



# NC Medicaid Bulletin

## April 2018

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*Providers are responsible for informing their billing agency of information in this bulletin.  
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**Attention: All Providers****Update to NC Medicaid Electronic Health Record Incentive Program****Program Reminders**

April is the last month to submit an attestation for the NC Medicaid Electronic Health Record (EHR) Incentive Program for Program Year 2017. North Carolina's Medicaid EHR Incentive Payment System ([NC-MIPS](#)) will close for Program Year 2017 at midnight on April 30, 2018. **No changes can be made after April 30.**

If the NC Medicaid EHR Incentive Program is unable to validate a provider's attestation with the information submitted on NC-MIPS as of midnight on April 30, 2018, the provider will be denied for Program Year 2017. **Attestations submitted within 30 days of the close of the tail period are not guaranteed to be reviewed prior to April 30.** Therefore, it is crucial that providers review their attestation for accuracy and completeness before submitting.

Eligible Professionals (EPs) can receive a maximum of \$63,750 for six years of successful participation. Program Year 2021 is the last year to participate; therefore, EPs who have received only one incentive payment prior to Program Year 2017 must successfully attest each year from Program Year 2017 through Program Year 2021 to receive all six payments. EPs who have successfully attested at least once in program years 2011 through 2016 can return in Program Year 2017, even if they were previously denied.

If the provider was paid for Program Year 2016 using a patient volume reporting period from calendar year 2016, they may use the same patient volume reporting period when attesting in Program Year 2017.

In Program Year 2017, providers have the option to attest to Modified Stage 2 Meaningful Use (MU) or Stage 3 MU. For objective and measure requirements, providers should refer to CMS' [Modified Stage 2 MU](#) or CMS' [Stage 3 MU](#) specification sheets.

The attestation guides are updated each year. Providers are encouraged to use the most current [Modified Stage 2 MU](#) or [Stage 3 MU](#) attestation guide. Attestation guides can also be accessed from the menu on the right-hand side of [NC-MIPS](#).

**NOTE:** Clinical Quality Measures (CQM) were updated in Program Year 2017. Providers will now select six CQMs from a list of 53. To see the Program Year 2017 CQMs, visit the [Electronic Clinical Quality Improvement Resource Center \(eCQI\) website](#).

**Updates for Program Year 2018**

On Aug. 14, 2017, the Centers for Medicare and Medicaid Services (CMS) issued the [Inpatient Prospective Payment System \(IPPS\) Final Rule](#). The release of this final rule has made the following impacts to the NC Medicaid EHR Incentive Program in Program Year 2018:

- Stage 3 MU is no longer required in Program Year 2018. Providers may attest to either Modified Stage 2 MU or Stage 3 MU.
- Providers may use a 2014 Edition Certified EHR Technology (CEHRT), 2015 Edition CEHRT, or a combination of 2014 Edition and 2015 Edition CEHRT.
- Providers will select six CQMs from a list of 53 (applicable in Program Year 2017).

- Providers may continue using a 90-day MU reporting period.

Visit the [NC Medicaid EHR Incentive Program website](#) for additional updates as they become available.

**NC Medicaid EHR Incentive Program**  
[NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov) (email preferred)

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## Attention: All Providers

### Clinical Coverage Policies

The following new or amended combined North Carolina Medicaid and NC Health Choice (NCHC) clinical coverage policies are available on Medicaid's [clinical coverage policy web pages](#).

- 12B, *Human Immunodeficiency Virus (HIV) Case Management*, March 1, 2018
- 1F, *Chiropractic Services*, March 5, 2018
- 3K-1, *Community Alternatives Program for Children (CAP/C)*, March 6, 2018
- 3A, *Home Health Services*, March 13, 2018
- 5A-2, *Respiratory Equipment and Supplies*, March 16, 2018
- 1A-9, *Blepharoplasty/Blepharoptosis (Eyelid Repair)*, April 1, 2018
- 1A-32, *Tympanometry and Acoustic Reflex Testing*, April 1, 2018
- 1A-36, *Implantable Bone Conduction Hearing Aids (BAHA)*, April 1, 2018
- 1A-42, *Balloon Ostial Dilation*, April 1, 2018
- 1K-7, *Prior Approval for Imaging Services*, April 1, 2018
- 1-O-5, *Rhinoplasty and/or Septorhinoplasty*, April 1, 2018

These policies supersede previously published policies and procedures.

**Clinical Policy and Programs**  
**DMA, 919-855-4260**

## Attention: All Providers

# NC HealthConnex Connection Required by June 1, 2018, for Medicaid Hospitals, Physicians, Mid-Level Practitioners and Extension Process

Per [Session Law \(S.L.\) 2015-241](#), as of **June 1, 2018**, hospitals, mid-level physicians and nurse practitioners who currently have an electronic health record system must be connected to NC HealthConnex to continue to receive payments for North Carolina Medicaid and NC Health Choice (NCHC) services.

NC HealthConnex links disparate systems and existing North Carolina HIE networks together to deliver a holistic view of a patient's record. It currently houses 3.9 million unique patient records, allowing providers to access their patients' comprehensive records across multiple providers, and review consolidated lists of items including labs, diagnoses, allergies and medications.

**By June 1, 2019**, all other Medicaid and state-funded providers must be connected, including the State Health Plan, (North Carolina Blue Cross Blue Shield State Health Plan), Program for All-Inclusive Care of the Elderly (PACE) and state grants.

The NC Health Information Exchange Authority (HIEA), the NC Department of Information Technology agency that manages NC HealthConnex, will host "How to Connect" webinars the last Monday of each month at noon to educate providers affected by this law, describe the technical and onboarding requirements, and answer questions about the legal [Participation Agreement](#) that governs the data connection. **To register for the next webinar at noon on Monday, April 30**, visit [nchealthconnex.gov](http://nchealthconnex.gov).

NC HIEA, in collaboration with the NC Department of Health and Human Services, has developed a process that allows health care providers to request extensions to complete their connection to NC HealthConnex. To request a connection extension, providers must:

1. Have signed an NC HIEA [Participation Agreement](#), and
2. Can demonstrate how their organization plans to connect to NC HealthConnex within one calendar year.

If the provider organization meets these criteria, complete a form located at [nchealthconnex.gov/providers/extension-process](http://nchealthconnex.gov/providers/extension-process).

**Note:** This extension process is not a request for a waiver or exemption from the state's requirements, but an extension of time to meet the state's requirements.

