



N.C. Medicaid Bulletin

September 2017

All Providers

NC Medicaid Electronic Health Record Incentive Program Announcement	2
NCTracks Provider Training Available in September 2017	3
Medicaid Required Enrollment Fees	6
Incomplete Manage Change Requests and Enrollment Applications	7
Visual Evoked Potential	8
Claims Pended for Incorrect Billing Location	9
New Opioid Educational Resources for Providers	10
The Office of the State Auditor: Single Audit – 2017	11
Abbreviated Application for Ordering, Prescribing and Referring Practitioners	12
Out of State Provider Enrollment	13
Re-credentialing Due Dates for Calendar Year 2017	14
Clinical Coverage Policies	15
Request for Disproportionate Share Hospital Data for MEDICARE:	
Change in Process-Update	16
Maintain Eligibility Process	17

Community Alternatives Program for Children

Consumer Direction under the Community Alternatives Program For Children and Disabled Adults (CAP/C and CAP/DA)	18
Community Alternatives Program for Disabled Adults Waiver Renewal Application	20

Community Alternatives Program for Disabled Adults

Community Alternatives Program for Disabled Adults Waiver Renewal Application	20
---	----

Durable Medical Equipment and Orthotics/Prosthetics Providers

Home Health Final Rule – Face-to-Face Encounter Guidance	21
--	----

Family Practice, Gynecologists, Internal Medicine, Obstetricians, Pediatricians, Urgent Care Providers

North Carolina Health Information Exchange Authority Hosts Monthly “How to Connect Webinars” Starting Sept. 25, 2017	24
--	----

Hospitals

Medicaid Integrity Contractor Audits Inpatient Short-Stays	25
--	----

Nurse Practitioners and Physician Assistants

Billing Code Update for Nurse Practitioners and Physician Assistants	26
--	----

Proposed Clinical Coverage Policies	29
---	----

**Providers are responsible for informing their billing agency of information in this bulletin.
CPT codes, descriptors and other data only are copyright 2016 American Medical Association.
All rights reserved. Applicable FARS/DFARS apply.**

Attention: All Providers**NC Medicaid Electronic Health Record Incentive Program
Announcement****Program Year 2017 Attestations**

Eligible providers are encouraged to submit their Program Year 2017 attestations on the North Carolina Medicaid Incentive Payment System (NC-MIPS) now. Submitting an attestation early affords the provider and the state's validation team time to identify and resolve discrepancies.

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 the Centers for Medicare and Medicaid Services (CMS) Specification Sheets. [Click here](#) for CMS' Modified Stage 2 MU Specification Sheets. [Click here](#) for CMS' Stage 3 MU Specification Sheets.

There are step-by-step attestation guides for each field when attesting to Modified Stage 2 and Stage 3 MU in NC-MIPS. These guides can be found on the right-hand side of NC-MIPS and should be used each year a provider attests.

As a reminder, if providers were 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. For more information, visit the [N.C. Medicaid EHR Incentive Program web page](#).

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

Attention: All Providers**NCTracks Provider Training Available in September 2017**

Registration is open for several instructor-led training courses for providers that will be held in September 2017. The duration varies depending on the course.

WebEx courses are limited to 115 participants. They can be attended remotely from any location with a telephone, computer and internet connection.

On-site courses include hands-on training and are limited to 45 participants. They are offered in-person at the CSRA facility at 2610 Wycliff Road in Raleigh.

Following are details on the courses, including dates, times and how to enroll.

Prior Approval - Medical (Professional) (On-Site)

- Friday, Sept. 15, 2017 - 9:30 a.m. to noon

This course will cover submitting prior approval (PA) requests to help ensure compliance with Medicaid clinical coverage policy and medical necessity. It also will cover PA inquiry to check on the status of a PA Request.

Submitting a Professional Claim (On-Site)

- Friday, Sept. 15, 2017 - 1 to 4 p.m.

This course will focus on how to submit a professional claim via the NCTracks Provider Portal. At the end of training, providers will be able to:

- Enter a professional claim
- Save a draft claim
- Use the Claims Draft Search tool
- Submit a claim
- View the results of a claim submission

Submitting Pharmacy Prior Approvals (WebEx)

- Friday, Sept. 22, 2017 - 9:30 a.m. to noon

This course will show participants how to submit and inquire about pharmacy Prior Approval (PA) requests on the NCTracks Provider Portal. It will also cover PA inquiry to check on the status of the pharmacy PA request.

How to Add or Update Credentials (WebEx)

- Wednesday, Sept. 13, 2017 – 1 to 3 p.m.

