Medicaid and NCHC Updates
October 2018
https://dma.ncdhhs.gov/documents/2018-medicaid-bulletin-and-index

1. Department updates

a. Division of Medical Assistance (DMA) is now the Division of Health Benefits (DHB)

i. Effective Aug. 1, 2018, the Division of Medical Assistance (DMA) and Division of Health Benefits (DHB) combined into one division called the NCDHHS Division of Health Benefits. Although the division has a new name, the programs remain the same and are collectively referred to as "NC Medicaid" or simply "Medicaid."

b. CSRA is Now GDIT

i. On April 2, 2018, General Dynamics Information Technology acquired CSRA Inc. CSRA is now "CSRA State and Local Solutions LLC, A General Dynamics Information Technology Company," or simply "GDIT."

c. Advanced Medical Home Program

i. The Department of Health and Human Services (DHHS) is transitioning its Medicaid and Health Choice programs from a predominantly fee-for-service delivery system to managed care. Advanced Medical Homes will be the primary vehicle for delivering care management as the state transitions to managed care.
ii. CCNCCA practices were grandfathered in as AMH Tier 1 or 2 practices in September but may attest to a higher tier by completing an attestation in NCTracks, which is available on the Status and Management page under Quick Links.
iii. DHHS will provide a list of participating providers to the chosen pre-paid health plans (PHP) on 2/1/19.
    i. All CAI providers should attest to Tier 2 by 1/31/19.
    ii. Any CCNC (CAII) provider that intends to meet Tier 3 capabilities by managed care launch should attest to Tier 3 by 1/31/19 to have the opportunity to contract as a Tier 3 with the PHP.
iv. There are training opportunities, recorded webinars, and an AMH Provider Manual available on the Advanced Medical Home webpage at https://Medicaid.ncdhhs.gov/advanced-medical-home.

d. Are you in Compliance with NC Law?

i. One of the goals of a transformed health care system is for real-time clinical and demographic date to be available to all health care providers involved in a patient's care. NC Providers are required to connect with NC HealthConnex by specific deadlines:
    i. June 1, 2018: hospitals, physicians, PAs, NPs with electronic health record systems
    ii. June 1, 2019: all other providers except dentists, ambulatory surgical centers and pharmacies
    iii. Early 2019: PHPs. PHPs must also submit encounter and claims data by start of their contract with NCDHHS.
    iv. June 1, 2020: LME/MCOs must submit encounter and claims data.
    v. June 1, 2021: Dentists and Ambulatory Surgical Centers. Pharmacies must submit claims data once per day.
ii. For more information, contact NCHIEA at 919-754-6912 or hiea@nc.gov.

3. Policy Updates

a. Routine Eye Examinations and Visual Aids – age 21 and older

i. Medicaid will begin covering routine eye exams and visual aids for adults once every two years. This service may be provided by an ophthalmologist or optometrist. The clinical coverage policy is currently available for review and comment at https://medicaid.ncdhhs.gov/get-involved/proposed-medicaid-and-nc-health-choice-policies.

b. Proposed Policy Changes

i. Several clinical coverage policies are open for public comment. See the October bulletin for a link to each policy. Of specific interest, the Family Planning Services policy is being amended to clarify the differences between coverage under "traditional" Medicaid and Family Planning Medicaid.

c. Diabetes Outpatient Self-Management Education policy updates

i. Subsection 7.3 has been updated to add Clinical Pharmacist Practitioner and remove NP, CNM, PA and Pharmacists from non-physician practitioners (these are now on the list of recognized providers).
ii. CPT codes 97802-97804, 99078 have been replaced with HCPCS codes G0108 and G0109; and the ICD-10 diagnosis codes have been updated.
iii. See https://files.nc.gov/ncdma/documents/files/1A-24.pdf for more detailed information.

d. Outpatient Specialized Therapies (PT/OT/ST)

i. Effective 9/15/18, the policy was updated to increase therapy visit limits for beneficiaries ages 21 and older. Most significantly, the language in Section 5.4 specific to annual and episodic visits was replaced. See the Medicaid bulletin or policy for additional information.

e. Influenza Vaccine and Reimbursement Guidelines for 2018-2019

i. NCIP/VFC influenza vaccine–all quadrivalent–is available at no charge to providers for children 6 months - 18 years of age who are eligible for the VFC program. Eligible VFC children include Medicaid beneficiaries and NC Health Choice beneficiaries who are American Indian and Alaska Native (AI/AN).