Providers can learn more at [nchealthconnex.gov/how-connect](http://nchealthconnex.gov/how-connect). Providers with questions can contact the NC HIEA staff at 919-754-6912 or [hiea@nc.gov](mailto:hiea@nc.gov).

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

**Attention: All providers****The Office of the State Auditor Single Audit – State Fiscal Year 2018**

Every year, in accordance with [2 CFR part 200, subpart F](#), the NC Office of the State Auditor (OSA) selects a sample of North Carolina Medicaid and NC Health Choice (NCHC) claims to review to determine the state's compliance with federal and state regulations for claims paid in the prior state fiscal year (SFY), which runs from July 1 to June 30.

The NC Division of Medical Assistance (DMA) Office of Compliance and Program Integrity (OCPI) will send out medical record requests during the fourth quarter of SFY 2018 to providers who have a claim in the randomly selected sample.

To minimize costs and prevent delays, providers who are selected as part of the sampling will receive a call from OCPI to verify the address of the provider's Compliance Department or Health Information Management Department, where these medical record requests should be mailed.

For inpatient hospital services, OCPI will also request the name and address of the chief financial officer.

The record request will contain a list of the documents to be submitted to OCPI for the initial review of the claim. The requested documents **must** be sent as soon as possible, but **no later than 30 calendar days after the receipt of the medical records request**. Providers who have more than 25 pages of documentation must submit the documents on an encrypted CD or flash drive, with the password sent separately via unencrypted email to [Medicaid.SA@dhhs.nc.gov](mailto:Medicaid.SA@dhhs.nc.gov). This will prevent payment error findings related to missing documentation.

During the medical record request process, OCPI may ask for additional documentation to support the payment of the claim. Failure to respond in a timely manner may result in placement on prepayment claims review. Providers must follow [G.S 108C-11, Cooperation with investigations and audits](#).

DMA is authorized by [Section 1902 \(a\) \(27\)](#) of the Social Security Act and [42 CFR. 431.107](#) to access patient records for purposes directly related to the administration of Medicaid and NCHC. When applying for Medicaid benefits, beneficiaries sign a release which authorizes DMA and other appropriate regulatory authorities to access Medicaid records. Therefore, it is **not** necessary to secure a signed consent for the release of records from any affected Medicaid beneficiary before submitting the necessary documentation for this review.

Providers with concerns or questions can contact OCPI at 919-814-0172.

**Office of Compliance and Program Integrity  
DMA, 919-814-0172**

**Attention: All Providers****Update: Clinical Coverage Policy 2A-1, Acute Inpatient Hospital Services and 1A-4, Cochlear and Auditory Brainstem Implants**

Changes to two clinical coverage policies – [2A-1, Acute Inpatient Hospital Services](#) and [1A-4, Cochlear and Auditory Brainstem Implants](#) – will soon become effective.

**2A-1, Acute Inpatient Hospital Services**

Effective April 1, 2018, North Carolina Medicaid will revise Clinical Coverage Policy 2A-1, *Acute Inpatient Hospital Services*, to align with [42 CFR 456.60](#), *Certification and recertification of need for inpatient care*. 42 CFR 456.60 specifies that only a physician may perform the initial certification for admission.

**1A-4, Cochlear and Auditory Brainstem Implants**

Effective May 1, 2018, North Carolina Medicaid will revise Clinical Coverage Policy 1A-4, *Cochlear and Auditory Brainstem Implants*. The following changes will be made:

- Medicaid coverage for cochlear implantation and aural rehabilitation will be expanded. Beneficiaries ages 12 months and older will be eligible when criteria are met. The coverage requirement for the level of hearing loss for the ear to be implanted will be changed to “greater than or equal to 70 dB HL.”
- Medicaid coverage allows an adult to receive a cochlear implant replacement when medically necessary. Medicaid and NCHC shall cover the replacement of an existing traditional cochlear implant as medically necessary when any of the following criteria are met:
  1. The currently used component is no longer functional, cannot be repaired and there is no evidence to suggest that the device has been abused or neglected
  2. The currently used component renders the implanted beneficiary unable to adequately or safely perform age-appropriate activities of daily living, or
  3. The current technology has been made obsolete by the manufacturer.

The adult beneficiary will be able to receive the necessary diagnostic analysis and programming of the new device per policy as needed.

- Medicaid coverage allows an adult to receive a contralateral cochlear implant when criteria are met.
- Postoperatively, Medicaid will cover diagnostic analysis and programming as defined in the policy for an adult that receives cochlear implants.
- ICD 10 code H90.5 was deleted. ICD 10 codes H90.A21, H90.A22, H90.41 and H90.42 were added.

**Clinical Policy and Programs**

**DMA, 919-855-4260**

**Attention: All Providers****NCTracks Provider Training Available in April 2018**

Registration is open for the April 2018 instructor-led provider training course and annual seminar listed below. Slots are limited.

WebEx courses: Participants can attend remotely from any location with a telephone, computer and internet connection.

**Prior Approval Pharmacy (WebEx)**

Tuesday, April 17, 2018 - 9 to 11 a.m.

How to submit prior approval (PA) requests to ensure compliance with Medicaid clinical coverage policy and medical necessity. At the end of training, providers will be able to:

- Navigate the NCTracks portal to enter a PA
- Search and review PA information
- Identify whether a PA is approved or denied determined by set criteria from business rules

**Annual Seminar (Greensboro, NC)**

Thursday, April 19, 2018 - 9 a.m. to 4 p.m.

Annual seminars run from 9 a.m. to 4 p.m. at different dates and locations across the state. The second is scheduled for Greensboro on April 19. See the [announcement](#) listing the other dates and times.

**Training Enrollment Instructions**

Providers can register for these courses in SkillPort, the NCTracks Learning Management System. Logon to the secure NCTracks Provider Portal and click Provider Training to access SkillPort. Open the folder labeled **Provider Computer-Based Training (CBT) and Instructor Led Training (ILT)**. The courses can be found in the sub-folders labeled **ILTs: On-site** or **ILTs: Remote via WebEx**, depending on the format of the course.

Refer to the [Provider Training page](#) of the public Provider Portal for specific instructions on how to use SkillPort. The Provider Training page also includes a quick reference about downloading Java, which is required for the use of SkillPort.