This course shows authorized users how to add or update credentials on a provider's record in NCTracks, including Accreditations, Certifications, and Licensure.

Submitting Institutional Prior Approvals (On-site)

- Wednesday, Sept. 20, 2017 – 9:30 a.m. to noon

This course will cover submitting Prior Approval (PA) requests with a focus on nursing facilities, to help ensure compliance with Medicaid clinical coverage policy and medical necessity. It also will cover PA inquiry to check on the status of a PA Request.

Submitting Institutional Claims (On-site)

- Wednesday, Sept. 20, 2017 – 1 to 4 p.m.

This course will focus on how to submit an institutional claim via the NCTracks Provider Portal with emphasis on long term care and secondary claims. At the end of training, providers will be able to:

- Enter an institutional claim
- Save a draft claim
- Use the Claims Draft Search tool
- Submit a claim
- View the results of a claim submission

Prior Approval - Dental and Orthodontic (WebEx)

- Tuesday, Sept. 26, 2017 - 9:30 a.m. to noon

This course will cover submitting Prior Approval (PA) Requests for Dental and Orthodontic procedures to help ensure compliance with Medicaid clinical coverage policy and medical necessity. It will also cover Prior Approval Inquiry to check on the status of the PA Request.

Submitting Dental and Orthodontic Claims (WebEx)

- Tuesday, Sept. 26, 2017 – 1 to 4 p.m.

This course will focus on how to submit dental and orthodontic claims via the NCTracks Provider Portal. At the end of training, providers will be able to:

- Enter dental and orthodontic claims
- Save a draft claim
- Use the Claims Draft Search tool
- Submit a claim
- View the results of a claim submission

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 regarding Java, which is required for the use of SkillPort.

CSRA, 1-800-688-6696

Attention: All Providers**M**edicaid Required Enrollment Fees

The N.C. Medicaid and N.C. Health Choice (NCHC) application fee is \$100, which covers costs associated with processing enrollment applications. The \$100 application fee is required for both in-state and border-area (within 40 miles) providers during initial enrollment, adding a new site location, re-enrollment, and when providers complete the five-year verification process.

Effective Oct. 29, 2017, out-of-state providers choosing the full enrollment option also will be subject to the \$100 application fee. Out-of-state providers selecting the lite enrollment option are not required to pay this state fee. (See bulletin article, [Out of State Enrollment](#), in this issue).

In addition, some providers are required to pay the Affordable Care Act (ACA) application fee. These providers are defined in federal regulation at [42 CFR 455.460](#), and in [N.C. General Statute 108C-3](#) (e) and (g) as moderate- or high-risk. The ACA application fee is \$560 for calendar year 2017, and may be adjusted annually. This fee covers the costs associated with provider screening during the enrollment process. The application fee will be collected during initial enrollment, adding a new site location, re-enrollment, and five-year reverification.

Note: Low-risk providers defined in N.C.G.S. 108C-3(c) are not subject to paying the ACA application fee. However, if the risk category changes to high- or moderate-risk, the provider will be subject to the fee.

Additional information about the ACA fee can be found on the NCTracks [FAQs for ACA Application Fee web page](#).

Provider Services
DMA, 919-855-4050

Attention: All Providers**Incomplete Manage Change Requests and Enrollment Applications**

The NCTracks Enrollment Team is receiving a significant number of incomplete Manage Change Requests (MCR) and enrollment applications from providers. Examples of common errors include:

- **Supporting documentation not attached** – If supporting documentation is required, it must be uploaded and attached prior to submission. Examples of supporting documentation are copies of the applicable consent order, certifications, or Medicare participation agreements. 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.
- **Incomplete Exclusion Sanction information** – The Exclusion Sanction questions must be answered, even if the provider has no legal or disciplinary actions. If the answer to the Exclusion Sanction questions is “yes,” then documentation regarding the disposition of the action must be attached to the application. For more information, refer to section 3.27 of Participant User Guide PRV111 Provider Web Portal Applications on the secure NCTracks provider portal.
- **Choosing the incorrect taxonomy code** – The taxonomy code selected when applying 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.

Errors like the ones cited above delay the review and approval process for applications. Expedited approval depends on submitting a complete and accurate request.

