NC Medicaid Bulletin
June 2018

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Providers are responsible for informing their billing agency of information in this bulletin.

Attention: Hospitals, Physicians, Physician Assistants and Nurse Practitioners

Message from Dave Richard, Deputy Secretary for Medical Assistance

Reminder: June 1, 2018, is the Deadline to Initiate Connection to NC HealthConnex

On June 1, 2018, hospitals, physicians, physician assistants and nurse practitioners with an electronic health record (EHR) system must have initiated a connection to NC HealthConnex, North Carolina's designated statewide health information exchange network.

Providers who cannot meet the deadline may receive an extension for their connection.

To request an extension, providers must:

1. Complete and sign an NC HIEA Participation Agreement
2. Have NC HIEA countersign the agreement, and,
3. Begin the onboarding process to connect to NC HealthConnex.

Providers Who Do Not Initiate Connection to NC HealthConnex by June 1, 2018

Medicaid will work collaboratively with providers to comply with the June 1, 2018, deadline, and will initiate corrective action, including requiring corrective action plans, to ensure all providers come into compliance. At this time, all providers will continue to be enrolled as Medicaid providers and, as they file claims, will receive reimbursements for services and treatment of Medicaid beneficiaries.

Medicaid appreciates the many providers across the state who have initiated a connection and are making data available through the system. We will continue to work closely with the HIEA to ensure that NC HealthConnex develops to support your priorities and enable all of us to better serve patients and families.

Currently NC HealthConnex houses 4.8 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.

Contact NC HIEA staff at hiea@nc.gov or Medicaid at Renee.McCoy@dhhs.nc.gov with questions.

Attention: All providers

Reprocessing of Mammography Claims Due to Rate Updates

Effective Jan. 1, 2018, North Carolina Medicaid increased the rates for mammography procedure codes 77065, 77066, and 77067. Medicaid has identified the claims that have been affected by this change.

A systematic reprocessing for professional, Medicare Part B Crossover Professional, Rural Health Clinic (RHC), Local Health Department (LHD) and Federally Qualified Health Center (FQHC) claims with dates of service Jan. 1, 2018 through Feb. 23, 2018 – that were paid in NCTracks from Jan. 1, 2018 through March 6, 2018 – will be reprocessed in the June 12, 2018, checkwrite.

The reprocessed claims will appear in a separate section of the paper Remittance Advice (RA) with a unique Explanation of Benefits (EOB) code EOB 10245 - CLAIM REPROCESSED FOR 2018 RATE UPDATE FOR PROCEDURE CODES 77065, 77066 AND 77067.

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 of the claims. 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.

Provider Reimbursement
DMA, 919-814-0060

Attention: All Providers

Policy Revision - Clinical Coverage Policy 1-O-3, Keloid Excision and Scar Revision

Effective July 1, 2018, North Carolina Medicaid has revised Clinical Coverage Policy (CCP) 1-O-3, *Keloid Excision and Scar Revision*, to clarify the procedure for proper submission of preoperative photographs to CSRA as part of the prior approval process. The preoperative photographs of keloids or scars should be clearly marked with:

- Beneficiary's first and last name
- Beneficiary's Medicaid or NCHC identification number
- Provider's name and NPI, and,
- Date the photograph(s) were taken.

After July 1, 2018, providers should refer to CCP 1-O-3, *Keloid Excision and Scar Revision*, on the Reconstructive Surgery Clinical Coverage Policy web page.

Clinical Policy and Programs
DMA, 919-855-4320

Attention: All Providers

Policy Revision - Clinical Coverage Policy 11A-15, Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood

Clinical Coverage Policy 11A-15, Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood, has been revised. The revisions, which will become effective Aug. 1, 2018, will add coverage criteria for the following:

- Tandem autologous stem-cell transplants for high-risk neuroblastoma, and,
- Single autologous stem-cell transplant for metastatic retinoblastoma.

