, *Respiratory Devices for the Treatment of Respiratory Disorders other than Obstructive Sleep Apnea (OSA),* which states:

> **"Nebulizers"**
>
> "A nebulizer with compressor and related supplies is considered medically necessary when the beneficiary's ability to breathe is severely impaired. Self-contained, ultrasonic nebulizer and related supplies are considered to be medically necessary when the:
>
> A. Beneficiary's ability to breathe is severely impaired; and
>
> B. Prescribing physician, physician assistant or nurse practitioner states that the ultrasonic nebulizer is medically necessary for the beneficiary to receive a smaller particle size than an ordinary nebulizer will provide.
>
> Prior approval is required for an ultrasonic nebulizer. Sterile saline is deemed medically necessary when used with the above equipment and accessories.
> For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Procedure Code(s)** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Respiratory Devices – Nebulizers."*

As indicated on the NC DMA Durable Medical Equipment (DME) Fee Schedule, Jan. 1, 2014:

N.C. Division of Medical Assistance Durable Medical Equipment Fee Schedule Effective January 1, 2014				
HCPCS Code	**Description**	**Rental**	**New**	**Used**
W4670*	STERILE SALINE, 3 CC VIAL, EACH		0.33	

*Indicates PA required

For more information, review the CMS transmittal on the change in coverage. Clinical Coverage Policies can be found on the N.C. Division of Medical Assistance (DMA) clinical coverage policy web page.

Outpatient Pharmacy Services
DMA, 919-855-4300

Attention: All Dental Providers

Extractions and Denture Delivery on the Same Day

N.C. Medicaid and N.C. Health Choice (NCHC) beneficiaries with complex and compromised medical needs (multiple medical diagnoses, taking blood thinners, etc.) are often referred to an oral surgeon for extractions and ridge preparation for partial and complete dentures. If the beneficiary will receive a partial or complete denture on the same day that the extractions are rendered, the oral surgeon can deliver the denture; however, the oral surgeon should not adjust the dentures. The beneficiary must return to the provider who fabricated the appliances for routine post-delivery care.

N.C. Medicaid and NCHC policy states:

- "Hand delivery of an appliance to a beneficiary does not constitute delivery of an appliance.

- Immediate dentures delivered by another provider must be forwarded directly to that provider."

The appliance(s) must not be given to the beneficiary to take to the oral surgeon. The general dentist/prosthodontist must forward the dentures directly to the oral surgeon. If the extractions are not rendered due to unforeseen circumstances, the oral surgeon must return the dentures directly to the general dentist/prosthodontist.

Providers are reminded that they must use the **date of delivery** as the date of service when requesting payment for a partial or complete denture. Submission of a claim for payment indicates that all services on the claim have been completed and delivered. Medicaid or NCHC payment may be recouped for claims filed using a date other than the delivery date.

Dental Program
DMA, 919-855-4280

Attention: Home Health Providers

Updated Bill Type for Home Health Providers

Notice to Providers: This was originally published as a Special Bulletin in October 2015.

Effective Nov. 1, 2015, providers should no longer submit original claims for home health services using Bill Type 33X. Providers should use Bill Type 32X or 34X instead. Bill Type 33X will be discontinued per the Centers for Medicare & Medicaid Services (CMS) and the National Uniform Billing Committee.

Service Limit Information Accessible via NCTracks and AVRS

Effective with date of service **Nov. 1, 2015,** home health providers will be able to obtain service limit information via the NCTracks Provider Portal or the Automatic Voice Response System (AVRS).

To access service limit information via the Provider Portal go to the "Eligibility" tab, input the required information and review the Medicaid Service Limits section of the screen.

The AVRS allows enrolled providers to access detailed information pertaining to the N.C. Medicaid program. Using a phone, providers may access service limit information by calling 1-800-723-4337.