**CSRA, 1-800-688-6696**

**Attention: All Providers****Avoid Delays in the Processing of Provider Enrollment Applications**

**Note:** This article was previously published in the [February 2018 Medicaid Bulletin](#).

If a provider's enrollment application or Manage Change Request (MCR) is clean and does not contain errors, it will process more quickly. The NCTracks Enrollment Team identified common errors that cause delays in processing applications and MCRs. Common errors include:

- **Supporting documentation not attached** – If supporting documentation is required, it must be uploaded and attached prior to submission (including license/certification/accreditation). For guidance on how to attach supporting documentation, refer to section 3.30.1 of Participant User Guide PRV111 Provider Web Portal Applications on the secure NCTracks Provider Portal.
- **Name on application** – Name on application should match National Plan and Provider Enumeration System (NPPES) National Provider Identifier (NPI).
- **Incomplete Exclusion Sanction information** – The Exclusion Sanction questions must be answered. On question K, **all** convictions (misdemeanors and felonies) must be disclosed regardless of how old the conviction is. (The only exception to this requirement is minor traffic offenses, such as a speeding ticket, expired registration, etc.) The questions must be answered for the enrolling provider and the practice's owners and agents in accordance with 42 CFR 455.100; 101; 104; 106 and 42 CFR 1002.3. If the answer to any of the Exclusion Sanction questions is "yes," then documentation regarding the disposition of the action must be attached to the application. If a provider submits a written attestation, it must be on company letterhead and signed and dated by the person to whom the attestation applies. For a complete list of questions, go to the [Provider User Guides and Training page](#) of the NCTracks Provider Portal and open either the *How to Enroll in North Carolina Medicaid as an Individual Practitioner* or *How to Enroll in North Carolina Medicaid as an Organization* user guides, both of which are located in the Enrollment and Re-Verification section. These documents contain the list of sanction questions.
- **Failure to upload Electronic Fingerprinting Submission Release of Information Form (Evidence)** – The form must be signed and dated by each person required to submit fingerprints. It must also be signed and dated by the law enforcement agency collecting the fingerprints. Providers must upload the Release of Information Form into NCTracks by the deadline on the notification letter.
- **Fingerprinting Card should not be mailed to address on the evidence form** – If the applicant opts to do a Fingerprint Card, it must be mailed to the State Bureau of Investigation (SBI) for processing at NCSBI/Applicant Unit, 3320 Garner Road, Raleigh, NC 27626.
- **Choosing the incorrect taxonomy code** – The taxonomy code selected must accurately reflect the type of provider. The provider must meet the enrollment qualifications for the taxonomy code selected and possess the required licensure and/or credentials. Providers who are uncertain which taxonomy code to select should consult the *Provider Permission Matrix* (and instruction sheet) on the [Provider Enrollment page](#) of the NCTracks Provider Portal. For additional guidance, refer to *How to View and Update Taxonomy on the Provider Profile in NCTracks* on the [Provider User Guides and Training page](#) of the NCTracks provider portal.



- **NCID misuse** – This continues to be an issue on applications and may result in adverse action on the provider’s application and record. Refer to the article, *Using NCIDs Properly in NCTracks*, in the [December 2016 Medicaid Bulletin](#).
- **Inaccurate entry of names, Social Security numbers (SSN) and date of birth (DOB) on applications** – This continues to be an issue which impacts the integrity of the application and Participation Agreement and may result in adverse action on the application.

For assistance with NCID and/or PIN, refer to the [Getting Started web page](#) on NCTracks and the NCTracks [NCID Fact Sheet](#).

Providers with questions can contact the CSRA Call Center at 1-800-688-6696 (phone), 1-855-710-1965 (fax), or [NCTracksProvider@nctracks.com](mailto:NCTracksProvider@nctracks.com).

**CSRA, 1-800-688-6696**

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## Attention: All Providers

### New Pricing Methodology for LARCs and Vaccines

**On April 29, 2018**, a new reimbursement methodology will be implemented for medical claims for physician-administered Long Acting Reversible Contraceptives (LARCs) and vaccines, **effective for claims with date of service July 1, 2017 and after**. The changes will impact professional claims, dialysis claims and all claim types for LARCs and vaccine procedure codes.

Claims for physician administered LARCs will be priced at Wholesale Acquisition Cost (WAC) plus 6 percent and vaccines will be priced at WAC plus 3 percent. Since this new pricing method is effective July 1, 2017, a future reprocessing effort for these claims may be performed. Details regarding reprocessing will be communicated in a future announcement.

The new pricing is based on a procedure code/National Drug Code (NDC) match. Therefore, **all** providers are required to submit the appropriate NDC that corresponds to the physician administered LARCs and vaccines used for administration and corresponding procedure code. If the procedure code/NDC combination is not found, the claim line will deny with Explanation of Benefit (EOB) 02047:

RATE NOT FOUND OR PROCEDURE/NDC XWALK DOES NOT EXIST. CONTACT THE M&S HELPDESK AT (855) 457-5264.

Secondary claims will continue to price using the lesser of logic and all existing Qualified Medicare Beneficiary (QMB) rules.

**Provider Reimbursement  
DMA, 919-814-0060**

**Attention: All Providers****Update to Clinical Coverage Policy 1A-42 Balloon Ostial Dilation (BOD)**

Effective Feb. 1, 2018, Clinical Coverage Policy 1A-42; *Balloon Ostial Dilation*, was revised to include new coverage of CPT code 31298 (balloon dilation of frontal and sphenoid sinus). North Carolina Medicaid will cover this procedure or one of the other Balloon Ostial Dilation (BOD) procedures once per sinus during the beneficiary's lifetime.

Prior approval for this procedure is required.

Providers will indicate whether the service is being performed unilaterally or bilaterally using modifier –LT (left), –RT (right), or –50 (bilateral). This procedure will be covered in the following places of service:

- Inpatient hospital
- Outpatient hospital
- Ambulatory surgical center, and
- office setting.

Providers should refer to policy 1A-42; *Balloon Ostial Dilation*, which was posted Feb. 1, 2018.

**Clinical Policy and Programs**  
**DMA, 919-855-4260**

**Attention: All Providers****C**hange in Edit Disposition: Claims Pended for Incorrect Billing Location

**Note:** This article was previously published in the [September 2017 Medicaid Bulletin](#). It is being republished with updates regarding edit disposition.