Practitioners, Facilities and Policy Development
DMA, 919-855-4320

Attention: All Providers

Policy Revision – Clinical Coverage Policy 2B-1, Nursing Facility Services

Effective Oct. 1, 2017, Clinical Coverage Policy 2B-1, *Nursing Facility Services*, was revised in accordance with 42 CFR 483 Subpart B. The following sections have been updated:

- Non-Covered Patient Care Items and Services
- Transfer and Discharge
- Readmissions
- Conditions of Participation
- Payments for Services
- Married Residents
- Personal Funds
- Request for Items and Services
- Private Rooms
- Attachment L: Nursing Facility Quality Initiatives

In addition, prior approval (PA) requirements are updated to comply with the current PA process and quality improvement initiatives now require the completion of a resident satisfaction survey. The revisions also update the requirements for a significant change referral for Preadmission Screening and Resident Review (PASRR) and the requirements of the Nursing Facility Transitions Program.

The appeals process language, which was inadvertently removed from Section 4.28 of the North Carolina State Plan, was replaced.

Clinical Policy, Long Term Services and Supports
DMA, 919-855-4378

Attention: All Providers

NC Medicaid Electronic Health Record (EHR) Incentive Program Announcement

Centers for Medicare & Medicaid Services (CMS) is overhauling and streamlining the Electronic Health Record (EHR) Incentive Program. The goal is to move the program beyond requirements for meaningful use (MU) to increase focus on interoperability and improving patient access to health information.

To better reflect this focus, effective **April 24, 2018**, CMS renamed the Medicaid EHR Incentive Program the "Promoting Interoperability Program" at the federal level. However, the NC Medicaid EHR Incentive Program will continue to operate under the same name at the state level. More information about the change can be found on the CMS Promoting Interoperability Program web page.

Program Year 2017 Update

The program is no longer accepting Program Year 2017 attestations.

Program Year 2017 attestations are being processed in the order they were received.

Attestations received in April will take approximately 12 weeks to be processed from the date the signed attestation was received.

Providers can check the status of their attestation at any time on the Status Page of the North Carolina Medicaid EHR Incentive Payment System (NC-MIPS).

NC-MIPS is Open for Program Year 2018

NC-MIPS is currently accepting Program Year 2018 Modified Stage 2 and Stage 3 MU attestations.

In Program Year 2018, Eligible Professionals (EPs) may continue using a 90-day EHR (MU objective) reporting period. EPs who have only attested to adopt, implement or upgrade (AIU) thus far and will be attesting to MU for the first time in Program Year 2018 may attest with a 90-day Clinical Quality Measures (CQM) reporting period. They will see no changes to the attestation process in NC-MIPS.

EPs who have met MU in a previous program year will be required to use a full calendar year CQM reporting period in Program Year 2018. Since the CQM reporting period must be a full calendar year for these EPs, they will not be able to submit CQM data in NC-MIPS until Jan. 1, 2019. EPs who would like an early review of requirements will be allowed to submit their attestation in two parts.

Part 1 of the attestation may be submitted between May 1, 2018 and Dec. 31, 2018. It includes demographic, license, patient volume, and MU objective data. EPs will **not** be required to sign or email any documentation for Part 1. The signed attestation packet will be emailed only once – after submission of CQMs.

Once Part 1 is submitted on NC-MIPS, program staff will conduct validations and if there are discrepancies, will conduct outreach giving EPs ample time to address any issues.

After program staff validate Part 1 of the attestation, EPs may return Jan. 1, 2019 through April 30, 2019, to submit their CQM data on NC-MIPS. After submitting that information on NC-MIPS, providers will email the signed attestation packet and CQM report from the EP's EHR to NCMedicaid.HIT@dhhs.nc.gov to complete Part 2 of the attestation.

Note: This process does not increase or reduce the information being submitted, but allows EPs to complete their attestation in a 12-month window instead of four.

Visit the program website for additional updates as they become available.

N.C. Medicaid EHR Incentive Program
NCMedicaid.HIT@dhhs.nc.gov (email preferred)

Attention: All Providers

Clinical Coverage Policies

The following new or amended combined North Carolina Medicaid and NC Health Choice clinical coverage policies are available on Medicaid's Clinical Coverage Policy web pages.

- 3K-1, *Community Alternatives Program for Children (CAP/C*), May 9, 2018
- 1A-6, *Invasive Electrical Bone Growth Stimulation*, May 15, 2018
- 1B, *Physician's Drug Program*, May 15, 2018
- 1A-33, *Vagus Nerve Stimulation for the Treatment of Seizures*, June 1, 2018
- 1D-4, *Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics*, June 1, 2018
- 1K-1, *Breast Imaging Procedure*, June 1, 2018
- 2B-1, *Nursing Facilities*, June 1, 2018

These policies supersede previously published policies and procedures.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

NCTracks Provider Training Available in June 2018

Registration is open for the June 2018 instructor-led provider training courses listed below. Slots are limited.