CSRA, 1-800-688-6696

Attention: All Providers**V**isual Evoked Potential

The N.C. Division of Medical Assistance (DMA) has revised Clinical Coverage Policy No: 1A-28 *Visual Evoked Potential (VEP)*. **Effective June 1, 2017**, optometrists may perform and interpret CPT code 95930 (visual evoked potential (VEP) testing central nervous system, checkerboard or flash). VEP is considered medically necessary to:

- Diagnose and monitor multiple sclerosis (acute or chronic phases) or other disease states by identifying conditions of the optic nerve, i.e. optic neuritis
- Localize the cause of a visual field defect not explained by lesions seen on Computerized Tomography (CT) or Magnetic Resonance Imaging (MRI), metabolic disorders, or infectious diseases; or,
- Evaluate signs and symptoms of visual loss in beneficiaries who are unable to communicate clearly

VEP is considered experimental and investigational for any other indications (See Subsection 4.2.1 of Clinical Coverage Policy 1A-28). This procedure is limited to one test per day.

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

Attention: All Providers**C**laims Pended for Incorrect Billing Location

When the billing provider address submitted on a claim does not match the service location(s) in the NCTracks provider's record, the claim will pend in NCTracks. Providers will receive a secure message in their NCTracks Message Center Inbox with a link to update the billing provider service location. This approach prevents a claim denial due to incorrect billing provider service location.

For additional information, providers can access the "How to Update a Claim in the Pend Status resulting from an Incorrect Billing Location," User Guide posted on the NCTracks provider portal located on the NCTrack's [Provider User Guides and Training page](#). There you will find guides to correct the:

- Location on the Pended Claim
- Source of the Incorrect Location; and,
- Location in NCTracks

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**New Opioid Educational Resources for Providers**

The N.C. Division of Medical Assistance (DMA) has published new information related to managing opioid usage by N.C. Medicaid and N.C. Health Choice (NCHC).

DMA realizes that upcoming changes in opioid criteria will impact prescribing behavior. Therefore, DMA has partnered with Community Care of North Carolina (CCNC) to communicate these changes and provide educational resources to N.C. providers. The new educational resources include:

- [Prior Approval Criteria for Opioid Analgesics](#)
- [Non-Opioid Alternatives](#)
- [DMA Opioid Safety – STOP Act Crosswalk](#)
- [FAQ on Naloxone Standing Order](#)
- [Provider Considerations for Tapering of Opioids](#)
- [NC DMA Preferred Drug List Opioid Daily MME](#)

Links to these opioid educational resources are on the NC DMA [Outpatient Pharmacy Services web page](#) and the NCTracks [Pharmacy Services web page](#).

For more information about the changes to opioid criteria, refer to the [August 2017 Medicaid Bulletin](#) and the [July 2017 Pharmacy Newsletter](#).

Outpatient Pharmacy Services
DMA, 919-855-4300

Attention: All Providers**The Office of the State Auditor: Single Audit – 2017**

Note: This article was previously published in the [August 2017 Medicaid Bulletin](#).

In accordance with [2 CFR part 200, subpart E](#), the N.C. Office of the State Auditor (OSA) annually selects a sample of N.C. Medicaid and N.C. Health Choice (NCHC) claims to determine the state's accuracy and error rate for claims paid in the prior state fiscal year (July through June). The Office of Compliance & Program Integrity (OCPI) is in the process of sending out record request notifications to providers with a claim in the sample. To minimize costs and prevent delays, OCPI may contact providers by phone to verify the mailing address for these record requests.

The record request contains a list of the documents that must be submitted to OCPI for review. The requested documents should be sent as soon as possible, but no later than 30 calendar days after receipt of the letter. OCPI is requesting providers with more than 25 pages of documentation scan the documents and send them on an **encrypted** CD or flash drive, with the **password submitted separately** via email to Medicaid.sa@dhhs.nc.gov.

During the record request process, OCPI may ask for additional documentation to support the claim payment. Failure of the provider to respond by the stated deadline to a request for documentation may result in the provider being placed on prepayment claims review.

[Section 7 of the NC DHHS Provider Administrative Participation Agreement](#), authorizes N.C. Medicaid to access patient records related to the administration of Medicaid, the Medicaid Waiver, and the N.C. Health Choice Program. In addition, when applying for Medicaid benefits, each recipient signs a release authorizing access to his or her Medicaid records by N.C. Medicaid and contracted covered entities and business associates as defined in the HIPAA Privacy Rule. Medicaid and NC Health Choice beneficiaries also receive a copy of the NC DHHS Notice of Privacy Practices. Therefore, it is not necessary for providers to require a signed consent for the release of records from any Medicaid beneficiary.

Providers with questions may contact the Office of Compliance and Program Integrity at the following email address Medicaid.sa@dhhs.nc.gov.

Office of Compliance & Program Integrity
DMA, 919-814-0172

Attention: All Providers**A**bbreviated Application for Ordering, Prescribing and Referring Practitioners

Note: This article was originally published in the [June 2017 Medicaid Bulletin](#). It is being republished until November 2017.

