



NC Medicaid Bulletin May 2018

All Providers

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Attention: All Providers**NC Medicaid Electronic Health Record Incentive Program
Announcement****Program Year 2017 and 2018 Updates**

The NC Medicaid Electronic Health Record (EHR) Incentive 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 may take up to 20 weeks to be processed from the date the signed attestation was received.

Providers may check the status of their attestation on the Status Page of the NC Medicaid EHR Incentive Payment System ([NC-MIPS](#)).

Updates for Program Year 2018

[NC-MIPS](#) is currently accepting Program Year 2018 Modified Stage 2 and Stage 3 Meaningful Use (MU) attestations.

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 impacts the following for the NC Medicaid EHR Incentive Program 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 Clinical Quality Measures (CQMs) from a list of 53.
- Providers may continue using a 90-day EHR reporting period (our MU objective reporting period).
- In Program Year 2018, providers who have met MU in a previous program year will be required to report a full calendar year CQM reporting period.

Because the CQM reporting period must be a full calendar year, this means EPs will not be able to submit CQM data in NC-MIPS until Jan. 1, 2019.

To accommodate providers who would like early review of requirements, excluding CQMs, the NC Medicaid EHR Incentive Program is allowing providers 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 the following information: demographic, license, patient volume, and MU objective data. Providers 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, we will conduct validations. If there are discrepancies, we will conduct outreach, giving providers ample time to address any issues.

After we validate Part 1 of the attestation, providers 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 then email the signed attestation packet and CQM report from the provider'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 providers to complete their attestation in a 12-month window instead of four.

Visit the [N.C. Medicaid EHR Incentive 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](#).

- 1A-4, *Cochlear and Auditory Brainstem Implants*
- 1C-1, *Podiatry Services*
- 1K-1, *Breast Imaging*
- 1T-1, *General Ophthalmological Services*

These policies supersede previously published policies and procedures.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers**Provider Risk Level Adjustment**

[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.

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: All Providers

Billing for Percutaneous Repair of Pelvic Ring Fractures

The NC Division of Medical Assistance (DMA) currently recognizes CPT Code 27216 (Percutaneous skeletal fixation of posterior pelvic bone fracture and/or dislocation, for fracture patterns that disrupt the pelvic ring, unilateral). **As of June 1, 2018**, North Carolina Medicaid will no longer recognize CPT **27216** and will require claims to be submitted with HCPCS Code **G0413** (percutaneous skeletal fixation of posterior pelvic bone fracture and/or dislocation, for fracture patterns that disrupt the pelvic ring, unilateral or bilateral) for dates of service on or after June 1, 2018.

Parenthetic notes in the annual Current Procedural Terminology (CPT) manual instruct providers to bill with modifier 50 to report a bilateral procedure. North Carolina Medicaid obtains rates and modifier information from the Centers for Medicare & Medicaid Services (CMS) Relative Value Unit (RVU) file and fee schedule. Since Medicare does not recognize code 27216, North Carolina Medicaid is unable to append modifier 50 to this procedure code. This change will allow North Carolina Medicaid to align with Medicare and allow accurate reporting and reimbursement for services rendered.

Clinical Policy and Programs
DMA, 919-855-4320

Attention: All Providers**Update to the 340B Claim Modifier**

In response to provider comments and questions regarding the [December 2017 Special Bulletin](#), *Billing Guidance: 340B Modifiers*, North Carolina Medicaid is publishing updated information regarding the use of the JG, TB and UD modifiers which are required to identify 340B drug claims.

Medicaid is now accepting Medicare crossover claims with the JG and TB modifiers. As these modifiers are not set to report or process drug rebates in NCTracks currently, providers will need to submit 340B claims with a modifier combination of JG **and** UD for dual eligible beneficiaries. Refer to the Centers for Medicaid & Medicaid Services (CMS) [January 2018 Update of the Hospital Outpatient Prospective Payment System \(OPPS\)](#) regarding the proper use of modifiers JG and TB.

Providers will continue to submit 340B drug claims with only the UD modifier when Medicaid is the primary payer. This is not a change from our current billing requirements.

Using the instructions above, providers may resubmit any 340B claims that denied for 'invalid modifier' for dates of service on or after Jan. 1, 2018, when the original claim was submitted with a JG or TB modifier.

Clinical Policy and Programs
DMA, 919-855-4320

Attention: All Providers**Columbus County Transition Effective July 2018**

The Secretary of the N.C. Department of Health and Human Services (DHHS) has approved the disengagement of Columbus County from the Eastpointe Local Management Entity – Managed Care Organization (LME-MCO) and their realignment with Trillium Health Resources LME-MCO.