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

Helpful Hints for Dental Prior Approval and Claim Submission (WebEx)

Thursday, June 7, 2018 1 - 3 p.m.

At the end of the training, providers will be able to identify:

- The three methods of Prior Approval submission
- How to upload documents when submitting Prior Approval requests or add to existing Prior Approval requests via NCTracks
- Common errors when completing American Dental Association form
- Common errors that require requests for Prior Approval additional information.
- Common mistakes when submitting claims

Provider Web Portal Application (WebEx)

Friday, June 8, 2018, 1 - 4 p.m.

This course will guide providers through the process of submitting all types of provider applications found on the NCTracks Provider Portal. This course will also detail what to expect once applications have been submitted.

At the end of this training, providers will be able to:

- Understand the Provider Enrollment Application processes
- Navigate to the NCTracks Provider Portal and complete the following Provider Enrollment Application processes:
  - Provider Enrollment
  - Manage Change Request (MCR)
  - Re-Enrollment
  - Re-verification, and,
  - Maintain Eligibility
- Track and submit applications using the Status and Management page

2018 Annual NCTracks Regional Seminar – Raleigh, NC

Thursday, June 14, 2018, 9 a.m. – noon

At the end of the seminar, providers will be able to:

- Identify common reasons why Enrollment and Manage Change Request (MCR) applications are delayed and how to avoid delays
- Helpful hints for submitting Prior Approvals
- The top 10 denial reasons for Professional and Institutional claims and the resolutions
- Information on submitting Pharmacy Prior Approvals
- Expectations when contacting the NCTracks Contact Center, and,
- Helpful hints for Family Planning.

2018 Annual Provider Help Center – Raleigh, NC

Thursday, June 14, 2018, 1- 3:30 p.m.

Providers can bring individual claim, enrollment and other issues directly to NCTracks team members for assistance resolving those issues. Registration required.

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

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

Note: This article was originally published as a Special Bulletin in January 2018, with updates regarding clinical pharmacist practitioners.

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 through Aug. 31, 2018**.

Clinical Pharmacist Practitioners (CPPs)

Effective July 30, 2018, Clinical pharmacist practitioners (CPPs) may enroll in Medicaid through NCTracks. The CPP taxonomy code 1835P0018X will be added to allow in-state, border, and out-of-state individual Medicaid/Health Choice providers to enroll. CPPs will be authorized to act as an ordering, prescribing, referring (OPR) and/or rendering provider working under the direction or supervision of a licensed physician. **Therefore, CPPs should complete the individual application (full enrollment) to bill for services rendered instead of the OPR Lite abbreviated application.**

Required licensure and certification for the CPP taxonomy includes:

- Full and unrestricted license to practice as a pharmacist in North Carolina or the state in which the provider resides
- Full and unrestricted certificate to practice as a CPP in North Carolina

Out-of-state providers must be certified to practice as a CPP according to the rules of the state in which they practice.

Residents and Interns

Residents and interns licensed through the NC Medical Board and NC Dental Board with a resident in training license (RTL) may enroll as 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.

General Guidelines

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
- Revalidation 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

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 Sec. 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 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 will also 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 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.

Provider Services
DMA, 919-855-4050

Attention: All Providers

Submit Fingerprinting Criminal Background Check and Related Information by Deadline to Prevent Termination

Providers must submit a Fingerprinting Criminal Background Check (FCBC) application **within 30 days of receiving the request notification** to avoid being terminated for cause. After submission of the FCBC application, providers will receive a letter with instructions to complete the fingerprinting process and the Electronic Fingerprint Submission Release of Information (EFSRI) form. If the EFSRI form is not uploaded to the NCTracks provider record **within 30 days**, the provider will be terminated for cause.

More information on the fingerprinting application process, including additional resources, frequently asked questions (FAQs) and locations for fingerprinting services, can be found in the NCTracks Fingerprinting Application Required Job Aid.