Effective Oct. 29, 2017, an abbreviated enrollment application will be available for **ordering, prescribing, and/or referring** (OPR) practitioners. As required by [42 CFR 455.410](#), physician and non-physician practitioners who solely order, refer, or prescribe items for NC Medicaid or NC Health Choice (NCHC) beneficiaries **must** enroll in the Medicaid program. OPR practitioners can request a retroactive effective date up to 365 days preceding the date of application.

Physician and non-physician practitioners may elect to enroll as OPR-only providers (OPR lite). Billing providers will use the NPI (National Provider Identifier) of the OPR lite provider on their claims when these providers order or refer items or services. NCTracks will not reimburse OPR lite providers when their NPI is used as rendering or attending on a claim.

The following enrollment requirements will apply to OPR lite providers:

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

Out-of-state and border providers are subject to the fingerprinting requirement. They may have the process completed in their home state and results stored in PECOS or verified through the state Medicaid agency. If the organization owner is out-of-state, that owner would be required to fingerprint in their home state and send the evidence to NC Medicaid.

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**O**ut of State Provider Enrollment

Note: This article was originally published in the [June 2017 Medicaid Bulletin](#). It is being republished until November 2017.

Effective Oct. 29, 2017, Out of State (OOS) providers who are seeking to enroll with N.C. Medicaid or the Children's Health Insurance Program (CHIP) – also known as N.C. Health Choice (NCHC) – will have the option to enroll using a full-enrollment application or a lite-enrollment application.

If an out of state provider chooses to enroll using the lite-enrollment application the following will apply:

- The provider will complete an abbreviated application
- Enrollment is limited to one year
- Credentialing and background checks will be required
- Fingerprint-based criminal background checks, if applicable
- There is no application fee for lite-enrollment

If an out of state provider chooses to enroll using the full-enrollment application the following will apply:

- The provider will complete a full-enrollment application
- The provider is required to complete re-verification every five years
- Credentialing and background checks will be required
- Fingerprint-based criminal background checks, if applicable
- The provider will be required to pay the \$100 N.C. application fee during enrollment and re-verification

Note: A provider has the option to change from lite enrollment to full enrollment by submitting a Manage Change Request (MCR). The provider will be required to pay the \$100 N.C. application fee.

Provider Services
DMA, 919-855-4050

Attention: All Providers**Re-credentialing Due Dates for Calendar Year 2017**

Note: This article is being republished monthly. It was originally published in the [December 2016 Medicaid Bulletin](#).

List of Providers Due for Re-credentialing

A list of providers scheduled for re-credentialing in calendar year 2017 is available on the [provider enrollment page](#) of the N.C. 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 spreadsheet, which includes National Provider Identifier (NPI) numbers and provider names, to compare with their provider list.

Providers will receive a notification letter 45 days before their re-credentialing due date. Providers are required to pay a \$100 application fee for re-credentialing/ re-verification. If the provider does not complete the process within the allotted 45 days, payment will be suspended until the process is completed. If the provider does not complete the re-credentialing process within 30 days from payment suspension and termination notice, participation in the N.C. Medicaid and Health Choice programs will be terminated. Providers must submit a reenrollment application to be reinstated.

Re-credentialing is not optional. It is crucial that all providers who receive a notice promptly respond and begin the process. Providers will receive a notification letter 45 days before their recredentialing due date. When it is necessary to submit a full Managed Change Request (MCR), the provider must submit the full MCR prior to the 45th day and the MCR application status must be in one of the following statuses to avoid payment suspension:

- In Review
- Returned
- Approved
- Payment Pending

Providers are required to complete the re-credentialing application after the full MCR is completed. Payment will be suspended if the provider does not complete the process by the due date. To lift payment suspension, the provider must submit a re-credentialing application or the full MCR (if required).

When the provider does not submit a re-verification application by the re-verification due date and the provider has an MCR application in which the status is “In Review, Returned, Approved or Payment Pending,” the provider’s due date resets to the current date plus 45 calendar days.

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.

Re-credentialing does not apply to time-limited enrolled providers, such as out-of-state providers. Out-of-state providers must complete the enrollment process every 365 days.

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.

Provider Services
DMA, 919-855-4050

Attention: All Providers

Clinical Coverage Policies

The following new or amended combined N.C. Medicaid and N.C. Health Choice clinical coverage policies are available on Medicaid's [Clinical Coverage Policies web page](#).