Effective July 1, 2018, Trillium Health Resources will be the LME-MCO responsible for enrollees who are residents of Columbus County. Any provider delivering Medicaid behavioral health services to a Columbus County enrollee after July 1, 2018, must be contracted with Trillium Health Resources. This only applies to mental health, substance abuse and intellectual/developmental disability services for Medicaid beneficiaries ages 3 and older.

Providers can reach Trillium Health Resources at 1-866-998-2597.

Behavioral Health Section
DMA, 919-855-4290

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

Registration is open for several instructor-led training courses for providers that will be held in May 2018. Slots are limited.

WebEx courses can be attended remotely from any location with a telephone, computer and internet connection.

On-site courses are offered at the CSRA facility at 2610 Wycliff Road in Raleigh.

How to Update Your Credentials (WebEx)

May 8, 2018, 1 to 3 p.m.

Some taxonomy codes require the provider to be licensed, accredited or certified according to the specific laws and regulations that apply to their service type. This course will provide instructions for adding and updating licensing or certifications to a provider record in NCTracks.

Dental Helpful Hints (WebEx)

Providers can select either of these two classes, as the same information will be presented in both.

- May 16, 2018, 1 to 3 p.m.
- May 29, 2018, 1 to 3 p.m.

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

- Three methods for prior approval submission
- How to upload documents when submitting or amending prior approval requests via NCTracks
- Common errors when completing American Dental Association forms and submitting claims
- Common errors that require additional information after prior approval requests have been submitted

2018 Annual Regional NCTracks Seminar – Concord, NC

May 25, 2018, 9 a.m. to noon

Annual seminars run from 9 a.m. to 4 p.m. at different dates and locations across the state (see the [announcement](#) listing the other dates and times).

This seminar will provide information on comment reasons enrollment and Manage Change Request (MCR) applications are delayed and how to avoid those delays; helpful hints for submitting prior approval requests, the top 10 reasons for denial of professional and institutional claims and their resolutions, submitting pharmacy prior approval requests, expectations when

contracting the NCTracks Contact Center and understanding the Medicaid family planning program.

2018 Annual Provider Help Center – Concord, NC

May 25, 2018, 1 to 3:30 p.m.

Providers can bring individual claim, enrollment and other issues directly to an NCTracks team member for assistance resolving those issues.

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

Coverage for Digital Breast Tomosynthesis

Effective May 1, 2018, North Carolina Medicaid will cover digital breast tomosynthesis (3D tomosynthesis) for both screening and diagnostic mammography. Providers must submit claims with Healthcare Common Procedure Coding System (HCPCS) code **G0279** (Diagnostic digital breast tomosynthesis, unilateral or bilateral) in addition to screening or diagnostic mammography Common Procedural Terminology (CPT) codes **77065-77067**.

Clinical coverage policy 1K-1, *Breast Imaging*, is in the process of being updated to reflect the new coverage.

Clinical Policy and Programs

DMA, 919-855-4320

Attention: All Providers**Update: Pharmacy Behavioral Health Clinical Edits**

Note: This article was originally published in [February 2017 Medicaid Bulletin](#).

Effective May 1, 2017, new pharmacy point of sale (POS) clinical edits for behavioral health medications were applied for pediatric and adult beneficiaries. These changes were communicated in the April and June 2017 [Pharmacy Newsletters](#) and the July 2017 [Medicaid Bulletin](#).

The edits are specifically related to dosage and quantity prescribed which exceed the Food and Drug Administration (FDA) approved maximum dosage, dosage schedule and in-class therapeutic duplication.

A phased implementation was planned for the POS behavioral health clinical edits:

- July 2017: The first two edits were implemented. These edits applied to the dosage and quantity of atypical antipsychotics prescribed for pediatric and adult beneficiaries.
- March 12, 2018: Edits were implemented which apply to the therapeutic duplication of atypical antipsychotics in pediatric and adult beneficiaries.
- May 14, 2018: Remaining edits will be implemented. These edits will apply to dosage and quantity prescribed and therapeutic duplication of Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD) drugs, anxiolytics and antidepressants prescribed to pediatric and adult beneficiaries.

Bypassing any of the POS behavioral health clinical edits requires an override that should be used by the pharmacist when the prescriber provides clinical rationale for the therapy issue identified by the edit. The edit override is “10” entered in a submission clarification code field.

The bulleted description for the pediatric and adult behavioral health edits follow.