Implementation of Prior Approval Requirement for the Miscellaneous Supply Procedure Code (T1999)

Effective with date of service **Nov. 1, 2015,** home health providers must submit prior approval requests for use of the T1999 procedure code through the NCTracks Provider Portal. Limits and prior approval of requirements for use of the T1999 code include the following:

- Total maximum miscellaneous billing limit of $250 per patient per year without prior approval required.
- Prior approval is required for total miscellaneous billing greater than $250.
- Total maximum miscellaneous billing limit of $1,500 per patient per year.

Verification of limits will be made available through the AVRS and via NCTracks in the Provider Portal.

Home Health Services
DMA, 919-855-4380

Attention: Hospice Providers

Hospice Rate Revisions

The N.C. Division of Medical Assistance (DMA) has determined that the hospice rates that were implemented into NCTracks effective October 2015 were incorrect. DMA has implemented the correct rates into NCTracks with an effective date of Oct. 1, 2015, and a revised fee schedule has been posted on the DMA website.

DMA also is in the process of updating the federal fiscal year (FFY) 2015 Core Based Statistical Areas (CBSA) delineations to the FFY 2016 delineations issued by Centers for Medicare & Medicaid Services (CMS).

Both of these changes also have been incorporated into NCTracks.

Either the rate or the CBSA delineation changes may have caused some claims to deny or incorrectly reimburse. A systematic reprocessing will be performed at a later date; however, if you have submitted hospice claims with a date of service on or after Oct. 1, 2015, you may submit an adjustment claim to replace your original claim.

Providers with questions should contact Michelle Counts in the DMA Provider Reimbursement Section at 919-814-0059.

Provider Reimbursement
DMA, 919-814-0060

Attention: Nurse Practitioners and Physicians Assistants

Billing Code Update for Nurse Practitioners and Physician Assistants

Since the transition to NCTracks, the N.C. Division of Medical Assistance (DMA) has received calls concerning claim denials for some services provided by nurse practitioners (NPs) and physician assistants (PAs).

DMA has provided instruction to NCTracks on updating the claims processing system. The following procedure code list has been updated to include additional NP and PA taxonomies. Codes currently in process for system updates will be published once system modifications are completed. New code problems will be addressed as DMA Clinical Policy becomes aware of them.

The complete list is as follows:

11000	11001	11301	11302	11305	11310	11900	11901
12032	16030	17000	17003	17004	17110	20206	20501
20551**	20611*	23350	23412*	25606***	27130*	27310*	27370
29065	29075	29345	29355	31515	32555	32557	36005
36010	36147	36148	36556	36568	36580	36584	36620
37191	38505	40490	47505	49180	49418	49423	49424
50387	50389	50390	50392	50393	50394	50398	51600
57456	57500	58100	61312*	61320*	62284	62290	62368
62370	63056*	63300*	63300***	63308*	66405	64400	64445
69100	69210	75902	76817	76882	77001	77003	82670
83014	83690	84100	86003	86706	86800	87101	87490
87590	92025	93279	93280	93285	93286	93287	93288
93289	93290	93291	93292	93293	93750	94640	94642
94664	95970	95974	95978	95991	96111	96450	96567
96920	99143	99144	99145	99148	99149	99150	99183
99201	99203	99211	99213	J7324			

***Codes updated for modifiers 80 and 82 only**

****Codes updated for modifier 59 only**

***** updated for modifier 55 only**

CSC, 1-800-688-6696

Proposed Clinical Coverage Policies

According to 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. 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 N.C. General Assembly or a change in federal law, then the 45- and 15-day time periods will instead be 30- and 10-day time periods.

Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
December 2015	12/03/15	12/08/15	12/09/15
	12/10/15	12/15/15	12/16/15
	12/24/15	12/29/15	12/30/15
	12/31/15	01/05/16	01/06/16
January 2016	01/07/16	01/12/16	01/13/16
	01/14/16	01/20/16	01/21/16
	01/21/16	01/26/16	01/27/16

Sandra Terrell, MS, RN
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