- 1A-30, *Spinal Surgeries*, Aug. 1, 2017
- 1A-41, *Office-Based Opioid Treatment: Use of Buprenorphine and Buprenorphine-Naloxone*, Aug. 1, 2017
- 1E-1, *Hysterectomy*, Sept. 1, 2017
- 1E-2, *Therapeutic and Non-therapeutic Abortions*, Aug. 2, 2017
- 1-I, *Dietary Evaluation and Counseling and Medical Lactation Services*, Aug. 3, 2017
- 1T-2, *Special Ophthalmological Services*, Aug. 1, 2017
- 3L, *State Plan Personal Care Services (PCS)* – Aug. 4, 2017
- 5A-1, *Physical Rehabilitation Equipment and Supplies*, Aug. 1, 2017
- 5A-2, *Respiratory Equipment and Supplies*, Aug. 1, 2017
- 5A-3, *Nursing Equipment and Supplies*, July 1, 2017
- 5B, *Orthotics & Prosthetics*, Aug. 1, 2017
- 8C, *Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers*, July 1, 2017

These policies supersede previously published policies and procedures.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers**R** **Request for Disproportionate Share Hospital Data for
MEDICARE: Change in Process-Update**

Note: This article was published with updates in the [June 2017 Medicaid Bulletin](#). It is being republished until September 2017.

Effective July 1, 2017, Medicaid and N.C. Health Choice Providers (NCHC) should obtain batch Medicare Disproportionate Share Hospital (DSH) Recipient Eligibility Verifications and Provider Statistical and Reimbursement (PS&R) reports through NCTracks. Hospitals or their designated representative should no longer manually submit Medicare DSH eligibility verification and claims data requests to the N.C. Medicaid program.

This change in process will enable the following:

PS&R Reports

Hospitals will receive PS&R data from NCTracks by submitting a CSRA PS&R Detailed Report Request Form located under the heading Provider Forms on the [Provider Policies, Manuals, Guidelines and Forms](#) web page of the NCTracks provider portal. The form includes information regarding the submission request, cost and delivery of the report.

Eligibility Verification

Hospitals will conduct recipient eligibility inquiry and response verifications from NCTracks through the X12 270/271 Transaction Method, at no cost.

X12 270 Transaction Method

Hospitals with a large volume of recipient eligibility inquiry verifications should submit batch uploads in the X12 270 transaction format. For information on how to format these files, refer to the 5010 ASC X12 TR3 national standard guidelines. Unique requirements for NCTracks can be found in the 270/271 Health Care Eligibility Benefit Inquiry and Response Companion Guide located on the [Trading Partner page](#) of the NCTracks provider portal.

Providers who submit X12 batch uploads are considered to be “trading partners” and are required to be authorized to submit electronic transactions in NCTracks. For more information on how to obtain authorization to submit electronic transactions, refer to the “How to Select a Billing Agent and Other Claim Submission Options in NCTracks” user guide under the heading Provider Record Maintenance on the [Provider User Guides and Training page](#) of the NCTracks provider portal. Additional information may be found in the NCTracks Trading Partner Connectivity Guide on the Trading Partner page.

Hospitals may also use a Clearinghouse or Billing Agent to submit the X12 270 transactions on their behalf.

Providers with questions can contact the NCTracks 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

Maintain Eligibility Process

Note: This article was originally published in the [June 2017 Medicaid Bulletin](#). It is being republished until November 2017.

Effective Oct. 29, 2017, NCTracks will implement a quarterly Maintain Eligibility Process which identifies providers with no claim activity within the past 12 months. NCTracks will notify the provider via the secure provider portal mailbox. The provider must attest electronically to remain active.

When a provider is identified with having no claims activity in 12 months, a Maintain Eligibility Due Date will be set. Providers will be notified 30 days before the due date that they must submit a Maintain Eligibility Application. Upon submission of the Maintain Eligibility Application, the provider's enrollment record will be updated with the current date.

If the provider does not submit the application by the due date, the provider's participation in the N.C. Medicaid and N.C. Health Choice (NCHC) programs **will be end dated**. This will prevent fraud, waste and abuse in the N.C. Medicaid and NCHC programs.

Provider Services
DMA, 919-855-4050

Attention: Community Alternatives Programs (CAP) Providers

Consumer Direction under the Community Alternatives Program For Children and Disabled Adults (CAP/C and CAP/DA)

The 1915(c) Home and Community-Based Services Waiver, Community Alternatives Program for Children and Disabled Adults (CAP/C and CAP/DA) allows statewide access to consumer-direction.