Effective Oct. 29, 2017, the NC Department of Health and Human Services (DHHS) validates through NCTracks that the billing provider's address submitted on the claim corresponds to the location listed on the provider record for the dates of service submitted. The billing provider address, city, state and zip code (first five digits) on all North Carolina Medicaid and NC Health Choice claims must match exactly with the corresponding information on the provider record. (The match is not case sensitive.)

**Note:** It was previously announced that the claim would pend for 60 days. The edit was implemented with a "pay and report" status. Providers receive an informational Explanation of Benefits (EOB) 04529 - BILLING ADDRESS SUBMITTED ON THE CLAIM DOES NOT MATCH THE ADDRESS ON FILE.

**NCTracks uses the address submitted on the claim (837 D, P, and I - Loop 2010AA / ADA Dental – box 48, CMS-1500 block 33 and UB04 – Form Locator 1) to match to a service location address on the provider's record.** If NCTracks cannot match the billing provider's address to an active service location in the NCTracks provider's file, the provider receives the informational EOB code 04529 - BILLING ADDRESS SUBMITTED ON THE CLAIM DOES NOT MATCH THE ADDRESS ON FILE on the paper Remittance Advice (RA).

This EOB indicates that the **provider should add or correct the billing provider address on the provider's record in NCTracks** or correct the address submitted on the claim.

Providers identified with EOB 04529 will be sent a notification via email. Provider records can be updated with a new billing provider address by submitting a Manage Change Request (MCR) in the secure NCTracks Provider Portal. Alternatively, providers can correct the billing provider's address on the claim so it matches a service location on the billing provider's record and then refile the claim.

**Note:** MCRs may be subject to credentialing and verification. For guidance on submitting an MCR, refer to the User Guide, *How to Change the Physical Address in NCTracks*, in SkillPort.

**The edit disposition of pay and report is temporary.** Providers will be notified when the edit disposition will change to pend. Once the disposition change to pend occurs, the claims pended with EOB 04529 will automatically recycle daily, so if the provider adds the correct address to the provider record, the claim will resume processing. If the provider does not add the correct address to the provider record within 60 days, the claim will be denied.

Claims with dates of service prior to Oct. 29, 2017, are not subjected to the edit. Pharmacy and crossover claims are also excluded from the edit. Providers with questions can contact the CSRA Call Center at 1-800-688-6696 or [NCTracksprovider@nctracks.com](mailto:NCTracksprovider@nctracks.com).

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

**Attention: All Providers****Fingerprinting Process for Providers**

**Note:** This article was originally published in the [October 2017 Medicaid Bulletin](#). This is the final Medicaid Bulletin publication.

“High risk” individual providers and provider organizations, as outlined in [NC General Statute 108C-3g](#), and individual owners with 5 percent or more direct or indirect ownership interest in a “high risk” organization are required to submit fingerprints to the North Carolina Medicaid program.

The provider’s Office Administrator (OA) will receive two notifications through the NCTracks Provider Portal, Provider Message Center Inbox, for each person required to submit fingerprints. One notification will be a letter with instructions and the other will be a Fingerprint Submission Release of Information Form. The OA also will receive an email for each party required to submit fingerprints. The email will have the Fingerprint Submission Release of Information Form attached.

The provider should print and complete the Fingerprint Submission Release of Information form prior to taking it to any one of the [LiveScan locations for fingerprinting services](#). This form **must be signed by the official taking the fingerprints**.

Once the provider is fingerprinted and the Fingerprint Submission Release of Information form is signed at the LiveScan location, the OA will electronically upload the form to the provider’s record in NCTracks by using the following steps:

1. From the Submitted Applications section of the Status and Management page, the OA will see that any NPI with a status of “In Review” will also have a hyperlink to Upload Documents.
2. Select the Upload Documents link. Once the link is selected, the OA will be able to browse for and attach the form.
3. Select the Upload Documents link found under the Fingerprint Evidence Documents section.

At this point the process is complete, and the provider will be able to access the Status and Management page for an updated application status.

**Note:** Individuals who are required to undergo the fingerprint-based background check will incur the cost of having their fingerprints taken. It is recommended that you contact the fingerprinting agency to confirm the fee prior to going.

**If the applicant opts to do a fingerprinting card, rather than a live scan, they must mail the Fingerprint Card to the SBI for processing at NCSBI/Applicant Unit 3320 Garner Road Raleigh, NC 27626. The Electronic Submission Release of information form is still required to be uploaded to NCTracks.**

**Note: The Fingerprinting card should not be mailed to the address on the form. Mailing these documents will delay the application processing and could result in a for cause denial or termination.**

More information on the Fingerprinting Application Process can be found in the [NCTracks Fingerprinting Application Required Job Aid](#). This link also provides additional resources and information including answers to Frequently Asked Questions (FAQs) and locations for fingerprinting services. Providers can also refer to the

Medicaid and NC Health Choice Provider Fingerprint-based Criminal Background Checks article in the [August 2017 Medicaid Bulletin](#).

Providers with questions can contact the CSRA Call Center at 1-800-688-6696 (phone), 1-855-710-1965 (fax) or [NCTracksProvider@nctracks.com](mailto:NCTracksProvider@nctracks.com).

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

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## Attention: All Providers

### **NPI Exemption List Extension to Aug. 31, 2018 - Update**

**Note:** This article was originally published as a [Special Bulletin in January 2018](#).

In response to provider feedback, the use of the NPI Exemption List for residents and interns enrolled in graduate dental and medical programs, and area health education centers **will be extended from Jan. 31, 2018 to Aug. 31, 2018**.

Clinical pharmacist practitioners will continue to use the NPI Exemption List until further notice. Residents and interns licensed through the NC Medical Board and NC Dental Board with a resident in training license (RTL) may enroll as ordering, prescribing and referring (OPR) lite providers via the abbreviated application in NCTracks. These practitioners will use the taxonomy 390200000X, Student Health Care, when enrolling as an OPR lite provider.

The services of residents or interns in a Graduate Medical Education teaching setting are **not** billable to Medicaid. Therefore, residents and interns who order services, prescribe medications or services, or make referrals **must** provide their NPI (if enrolled) or their supervising physician's NPI to the provider submitting claims for service reimbursement. The supervising physician may bill for the services they personally provided during the patient encounter.

The following enrollment requirements will apply to OPR lite providers:

- \$100 application fee
- Credentialing and criminal background checks including fingerprinting, if applicable
- Manage Change Request (MCR) submission to update or end date the provider record
- Revalidate every five years, and,
- MCR to change from an OPR lite enrollment provider to a fully enrolled provider if they meet the full enrollment criteria and are to be reimbursed for claims.