Phase One Implemented July 30, 2017

Edit 4110 Adult; Edit 7110 Pediatric

- Quantities more than the daily dosages recommended by the FDA for the atypical antipsychotics

Pharmacy POS message “Quantity exceeds the adult (pediatric) dosage recommended by the FDA for atypical antipsychotics.”

Phase Two Implementation March 12, 2018

Edit 58610 Adult; Edit 58650 Pediatric

- Concomitant use of three or more atypical antipsychotics (concomitant use is 60 or more days of overlapping therapy.)

Pharmacy POS message “Concomitant use of three or more atypical antipsychotics will be denied.”

Phase Three Implementation May 14, 2018

Edit 4125 Adult; Edit 7125 Pediatric

- Quantities more than the daily dosages recommended by the FDA for the antidepressants

Pharmacy POS message “Quantity exceeds the adult (pediatric) dosage recommended by the FDA for antidepressants.”

Edit 4140 Adult; Edit 7140 Pediatric

- Quantities more than the daily dosages recommended by the FDA for ADD/ADHD medications

Pharmacy POS message “Quantity exceeds the adult (pediatric) dosage recommended by the FDA for ADD/ADHD medications.”

Edit 4610 Adult; Edit 7610 Pediatric

- Quantities more than the daily dosages recommended by the FDA for the behavioral health medications (does not include antidepressants, atypical antipsychotics, stimulants and ADD/ADHD medications)

Pharmacy POS message “Quantity exceeds the adult (pediatric) dosage recommended by the FDA for behavioral health meds.”

Note: For the following edits, concomitant use is 60 or more days of overlapping therapy.

Edit 58620 Adult; Edit 58660 Pediatric

- Concomitant use of two or more antidepressants (Selective serotonin reuptake inhibitor - SSRIs includes combination products)

Pharmacy POS message “Concomitant use of two or more antidepressants will be denied.”

Edit 58630 Adult; Edit 58670 Pediatric

- Concomitant use of two or more antidepressants (Serotonin–norepinephrine reuptake inhibitor - SNRIs)

Pharmacy POS message “Concomitant use of two or more antidepressants will be denied.”

Edit 58640 Adult; Edit 58680 Pediatric

- Concomitant use of two or more anxiolytics

Pharmacy POS message “Concomitant use of two or more anxiolytics will be denied.”

The edits, with appendices of the drugs included in the edit, are posted on the [NCTracks Prior Approval Drugs and Criteria web page](#).

Outpatient Pharmacy Services
DMA, 919-855-4300

Attention: All Providers

Update to Clinical Coverage Policy 1C-1 Podiatry Services

Effective May 1, 2018, Clinical Coverage Policy (CCP) 1C-1, *Podiatry Services*, is revised to include annual updates to International Classification of Diseases (ICD-10-CM) codes. End dated ICD-10-CM codes are deleted. When appropriate the new seventh character is added so that the provider can bill to the highest level of specificity. In addition, codes that are not specific to the ankle and/or foot are removed.

For more information, providers should refer to CCP 1C-1, *Podiatry Services*, on Medicaid’s [podiatry CCP web page](#).

Practitioners, Facilities and Policy Development
DMA, 919-855-4260

Attention: All Providers**Billing Specific ICD-10-CM Diagnosis and Procedure Codes**

The implementation of ICD-10-CM allows specificity for accurate coding, resulting in greater justification of medical necessity. A provider's documentation must include details to completely depict the nature of a beneficiary's diagnosis and procedures performed. Comprehensive documentation ensures that the encounter can be coded to the highest level of certainty known and allows for proper claim reimbursement.

For codes which provide detailed specificity of anatomical laterality, the use of unspecified codes is not justified. The ICD-10-CM diagnosis code H02539 – eyelid retraction unspecified eye, unspecified lid is **not** acceptable because in the medical record **the provider should be able to identify** the specific eye and eyelid. ICD-10-CM diagnosis code H02531 – eyelid retraction right upper eyelid indicates laterality, is specific and has a higher level of certainty.

For further information, refer to the *2018 ICD-10-CM Professional for Physicians, ICD-10-CM Official Guidelines for Coding and Reporting 2018* and the Centers for Medicare & Medicaid Services (CMS) [ICD-10-CM/PCS Frequently Asked Questions](#) website.

Providers with questions can contact the CSRA Call Center at 1-800-688-6696 or NCTracksprovider@nctracks.com.

Clinical Policy and Programs
DMA, 919-855-4320

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 through 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
- 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**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 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 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**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.

CSRA, 1-800-688-6696

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 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.