Consumer-direction (also called self-direction) is a service delivery model that allows a CAP/C or CAP/DA Medicaid beneficiary, or designated representative, to act in the role of employer of record to direct personal care needs by:

- Freely choosing who will provide care to meet medical and functional needs
- Independently recruiting, hiring, supervising, and firing (when necessary) an employee (personal assistant)
- Independently setting a pay rate for an employee (personal assistant), and,
- Assigning work tasks for the employee (personal assistant) based on the beneficiary's medical and functional needs

In-home aide and pediatric personal care services are consumer-directable for CAP/C or CAP/DA beneficiaries. State Plan Nursing is **not** a directable service under the CAP consumer-direction model of care.

Stakeholder engagement was initiated in April 2017 to design a statewide consumer-direction program for the Community Alternatives Programs. From that engagement, provisions to monitor health, safety, and well-being of beneficiaries, and requirements to determine readiness and eligibility to self-direct were identified and outlined in an updated [self-assessment questionnaire](#).

The newly updated self-assessment questionnaire replaces the self-assessment questionnaire that is included in Appendix G of the Clinical Coverage Policy 3K-1, [Community Alternatives Program for Children](#), and Appendix C of the Clinical Coverage Policy, 3K-2, [Community Alternatives Program for Disabled Adults](#).

Statewide trainings were conducted in the months of June and July 2017 for case management entities and CAP/C beneficiaries or designated family members to build competencies in consumer-direction. Required competencies include an understanding of:

- How consumer-direction works
- The roles and responsibilities of key players in consumer-direction, including:
 - Beneficiaries and designated representatives
 - Care advisors
 - Financial managers
 - Employees (personal assistants)

- Representatives
- N.C. Division of Medical Assistance (DMA)
- How to complete the self-assessment questionnaire and evaluate responses
- How to identify training needs for key players
- How to ensure the health, safety, and well-being of beneficiaries while self-directing care
- How to create an emergency and disaster plan to ensure health, safety and well-being of the beneficiary
- How to identify and evaluate the competencies of individuals being considered for hire
- How to create person-centered plans of care to meet needs while self-directing care
- How to report critical incidents and understand mandatory reporting requirements for beneficiary abuse, neglect, and exploitation
- How to recognize signs of fraud, waste, and abuse of public funds, and when and how to make a report
- How to negotiate a pay rate that is within the Medicaid maximum limits
- The Internal Revenue Services (IRS) requirements and Department of Labor (DOL) laws mandatory for consumer-direction.

An eligible CAP/C or CAP/DA beneficiary or designated representative interested in enrolling in the consumer-direction option must comply with the following requirements:

- Participate in consumer-direction training that includes a mandatory orientation session and subsequent trainings based on the self-assessment questionnaire
- Actively use services listed in the person-centered plan in the amount, frequency and duration indicated in the plan
- Actively participate in care needs by attending interdisciplinary team meetings and scheduled meeting with case managers
- Willingly sign the *Beneficiary Rights and Responsibilities* form, which outlines rights and responsibilities of participating in CAP/C while self-directing care
- Complete a self-assessment questionnaire to determine the beneficiary's willingness and ability to self-direct care and comply with DMA health, safety, and well-being recommendations
- Participate in necessary training opportunities to build competencies in consumer-directed care

Provider agencies interested in rendering services to a CAP beneficiary in consumer-direction shall include consumer-direction specific procedure codes on their Medicaid provider enrollment application and agreement.

**Long-Term Services and Supports Section CAP/C
DMA, 919-855-4360**

Attention: Community Alternatives Program for Disabled Adults Stakeholders

Community Alternatives Program for Disabled Adults Waiver Renewal Application

The § 1915 (c) Home and Community-Based Services Waiver for the Community Alternatives Program for Disabled Adults (CAP/DA) is scheduled to expire on Sept. 30, 2018. The N.C. Division of Medical Assistance (DMA) must submit a waiver renewal application to the Centers for Medicare and Medicaid Services (CMS) no later than June 1, 2018, 90 days prior to the expiration date, to ensure the continuation of the waiver. In addition to the waiver renewal application, the Clinical Coverage Policy, 3K-2, *Community Alternatives program for Disabled Adults (CAP/DA)*, will be revised to support the clinical operation of CAP/DA.

This notice is being provided to inform stakeholders about the expiration of the CAP/DA waiver and upcoming stakeholder engagement activities. The stakeholder engagement activities will include statewide listening sessions, focus groups, work sessions, surveys, public comments, and information sharing. Engagement will capture a wide range of stakeholder perspectives and experiences from across the state. A calendar of events will be posted to the DMA website as early as September 2017 to allow participation and seek feedback during these planned engagement activities.