**Note:** OPR lite providers may request a retroactive effective date up to 365 days preceding the date of application.

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

**Attention: All Providers****Re-credentialing and Ongoing Verification Updates**

**Note:** This article was originally published in the [February 2018 Medicaid Bulletin](#).

**List of Providers Due for Re-credentialing**

A list of providers scheduled for re-credentialing January through April 2018 is available on the [provider enrollment page](#) of the North Carolina Medicaid website under the “Re-credentialing” header. Providers can use this resource to determine their re-credentialing/re-validation due date and determine which month to begin the re-credentialing process. Organizations and systems with multiple providers may download this list, which includes National Provider Identifier (NPI) numbers and provider names, to compare with their provider list.

**Note:** The terms re-credentialing, re-verification, and re-validation are synonymous.

**Changes to Re-credentialing Process**

Beginning April 30, 2018, the re-credentialing notification and suspension will be modified to the following:

1. The notification, suspension, and termination timeline will be modified to the following:
  - First notification will now be sent 70 days prior to the provider re-credentialing due date.
  - If re-credentialing is not submitted, reminders will be sent at 30 days, 15 days, and 5 days prior to the provider re-credentialing due date.
  - Providers will be suspended if the re-credentialing application is not submitted by their re-credentialing due date.
  - The provider will be terminated from the North Carolina Medicaid and NC Health Choice programs at the end of the month following 30 days of suspension.
2. Re-credentialing is not optional. It is crucial that all providers who receive a notice promptly respond and begin the process.
3. Providers are required to pay a \$100 application fee for re-credentialing.
4. The existing rules to extend the re-credentialing due date if a Manage Change Request (MCR) Application is “In Review” will be removed. Therefore, if a change is required via a MCR, the MCR process must be completed before the re-credentialing due date.
5. The Re-credentialing Application on the NCTracks Provider Portal will be modified to display the existing owners and managing employees and allow the provider to edit, end-date, or add to the Re-credentialing Application.

**Note:** Providers must thoroughly review their electronic record in NCTracks to ensure all information is accurate and up-to-date and take any actions necessary for corrections and updates.

If terminated, the provider must submit a re-enrollment application to be reinstated.

Re-credentialing does not apply to time-limited enrolled providers, such as out-of-state (OOS) lite providers. OOS providers who enroll using the OOS-lite application must complete the enrollment process every 365 days. OOS providers who are fully enrolled must re-credential every five years.

**Because of the system changes, all enrollment, re-enrollment, MCR and re-verification applications currently in “saved draft” status will be deleted on April 28, 2018.** To prevent these applications from being deleted, the draft must be submitted. Applications created on or after April 29, 2018, can once again be saved to draft.

### **Changes to Ongoing Verification Process**

Providers must also update their expiring licenses, certifications and accreditations. The system currently suspends and terminates providers who fail to respond within the specified time limits.

With system modifications, the notification, suspension, and termination timeline will be modified to the following:

1. First notification will be sent 60 days prior to expiration
2. If the expired item has not been updated, a reminder will be sent on days 30, 14, and the final reminder on day 7 prior to expiration
3. The provider will be suspended if the expired item has not been updated by the due date. The suspension will remain for 60 days, and can be removed at any time if the expired item is updated.
4. The provider’s participation in the North Carolina Medicaid and NC Health Choice programs will be terminated if the item has not been updated by day 61 after suspension.

Providers with questions about the re-credentialing process can contact the NCTracks Call Center at 1-800-688-6696 (phone), 919-710-1965 (fax) or [NCTracksprovider@nctracks.com](mailto:NCTracksprovider@nctracks.com) (email).

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

**Attention: All Providers****A** **Accepting and Billing Medicaid Beneficiaries**

In accordance with 10A NCAC 22J .0106, a provider may refuse to accept a patient as a Medicaid patient and bill the patient as a private pay patient only if the provider informs the patient that the provider will not bill Medicaid for any services, but will charge the patient for all services provided. Acceptance of a patient as a Medicaid patient by a provider includes, but is not limited to, entering the patient's Medicaid number or card into any sort of patient record or general record-keeping system, obtaining other proof of Medicaid eligibility, or filing a Medicaid claim for services provided to a patient.

A provider who accepts a patient as a Medicaid patient shall agree to accept Medicaid payment plus any authorized deductible, co-insurance, co-payment and third-party payment as payment in full for all Medicaid covered services provided, except that a provider shall not deny services to any Medicaid patient on account of the individual's inability to pay a deductible, co-insurance or co-payment amount.

Providers may bill a patient accepted as a Medicaid patient only in the following situations:

- For allowable deductibles, co-insurance, or co-payments;
- Before the service is provided the provider has informed the patient that the patient may be billed for a service that is not one covered by Medicaid regardless of the type of provider or is beyond the limits on Medicaid services;
- The patient is 65 years of age or older and is enrolled in the Medicare program at the time services are received but has failed to supply a Medicare number as proof of coverage; or
- The patient is no longer eligible for Medicaid as defined in 10A NCAC 21B.

When a provider files a Medicaid claim for services provided to a Medicaid patient, the provider shall not bill the Medicaid patient for Medicaid services for which it receives no reimbursement from Medicaid when:

- The provider failed to follow program regulations; or
- The Division denied the claim on the basis of a lack of medical necessity; or
- The provider is attempting to bill the Medicaid patient beyond the situations stated in Paragraph (c) of 10A NCAC 22J.0106.

**Annual Office Visit Limit for Mandatory Services**

North Carolina Medicaid has an annual office visit limit of 22 visits per beneficiary for mandatory services. Prior approval (PA) may be requested for additional office visits beyond the legislative limit. Approval must be received before the service is rendered. If a PA is not obtained, a provider may privately bill beneficiaries for visits more than the legislative annual visit limit, but only if beneficiaries were notified, either orally or in writing, in advance of each office visit that Medicaid will not be billed and they will be financially responsible.

If the service has already been rendered and the claim is denied due to exceeding the annual visit limit, the provider may complete a [Medicaid Claim Adjustment Request Form](#). Optional services (podiatry, optometry and chiropractic) have different limits. Refer to [Medicaid's Annual Visit](#) web page for more information.

For more information, refer to [10A NCAC 22J .0106](#) or [Medicaid's Annual Visit](#) web page.