Provider Services
DMA, 919-855-4050

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) does not contain errors, it will process more quickly. The NCTracks Enrollment Team identified commons 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.

CSRA, 1-800-688-6696

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 in 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 was 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 50 days, 20 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 following 50 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 an 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 and 14, and the final reminder seven days 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 taxonomy code(s) in which the expired item is required 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 (email).

Provider Services
DMA, 919-855-4050

Attention: All Providers

Provider Risk Level Adjustment

Note: This article was originally published in the May 2018 Medicaid Bulletin.

Federal regulation 42 CFR 455.450 requires a state Medicaid agency to screen all initial provider applications based on a categorical risk level of "limited," "moderate," or "high." This includes applications for new practice locations and any applications received in response to a re-enrollment or re-validation of enrollment request.

Providers are categorized by risk level as outlined in NC General Statute Sec. 108-C3.

Note: The NCTracks Provider Permission Matrix provides a full list of provider types and their assigned risk levels for both enrollment and revalidation.

Further, 42 CFR 455.450(e) mandates that state Medicaid agencies adjust the categorical risk level of providers. Per NC General Statute Sec. 108-C3(g) - The N.C. Department of Health and Human Services (the "Department") must adjust the categorical risk level to "high" for providers who:

- Received a payment suspension based upon a credible allegation of fraud in accordance with 42 CFR 455.23 within the previous 12-month period. The Department shall return the provider to its original risk category no later than 12 months after the cessation of the payment suspension.

- Were excluded, or whose owners, operators, or managing employees were excluded, by the U.S. Department of Health and Human Services Office of Inspector General, the Medicare program, or another state's Medicaid or Children's Health Insurance Program within the previous 10 years.

- Incurred a Medicaid or Health Choice final overpayment, assessment, or fine from the Department more than 20 percent of the provider's payments received from Medicaid and Health Choice in the previous 12-month period. The Department shall return the provider to its original risk category not later than 12 months after the completion of the provider's repayment of the final overpayment, assessment, or fine. [NC General Statute 108-C3(g)(11)]

- Were convicted of a disqualifying offense pursuant to G.S. 108C-4, including by owners, operators, or managing employees, but were granted an exemption by the Department within the previous 10 years.

In these instances, the provider will be notified by the Department and the new risk level will apply to processing enrollment-related transactions. This may include payment of applicable application fees, submission of fingerprints and onsite visits.

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

Provider Services
DMA, 919-855-4050

Attention: Adult Care Homes and Nursing Facilities

Pre-Admission Screening and Resident Review (PASRR) Program Update

Beginning Sept.1, 2018, adult care home and nursing home Pre-Admission Screening and Resident Review (PASRR) submissions through Provider Link will no longer be accepted. PASRR submissions will only be accepted via NC Medicaid Uniform Screening Tool (NC MUST). Identify members of your staff who will be submitting PASRR information to the NC MUST application and arrange for them to acquire a North Carolina Identity Management Service NCID.

Once NCIDs are in place, contact DXC Technology at 1-855-883-8018 to secure access to the NC MUST application.

Visit the NC Department of Information Technology NICD Frequently Asked Questions (FAQ) web page for more information about NCID.

Visit the NC Must website for more information about NC Must.

Those with questions regarding the PASRR program may contact the DMA Clinical Policy Long Term Services and Supports Section at 919-855-4364.

Long-Term Services and Supports
DMA, 919-855-4364

Attention: Behavioral Health Providers

Behavioral Health Providers Needing Reverification

Effective July 1, 2018, North Carolina Medicaid and NC Health Choice (NCHC) behavioral health providers who were added to NCTracks via the Local Management Entity/Managed Care Organization (LME/MCO) Provider Upload process must complete reverification. Medicaid identified 474 behavioral health providers as needing to complete reverification. Providers identified are being notified of their reverification due date via NC Tracks communication to the Office Administrator (OA) on record.

Providers who do not respond by the July 1, 2018 reverification due date will be subject to claims payment suspension. Providers must submit either a reverification application or a full Managed Change Request (MCR) to NCTracks for a claims payment suspension to be removed.

Note: A list of providers scheduled for reverification is available on Medicaid's provider enrollment web page under the "Re-credentialing" header.