**Long-Term Services and Supports Section, CAP/DA
DMA, 919-855-4360**

Attention: Durable Medical Equipment and Orthotics/Prosthetics Providers

Home Health Final Rule – Face-to-Face Encounter Guidance

As indicated in the [July 2017 Medicaid Bulletin](#), Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) policies [5A-1](#), [5A-2](#), [5A-3](#) and [5B](#) have been updated to comply with the Centers for Medicare & Medicaid Services (CMS) Home Health Final Rule, [42 CFR, Part 440.70](#). Below are responses to questions N.C. Medicaid received during the first month of implementation.

Q – Will the policy take effect for any Certificate of Medical Necessity/Prior Approval (CMN/PA) starting with the dates of service July 1, 2017?

A – The CMS statute requires the encounter note only with medical equipment, supplies and appliances that are **initiated** on or after July 1, 2017. Reauthorization requests for ongoing medical equipment, supplies and appliances do not require a face-to-face encounter note.

Q – Does the policy regarding face-to-face appointments apply to pediatrics?

A – It applies to all “medical equipment, supplies and appliances.” The CMS statute does not make any mention of the recipient’s age.

Q – Please clarify the term “start of services.” Does the term refer to the “from date” in the service information section of the CMN?

A – Yes, the term start of services is meant to refer to the requested “from” date indicated on the CMN/PA.

Q – If yes, is it correct to say that any CMN that has the “from date” of July 1, 2017 on, would require a face-to-face appointment?

A – The face-to-face encounter note is required for the initiation of medical equipment, supplies and appliances when the “from” date on the CMN/PA is on or after July 1, 2017, **and** the PA request is submitted to CSRA on or after July 1, 2017 (or kept on file if the codes do not require PA).

Q – Is the appointment for the exact need of a particular piece of equipment (e.g., stander, gait trainer, etc.) or for the diagnosis that causes the patient to need the equipment?

A – The statute requires the face-to-face encounter be “related to the primary reason the beneficiary requires medical equipment,” supplies or appliances. CMS guidance on this question is “...we are requiring an overall description of the linkage of the health status and the services ordered.” ([Federal Register, Vol. 81, No. 21](#), page 5562) To be consistent with this guidance, CSRA has been instructed to employ clinical judgement to find a connection between the note and the requested equipment, supply or appliance.

Q – The majority of our equipment falls in the purchase category. The comment on page 35 of the [July 2017 Medicaid Bulletin](#) is confusing. It states “The requirement for the ordering physician’s annual review of the beneficiary’s need for medical equipment and supplies can be met by the completion of a new CMN/PA form at least annually.” Does the sentence above indicate that if the doctor signs form DMA372-131-V1.0, that acts as the annual physical?

A – The annual review would only apply to ongoing supplies or equipment rentals, not one-off purchases that don’t repeat. In the case of ongoing supplies or equipment rentals, after the encounter for the initiation of services, if reauthorization is needed, since the CMN/PA is required at least annually, we believe the prescriber’s signature on the CMN/PA at least annually would meet the requirement for an annual review.

Q – If yes, why can’t the signed CMN for a particular piece of equipment act as the documentation on the face-to-face requirement?

A – It can, **only** if the signed CMN/PA form also includes documentation from the provider attesting that a qualified encounter occurred and the date of the encounter indicated is within six months of the requested “from” date.

Q – How does the new policy affect parts needed to repair and/or modify existing equipment?

A – CMS guidance on this question is “...an additional face-to-face requirement [encounter] would only be required if a new medical equipment, supply or appliance is needed. Renewals, repairs and the need for ancillary equipment would not trigger the need for an encounter.” ([Federal Register, Vol. 81, No. 21](#), page 5560)

Q – Is it sufficient for the provider to have documentation on file from the qualified practitioner (physician, PA, or NP) that a face-to-face encounter note exists rather than having a copy of the actual face-to-face note on file?

A – No, the actual note must be on file along with the signed CMN/PA and other supporting documentation. However, the encounter note does not have to be a visit note. It can be a hospital discharge summary, or a note from the prescriber describing an appropriately dated encounter where the primary reason the beneficiary required medical equipment, supplies or appliances was addressed.

Q – I continue to receive approvals from Medicaid. I have not received an additional information request yet wanting chart notes on the face-to-face appointment.

A – The policy is effective and being enforced with the **initiation** of medical equipment, supplies and appliances that begin on or after July 1, 2017. The CMS statute requires the encounter note only with the initiation of services, not with every PA request.