Under federal Early Periodic Screening, Diagnostic, and Treatment (EPSDT) law, some limits and restrictions do not apply to recipients under the age of 21. Refer to Medicaid's [EPSDT](#) web page for more information.

**Clinical Policy and Programs**  
**DMA, 919-855-4320**

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## **Attention: Community Alternatives Program for Children and Personal Care Services Providers**

### **NCTracks Update: Reprocessing of Claims due to Personal Care Services Rate Change**

As previously communicated in the [December 2017 Medicaid Special Bulletin](#), *Reimbursement Rate Increase*, North Carolina Medicaid retroactively increased the rate for Personal Care Services (PCS) and the Community Alternatives Program for Children (CAP/C).

Medicaid will initiate a systematic reprocessing for applicable PCS claims for dates of service Aug. 1, 2017 through Dec. 31, 2017, in the April 24, 2018 checkwrite.

An additional reprocessing notice will be sent through the NCTracks provider portal for those providers directly affected.

Reprocessed claims will be displayed in a separate section of the paper Remittance Advice (RA) with the unique Explanation of Benefits (EOB) code 10400 - CLAIM ADJUSTED FOR PCS RATE CHANGE. The 835 electronic transactions will include the reprocessed claims along with other claims submitted for the checkwrite. (There is no separate 835.)

Reprocessing does not guarantee payment for the claims. Applicable PCS claims will be reprocessed. While some edits may be bypassed as part of the claim reprocessing, changes made to the system since the claims were originally adjudicated may apply to the reprocessed claims. Therefore, the reprocessed claims could deny.

Providers with claims for date of service Aug. 1, 2017 through Dec. 31, 2017, that billed \$3.47 and were paid \$3.47 will not be reprocessed during the systematic reprocessing. Submit replacement claims to receive the increased reimbursement. Providers are advised to bill their usual and customary amount.

Providers with questions regarding the approved rate increase may contact Medicaid's Provider Reimbursement Section. Those with questions regarding the submission of replacement claims can contact CSRA at 800-688-6696.

**Provider Reimbursement**  
**DMA, 919-814-0060**

**Attention: Community Alternatives Program for Disabled Adults****Institutional Respite Under the Community Alternatives Program for Disabled Adults**

The Community Alternatives Program for Disabled Adults (CAP/DA) Waiver allows Adult Day Health (ADH) centers licensed to provide overnight respite to be providers of CAP/DA Institutional Respite.

The CAP waiver allows ADH providers to be designated as institutional respite providers based on the scope of their service (providing a service away from the beneficiary's home with provision of overnight care for a 24-hour duration). ADH centers must meet regulatory requirements designated by the NC Division of Health Services Regulation (DHSR) to provide overnight care. The ADH centers are also certified by the NC Division of Aging and Adult Services (DAAS) and are required to meet DAAS-specified qualifications based on the scope of the service being rendered.

ADH centers wishing to provide overnight respite may claim Medicaid reimbursement using the institutional respite procedure code (H0045) under the CAP/DA waiver. These provider types will need to perform a Manage Change Request (MCR) through NCTracks to add the institutional respite taxonomy and service location to their non-endorsed services.

Case management entities may begin authorizing ADH providers in their catchment areas that meet the qualifications to provide overnight respite using procedure code H0045 (institutional respite).

**Long-Term Services and Supports  
DMA, 919-855-4360**

**Attention: Nurse Practitioners and Physician Assistants**

**Billing Code Update for Nurse Practitioners and Physician Assistants**

The NC 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 instructions to NCTracks on updating the claims processing system. The following procedure code list has been updated recently to include additional NP and PA taxonomies. The newly added codes are:

43200	43200 (B)	50385	50385 (B)
50386	50386 (B)	52000	52000 (B)
52005	52005 (B)	52204	52204 (B)
52281	52281 (B)	52310	52310 (B)
53621	53621 (B)	53660	53660 (B)

**\*Codes marked with a (B) were updated for modifier 59**

The Medicaid website has a complete list of [previously denied billing codes for NP, PAs and Certified Nurse Midwives](#).

**Note:** 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.

**CSRA, 1-800-688-6696**

**Attention: Nurse Practitioners, Physician Assistants and Physicians**

**Billing Guidelines: Etelcalcetide injection, for intravenous use (Parsabiv) HCPCS code J0606**

Effective with date of service Jan. 4, 2018, the North Carolina Medicaid and NC Health Choice (NCHC) programs cover etelcalcetide injection, for intravenous use (Parsabiv) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J0606 - Injection, etelcalcetide, 0.1 mg.

Parsabiv is available as a 2.5 mg/0.5 mL, 5 mg/mL or 10 mg/2 mL solution in a single-dose vial and indicated for secondary hyperparathyroidism (HPT) in adult patients with chronic kidney disease (CKD) on hemodialysis. Parsabiv has not been studied in adult patients with parathyroid carcinoma, primary hyperparathyroidism or with CKD who are not on hemodialysis and is not recommended for use in these populations.

**Recommended Dose:**

- The recommended starting dose is 5 mg administered by intravenous bolus injection three times per week at the end of hemodialysis treatment.
- The maintenance dose range is 2.5 to 15 mg three times per week.
- The dose may be increased in 2.5 mg or 5 mg increments no more frequently than every four weeks.

See full prescribing information for further detail.

**For Medicaid and NCHC Billing**

- The ICD-10-CM diagnosis code required for billing is N25.81 - Secondary hyperparathyroidism of renal origin (must be billed with Z99.2 - Dependence on renal dialysis).
- Providers must bill with HCPCS code J0606 - Injection, etelcalcetide, 0.1 mg.
- One Medicaid and NCHC unit of coverage is 0.1 mg.
- The maximum reimbursement rate per unit is \$3.53.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs are 55513-0740-01, 55513-0740-10, 55513-0741-01, 55513-0741-10, 55513-0742-01 and 55513-0742-10.
- The NDC units should be reported as "UN1."
- For additional information, refer to the January 2012, Special Bulletin, [National Drug Code Implementation Update](#).
- For additional information regarding NDC claim requirements related to the PDP, refer to the [PDP Clinical Coverage Policy No. 1B](#), Attachment A, H.7 on North Carolina Medicaid's website.
- Providers shall bill their usual and customary charge for non-340-B drugs.
- PDP reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340-B participating providers who have [registered with the Office of Pharmacy Affairs \(OPA\)](#). Providers billing for 340-B drugs shall bill the cost that is reflective of their acquisition cost. Providers shall indicate that a drug was purchased under a 340-B purchasing agreement by appending the "UD" modifier on the drug detail.
- The fee schedule for the PDP is available on Medicaid's [PDP web page](#).