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, 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 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**NC HealthConnex, State Designated Health Information Exchange, Connection Required by June 1, 2018, for Medicaid Hospitals, Physicians and Mid-Level Practitioners; Extension Process Available**

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 Medicaid and NCHC services. All other Medicaid and state-funded providers must be connected by June 1, 2019, 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.

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 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.

The NC Health Information Exchange Authority (HIEA), the N.C. Department of Information Technology agency that manages NC HealthConnex, hosts "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 [Participation Agreement](#) that governs the data connection. In the meantime, providers can learn more at nchealthconnex.gov/how-connect.

To register for the next webinar at noon on Monday, May 28, 2018, and to learn more about **NC HealthConnex**, visit nchealthconnex.gov.

Alternatively, the NC Health Information Exchange Authority (NC HIEA), in collaboration with the N.C. Department of Health and Human Services, 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. Sign an NC HIEA [Participation Agreement](#); and
2. 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.

Note: This 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.

More than 1,100 facilities are currently live on NC HealthConnex with another 2,800 in onboarding. For a list of who is connected, visit nchealthconnex.gov.
Providers with questions can contact the NC HIEA staff at 919-754-6912 or hiea@nc.gov.

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

Attention: Behavioral Health Providers**M**edicaid Behavioral Health Provider Enrollment

By July 1, 2018, Medicaid behavioral health providers added to NCTracks by their current Local Management Entity/Managed Care Organization (LME/MCO) Provider Upload Process must complete re-verification. On March 1, 2018, NCTracks sent letters to Behavioral Health providers due for reverification. Providers who did not respond by the reverification due date of April 16, 2018, had payment suspended. Providers must submit either a reverification application or a full Managed Change Request to NCTracks for the payment suspension to be lifted.

Per [42 CFR 438.608 \(b\)](#), Provider Screening and Enrollment Requirements, the state, through its contracts with Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), or Primary Care Case Management (PCCM) entities 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](#), subpart B and subpart E.

Reverification of 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 Sec.108C-3](#), and the [Provider Permission Matrix](#).
2. Medicaid providers in moderate- and high-risk categories as defined by N.C. General Statute Sec.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 of direct or indirect ownership interest in the provider as a condition of enrollment in the North Carolina Medicaid Program, [42 CFR 455.434](#) and [42 CFR 455.450 \(c\)](#).

Providers who fail to comply with the fingerprinting requirement are subject to a “for cause” denial or termination. A “for cause” action is one related to program compliance, fraud, integrity, or quality. North Carolina Medicaid is required to report providers terminated or denied for cause to CMS.

Providers who have already undergone fingerprint-based criminal background checks for Medicare or another state’s Medicaid or CHIP program are not required to submit new ones.

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

Provider Services
DMA, 919-855-4050

Attention: Durable Medical Equipment Providers**Metabolic Formula Rate Changes Pending Approval from The Center for Medicare & Medicaid Services**

The Department of Health and Human Services, Division of Medical Assistance (DMA), hereby provides notice of its intent to amend the Medicaid State Plan to increase the rates for metabolic formula – Durable Medical Equipment (DME).

If approved by the Centers for Medicare & Medicaid Services (CMS), this amendment will be effective April 3, 2018.

The annual estimated state fiscal impact of this change is:

- a. State Fiscal Year 2019 \$604,764
- b. State Fiscal Year 2020 \$604,764

State fiscal years run from July 1 to June 30.

A copy of the proposed public notice may be viewed at any county Department of Social Services or on the DMA [Medicaid State Plan Public Notices](#) web page under heading, “Proposed Public Notices for State Plan.”

Questions, comments and requests for copies of the proposed State Plan amendment should be directed to DMA at:

Dave Richard
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501

Provider Reimbursement
DMA, 919-814-0060

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 May 1, 2018, the following policies are open for public comment:

Proposed Policy	Date Posted	Comment Period End Date
Preferred Drug List Corticosteroids	04/02/2018	05/17/2018
PA Criteria PCSK9 Inhibitors	04/02/2018	05/17/2018
PA Criteria Oral Inhaled Steroids	04/02/2018	05/17/2018
PA Criteria Opioid Dependence Therapy Agents	04/02/2018	05/17/2018
PA Criteria Opioid Analgesics	04/02/2018	05/17/2018
PA Criteria Monoclonal Antibody	04/02/2018	05/17/2018
PA Criteria Systemic Immunomodulators	04/02/2018	05/17/2018
PA Criteria Cystic Fibrosis	04/02/2018	05/17/2018
11A-15. Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood	03/27/2019	05/11/2018

Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date*	Checkwrite Date	EFT Effective Date
May 2018	04/27/18	05/01/18	05/02/18
	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
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

* 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