Additional Resources

For additional information, please link to the updated policies at [Durable Medical Equipment](#) and to the CMS final rule at [42 CFR Part 440](#).

DMA Clinical Policy and Programs
DMEPOS section, 919-855-4310

Attention: Family Practice, Gynecologists, Internal Medicine, Obstetricians, Pediatricians and Urgent Care Providers

North Carolina Health Information Exchange Authority Hosts Monthly “How to Connect Webinars” Starting Sept. 25, 2017

Per [Session Law \(S.L.\) 2015-241](#), as amended by [S.L. 2017-57](#), North Carolina providers who are reimbursed by the state for providing health care services under Medicaid and NC Health Choice programs must join NC HealthConnex, the state-designated Health Information Exchange. Connection deadlines are in 2018 or 2019, depending on the type of provider.

The NC Health Information Exchange Authority (HIEA), the N.C. Department of Information Technology agency that manages NC HealthConnex, will be hosting “How to Connect” webinars on the last Monday of each month at noon to educate providers affected by this law, describe the technical and onboarding requirements, and answer questions. In the meantime, providers can learn more at nchealthconnex.gov/how-connect.

To register for the next webinar at noon on Monday, Sept. 25, 2017, and to learn more about NC HealthConnex, visit nchealthconnex.gov.

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 3.7 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.

Providers with questions can contact the NC HIEA staff at 919-754-6912 or hiea@nc.gov.

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

Attention: Hospitals**M**edicaid Integrity Contractor Audits Inpatient Short-Stays

Health Integrity, LLC (HI), a Medicaid Integrity Contractor for the Centers for Medicare & Medicaid Services (CMS) – in partnership with the N.C. Division of Medical Assistance (DMA), Office of Compliance and Program Integrity – will be conducting audits of N.C. hospitals in the coming months. HI will review inpatient short-stays using statistical sampling to determine if services were paid for at the appropriate level of care, or if they could have been provided at the observation or outpatient levels.

These audits will be conducted in accordance with the procedures specified in appropriate state regulations, Government Auditing Standards issued by the U.S. Government Accountability Office, and other guidelines established by CMS and North Carolina. These audits may include a field component, wherein HI staff will acquire and begin review of medical record documentation at the hospital. This also will include discussion of internal control processes used by the facility during the period under review.

Upon completion of the review, and with N.C. Department of Health and Human Services (DHHS) permission, HI will extrapolate any findings identified in the audit in accordance with [N.C. General Statutes § 108C-5](#) and [10A N.C. Administrative Code 22F .0606](#).

Office of Compliance and Program Integrity
DMA, 919-814-0143

Attention: Nurse Practitioners and Physician Assistants

Billing Code Update for Nurse Practitioners and Physician Assistants

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

Medicaid 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:

11043	11045	11045 (B)	11046	22310	22310 (B)	25565
25565 (B)	27220	27220 (B)	27508	27508 (B)	36471	36471 (B)
93923 (E)						

- * Codes marked with a (B) were updated for modifier 59
- * Codes marked with a (E) were updated for modifier TC

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 N.C. Medicaid’s Clinical Policy section becomes aware of them.

CSRA, 1-800-688-6696

Proposed Clinical Coverage Policies

Per NCGS §108A-54.2, proposed new or amended Medicaid clinical coverage policies are available for review and comment on the N.C. 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 N.C. 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 Aug 1, 2017, the following policies are open for public comment on the [Proposed Clinical Coverage Policies web page](#):

Proposed Policy	Date Posted	Comment Period End Date
Preferred Drug List (PDL)	07/19/17	09/02/17
3G-1, Private Duty Nursing for Beneficiaries Age 21 and Older	08/02/17	09/16/17
3G-2, Private Duty Nursing for Beneficiaries Under 21 Years of Age	08/02/17	09/16/17
3D, Hospice Services	08/02/17	09/16/17
10C, Local Education Agencies (LEAs)	08/02/17	09/16/17
11C, Ventricular Assist Devices (VAD)	08/31/17	10/15/17
PA Criteria Hepatitis C Virus Medication	09/01/17	10/16/17

Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date*	Checkwrite Date	EFT Effective Date
September 2017	09/01/17	09/06/17	09/07/17
	09/08/17	09/12/17	09/13/17
	09/15/17	09/19/17	09/20/17
	09/22/17	09/26/17	09/27/17
	09/29/17	10/03/17	10/04/17
October 2017	10/06/17	10/11/17	10/12/17
	10/13/17	10/17/17	10/18/17
	10/20/17	10/24/17	10/25/17
	10/27/17	10/31/17	11/01/17

* 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