**CSRA 1-800-688-6696**

**Attention: Nurse Practitioners, Physician Assistants and Physicians****Billing Guidelines: Hepatitis B vaccine (recombinant), adjuvanted solution for intramuscular injection (Heplisav-B) HCPCS code 90739**

Effective with date of service Jan. 8, 2018, the North Carolina Medicaid and NC Health Choice (NCHC) programs covers hepatitis B vaccine (recombinant), adjuvanted solution for intramuscular injection (Heplisav-B) for use in the Physician's Drug Program (PDP) when billed with HCPCS code 90739 - Hepatitis B vaccine (HepB), adult dosage, two dose schedule, for intramuscular use.

Heplisav-B is available as a solution for injection supplied as a 0.5 mL single-dose vial and is indicated for the prevention of infection caused by all known subtypes of hepatitis B virus in adults 18 years of age and older. The recommended dose is two doses (0.5 mL each) administered intramuscularly one month apart. See full prescribing information for further detail.

**For Medicaid and NCHC Billing**

- The ICD-10-CM diagnosis code required for billing is Z23 - Encounter for immunization.
- Providers must bill with HCPCS code 90739 - Hepatitis B vaccine (HepB), adult dosage, two dose schedule, for intramuscular use.
- One Medicaid unit is 0.5 mL. NCHC bills according to Medicaid units.
- The maximum reimbursement rate per unit is \$118.45.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs are 43528-0002-01 and 43528-0002-05.
- The NDC units should be reported as "UN1."
- For additional information, refer to the January 2012, Special Bulletin, [National Drug Code Implementation Update](#).
- For additional information regarding NDC claim requirements related to the PDP, refer to the [PDP Clinical Coverage Policy No. 1B](#), Attachment A, H.7 on North Carolina Medicaid's website.
- Providers shall bill their usual and customary charge for non-340-B drugs.
- PDP reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340-B participating providers who have [registered with the Office of Pharmacy Affairs \(OPA\)](#). Providers billing for 340-B drugs shall bill the cost that is reflective of their acquisition cost. Providers shall indicate that a drug was purchased under a 340-B purchasing agreement by appending the "UD" modifier on the drug detail.
- The fee schedule for the PDP is available on Medicaid's [PDP web page](#).

**CSRA 1-800-688-6696**

**Attention: Nurse Practitioners, Physician Assistants and Physicians****Billing Guidelines: Vestronidase alfa-vjvk injection, for intravenous use (Mepsevii) HCPCS code J3590**

Effective with date of service December 1, 2017, the North Carolina Medicaid and NC Health Choice (NCHC) programs cover vestronidase alfa-vjvk injection, for intravenous use (Mepsevii) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3590 – Unclassified biologics.

Mepsevii is available as 10 mg/5 mL (2 mg/mL) in a single-dose vial for IV injection. Mepsevii is approved by the U.S. Food and Drug Administration (FDA) for the treatment of Mucopolysaccharidosis VII (MPS VII, Sly syndrome) in pediatric and adult patients. The effect of Mepsevii on the central nervous system manifestations of MPS VII has not been determined.

The recommended dose is 4 mg/kg administered every two weeks as an intravenous infusion. See full prescribing information for further detail.

**For Medicaid and NCHC Billing**

- The ICD-10-CM diagnosis code required for billing is E76.29 - Other mucopolysaccharidoses.
- Providers must bill with HCPCS code J3590 - Unclassified biologics.
- One Medicaid unit of coverage is 1 mg. NCHC bills according to Medicaid units.
- The maximum reimbursement rate per unit is \$228.42.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC is 69794-0001-01.
- The NDC units should be reported as "UN1."
- For additional information, refer to the January 2012, Special Bulletin, [National Drug Code Implementation Update](#).
- For additional information regarding NDC claim requirements related to the PDP, refer to the [PDP Clinical Coverage Policy No. 1B](#), Attachment A, H.7 on North Carolina Medicaid's website.
- Providers shall bill their usual and customary charge for non-340-B drugs.
- PDP reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340-B participating providers who have [registered with the Office of Pharmacy Affairs \(OPA\)](#). Providers billing for 340-B drugs shall bill the cost that is reflective of their acquisition cost. Providers shall indicate that a drug was purchased under a 340-B purchasing agreement by appending the "UD" modifier on the drug detail.
- The fee schedule for the PDP is available on Medicaid's [PDP web page](#).

**CSRA 1-800-688-6696**

**Attention: Nurse Practitioners, Physician Assistants and Physicians****Billing Guidelines: Coagulation Factor IX (Recombinant), GlycoPEGylated, lyophilized powder for solution for intravenous injection (Rebinyn) HCPCS code J7199**

Effective with date of service Jan. 30, 2018, the North Carolina Medicaid and NC Health Choice (NCHC) programs cover Coagulation Factor IX (Recombinant), GlycoPEGylated, lyophilized powder for solution for intravenous injection (Rebinyn) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J7199 - Hemophilia clotting factor, not otherwise classified.

Rebinyn is available as 500, 1000 and 2000 IU single-use vials of lyophilized powder. Rebinyn is approved by the U.S. Food and Drug Administration (FDA) for use in adults and children with hemophilia B for on-demand treatment and control of bleeding episodes and perioperative management of bleeding. Rebinyn is not indicated for routine prophylaxis in the treatment of patients with hemophilia B or for immune tolerance induction in patients with hemophilia B.

**Recommended Dose**

- On-demand treatment and control of bleeding episodes: 40 IU/kg body weight for minor and moderate bleeds, and 80 IU/kg body weight for major bleeds. Additional doses of 40 IU/kg can be given.
- Perioperative management of bleeding: Pre-operative dose of 40 IU/kg body weight for minor surgery, and 80 IU/kg body weight for major surgery. As clinically needed, repeated doses of 40 IU/kg (in one- to three-day intervals) within the first week after major surgery may be administered. Frequency may be extended to once weekly after the first week until bleeding stops and healing is achieved.

See full prescribing information for further detail.