Pursuant to 42 CFR 438.608 (b), *Provider screening and enrollment requirements*, the state, through its contracts with a Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP), Prepaid Ambulatory Health Plan (PAHP), Primary Care Case Management (PCCM), or PCCM entity must ensure that all network providers are enrolled with the State as Medicaid providers, consistent with the disclosure, screening and enrollment requirements of 42 CFR 455, subparts B and subpart E.

Reverification of Behavioral Health providers in NCTracks will generate the following requirements:

1. A state-mandated application fee of $100. Additionally, the Federal Application fee of $569 may be charged to moderate or high-risk provider as defined in N.C. General Statute 108C-3, and the Provider Permission Matrix.

2. Medicaid providers in moderate-and high -risk categories as defined by N.C. General Statute 108C-3 are subject to site visits and required by 42 CFR 455 Subpart B. The site visits will be conducted by Public Consulting Group (PCG).

3. Fingerprint-based background checks for all high-categorical risk providers and any person with a 5 percent or more direct or indirect ownership interest in the provider as a condition of enrollment in the NC Medicaid Program, Federal Regulation 42 CFR 455.434 and 42 CFR 455.450 (c).

For more information on the Fingerprint process, refer to the articles titled, *Fingerprinting Process for Providers* or *Submit Fingerprinting Criminal Background Check and Related Information by Deadline to Prevent Termination* in this Medicaid Bulletin, or the Frequently Asked Questions (FAQs) posted on NCTracks.

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.

Providers with questions about this article can submit them to Medicaid.BehavioralHealth@dhhs.nc.gov.

Provider Services
DMA, 919-855-4050

Attention: Nurse Practitioners and Physician Assistants

Billing Code Update for Nurse Practitioners and Physician Assistants

The procedure code list for nurse practitioners (NPs) and physician assistants (PAs) has been updated recently to include additional NP and PA taxonomies. The newly added codes are:

11306 (B)	11311 (B)	27093	27093 (B)
36598	36598 (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

Ibalizumab-uiyk injection, for intravenous use (Trogarzo) HCPCS code J3590: Billing Guidelines

Effective with date of service April 1, 2018, the North Carolina Medicaid and N.C. Health Choice (NCHC) programs cover ibalizumab-uiyk injection, for intravenous use (Trogarzo) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3590 - Unclassified biologics.

Trogarzo is available as an injection of 200 mg/1.33 mL (150 mg/mL) in a single-dose vial. Its FDA approved indication includes the use, in combination with other antiretrovirals, for the treatment of human immunodeficiency virus type 1 (HIV-1) infection in heavily treatment-experienced adults with multidrug resistant HIV-1 infection failing their current antiretroviral regimen. The recommended dose is a single-loading dose intravenously of 2,000 mg followed by a maintenance dose of 800 mg every two weeks. See full prescribing information for further detail.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis code required for billing is B20 - Human immunodeficiency virus (HIV) disease.
- Providers must bill with HCPCS code J3590 - Unclassified biologics.
- One Medicaid and NCHC unit of coverage is 1 mg.
- The maximum reimbursement rate per unit is $6.129.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NCD is 62064-0122-02.
- 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 the North Carolina Medicaid 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 Physician's Drug Program is available on Medicaid's PDP web page.

CSRA 1-800-688-6696

Proposed Clinical Coverage Policies

Per NCGS Section108A-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 June 1, 2018, the following policies are open for public comment:

Proposed Policy	Date Posted	Comment Period End Date
PA Criteria Spinraza (Termination)	05/14/18	06/28/18
PA Criteria Movement Disorders	05/14/18	06/28/18
8A-3, Mobile Crisis Management	05/03/18	06/17/18
8A-4, Psychiatric Rehabilitation (Psychosocial Rehabilitation)	05/03/18	06/17/18

Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date*	Checkwrite Date	EFT Effective Date
June 2018	06/01/18	06/05/18	06/06/18
	06/08/18	06/12/18	06/13/18
	06/15/18	06/19/18	06/20/18
July 2018	06/28/18	07/03/18	07/05/18
	07/05/18	07/10/18	07/11/18
	07/12/18	07/17/18	07/18/18
	07/19/18	07/24/18	07/25/18
	07/26/18	07/31/18	08/01/18

* Batch cutoff date is previous day

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

Paul Guthery
Executive Account Director
CSRA