**For Medicaid and NCHC Billing**

- The ICD-10-CM diagnosis code required for billing is D67 - Hereditary factor IX deficiency.
- Providers must bill with HCPCS code J7199 - Hemophilia clotting factor, not otherwise classified.
- One Medicaid unit of coverage is 1 IU. NCHC bills according to Medicaid units.
- Providers may contact the North Carolina Pharmacy Help Desk at 1-800-591-1183 or [NCParmacy@mslc.com](mailto:NCParmacy@mslc.com) and submit their invoice to establish a reimbursement rate.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs are 00169-7901-01, 00169-7902-01 and 00169-7905-01.
- The NDC units should be reported as "UN1."
- For additional information, refer to the January 2012, Special Bulletin, [National Drug Code Implementation Update](#).
- For additional information regarding NDC claim requirements related to the PDP, refer to the [PDP Clinical Coverage Policy No. 1B](#), Attachment A, H.7 on North Carolina Medicaid's website.
- Providers shall bill their usual and customary charge for non-340-B drugs.
- PDP reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340-B participating providers who have [registered with the Office of Pharmacy Affairs \(OPA\)](#). Providers billing for 340-B drugs shall bill

the cost that is reflective of their acquisition cost. Providers shall indicate that a drug was purchased under a 340-B purchasing agreement by appending the “UD” modifier on the drug detail.

- The fee schedule for the PDP is available on Medicaid’s [PDP web page](#).

**CSRA 1-800-688-6696**

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## Attention: Nurse Practitioners, Physician Assistants and Physicians

### **C**hange in Coverage: Hyaluronan or derivative, intra-articular injection

North Carolina Medicaid was recently made aware that several manufacturers of viscous hyaluronic acid products changed the status of their products from “drugs” to “devices” effective Oct. 24, 2017 and are therefore no longer offering rebate agreements with the Centers of Medicare & Medicaid Services (CMS). For this reason, North Carolina Medicaid will **no longer** cover the viscous hyaluronic acid products listed below:

- J7321 Hyaluronan or derivative, intra-articular injection (Hyalgan or Supartz)
- J7323 Hyaluronan or derivative, intra-articular injection (Euflexxa)
- J7324 Hyaluronan or derivative, for intra-articular injection (Orthovisc)
- J7325 Hyaluronan or derivative, intra-articular injection (Synvisc)
- J7326 Hyaluronan or derivative, for intra-articular injection (Gel-One)
- J7327 Hyaluronan or derivative, for intra-articular injection (Monovisc)
- J7328 Sodium hyaluronate injection, for intra-articular injection (Gelsyn-3)

Professional and outpatient pharmacy claims submitted for the above listed HCPCS codes/products with a date of service after Oct. 24, 2017 will be denied.

Per the information available from CMS, the following hyaluronic acid products continue to be listed as “drugs” and their manufacturer continues to have a CMS rebate agreement. Therefore, North Carolina Medicaid will continue to cover the following products:

- J3470 Hyaluronidase injection (Amphadase and Vitrase)
- J3473 Hyaluronidase, recombinant (Hylenex)

Providers will be notified of any change in coverage in a future bulletin should the status of the above products change.

Additional information can be found on the CMS [Medicaid Drug Rebate Program](#) web page and North Carolina Medicaid’s [PDP Clinical Coverage Policy](#) and [PDP Fee schedule](#) web page.

**CSRA 1-800-688-6696**



**Attention: Pharmacists****P**harmacy Reimbursement Methodology Changes

On July 21, 2017, the Centers for Medicare & Medicaid Services (CMS) notified North Carolina Medicaid that its State Plan Amendment (SPA TN17-0003) had been reviewed and was approved effective April 1, 2017. The purpose of the proposed changes is to align the State Plan with changes to [CFR 447.512](#) and [447.518](#) enacted in the covered outpatient drugs final rule ([CMS-2345-FC](#)).

This SPA implements changes to the pharmacy reimbursement methodology for ingredient costs and professional dispensing fees for clotting factor based on a survey of costs for Hemophilia Treatment Centers (HTCs) and non-HTCs. A 340-b and a non-340-b state maximum allowable cost (SMAC) rate will be established based on actual acquisition costs for all clotting factor drugs to determine reimbursement of the ingredient cost and the professional dispensing fees for all clotting factor drugs will be \$0.04 per unit for HTCs and \$0.025 per unit for non-HTCs

Moreover, the SPA specifies that drugs purchased through 340-B covered entities, Federal Supply Schedule, nominal price, and specialty drugs will be reimbursed at their actual acquisition costs.

**The updated reimbursement methodology will be implemented into NCTracks April 29, 2018.** Claims for clotting factor submitted after that date will be processed and reimbursed using the updated reimbursement methodology.

Pharmacy providers are reminded that clotting factor claims paid between April 1, 2017 and April 29, 2018, will be reprocessed using the updated reimbursement methodology. A future announcement will be posted in the Medicaid Bulletin and Pharmacy Newsletter when the date for the claim reprocessing has been finalized.

Pharmacy providers are advised that any overpayment determined during the reprocessing of these claims will be recouped against future payments.

**CSRA, 1-800-688-6696**

**Proposed Clinical Coverage Policies**

Per NCGS Section 108A-54.2, proposed new or amended Medicaid clinical coverage policies are available for review and comment on the NC Division of Medical Assistance’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 because of the initial comment period. If the adoption of a new or amended medical coverage policy is necessitated by an act of the NC General Assembly or a change in federal law, then the 45- and 15-day periods will instead be 30- and 10-day periods.

**As of April 1, 2018**, the following policies are open for public comment:

Proposed Policy	Date Posted	Comment Period End Date
11A-15, Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood	03/27/2018	05/11/2018

**Checkwrite Schedule**

Month	Checkwrite Cycle Cutoff Date*	Checkwrite Date	EFT Effective Date
<b>April 2018</b>	03/30/18	04/03/18	04/04/18
	04/06/18	04/10/18	04/11/18
	04/13/18	04/17/18	04/18/18
	04/20/18	04/24/18	04/25/18
<b>May 2018</b>	05/04/18	05/08/18	05/09/18
	05/11/18	05/15/18	05/16/18
	05/18/18	05/22/18	05/23/18
	05/25/18	05/30/18	05/31/18

\* Batch cutoff date is previous day

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**Sandra Terrell, MS, RN**  
 Director of Clinical and Operations  
 Division of Medical Assistance  
 Department of Health and Human Services

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**Paul Guthery**  
 Executive Account Director  
 CSRA