ii. Providers must purchase vaccines for children who are not VFC-eligible (including all NC Health Choice children who are not AI/AN) and adult patients. For Medicaid-eligible beneficiaries age 19 years and older, purchased vaccine and administration costs may be billed to Medicaid.

iii. Effective January 1, 2016, Medicaid will reimburse pharmacies for covered vaccines, including influenza vaccines, when administered to Medicaid beneficiaries 19 years of age and older by an immunizing pharmacist. The CG modifier must be appended to every vaccine and administration CPT code used by pharmacists.

iv. **NDCs Change Each Year for Influenza Vaccines.** It is important to report the correct code for the products you are using to avoid having claims deny. Below are the influenza vaccine procedure (CPT) codes and corresponding NDCs that should be used for the 2018-2019 influenza season:

CPT Codes	NDC codes
90672	FluMist Quadrivalent: 66019-0305-01, 66019-0305-10
90685	Fluzone Quadrivalent: 49281-0518-00, 49281-0518-25
90686	Fluarix Quadrivalent: 58160-0898-41, 58160-0898-52 FluLaval Quadrivalent: 19515-0909-41, 19515-0909-52 Fluzone Quadrivalent: 49281-0418-50, 49281-0418-88, 49281-0418-10. 49281-0418-58
90687	Fluzone Quadrivalent: 49281-0629-15, 49281-0629-78
90688	Fluzone Quadrivalent: 49281-0629-15, 49281-0629-78
90756	Flucelvax Quadrivalent: 70461-0418-10, 70461-0418-11

v. For more specific billing guidance, see the September Medicaid bulletin, pages 3-12.

f. Procedures for Prior Authorization of Synagis® (palivizumab) for Respiratory Syncytial Virus Season 2018/2019

i. The coverage season is Nov. 1, 2018, through March 31, 2019.

ii. During the Synagis coverage period, submit all prior approval (PA) requests electronically to www.documentforsafety.org. The web-based program will process PA information in accordance with the guidelines for use. A PA request can be automatically approved based on the information submitted. The program allows a provider to self-monitor the status of a request. Up to five doses can be approved for coverage.

iii. Coverage of Synagis for CHD, neuromuscular disease or congenital anomaly that impairs ability to clear respiratory secretions from the upper airway will terminate when the beneficiary exceeds 12 months of age. Coverage of Synagis for CLD, profound immunocompromise, or cardiac transplantation will terminate when the beneficiary exceeds 24 months of age.

iv. The provider should use the Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age to request Synagis doses exceeding policy or for coverage outside the defined coverage period. Fax the form to 919-715-1255. The form is available on the NCTracks Prior Approval web page. Information about EPSDT coverage is found on Medicaid's Health Check and EPSDT web page.

v. For more specific guidance, see the September Medicaid bulletin, pages 12-14.

g. Sterilization Procedures

i. Sterilization claims must be submitted with ICD-10-CM diagnosis Z30.2 (encounter for sterilization) as the primary or secondary diagnosis code on the claim.

1. Effective Oct. 1, 2018, claims submitted without diagnosis Z30.2 as the primary or secondary diagnosis on the claim, will be denied.

ii. Facility providers can access Sterilization Consent Form status including denial reasons, on the secure NCTracks Provider Portal, if the sterilization consent form has been properly completed.

1. Once the beneficiary has had the sterilization procedure and before submitting the completed sterilization consent form to the NCDHHS fiscal contractor, the following is required:
    a. Surgeon's NPI must be added to the top left of the consent form.
    b. Beneficiary's identification number must be added to the top right of the Sterilization Consent Form.
    c. The NPI of the facility in which the sterilization procedure was performed may be added to the top center of the consent. The service facility may inquire on the status of the sterilization consent and shall have access to any documents, including the denial letter, associated with the record.
2. The rendering provider, service facility provider, rendering provider's office administrator or service facility's office administrator may receive consent form status from the NCTracks Call Center. The caller's NPI must match one of the NPI's submitted on the sterilization consent form.

iii. Providers are encouraged to review Clinical Policy 1E-3 Sterilization Procedures for guidance on billing and completing the sterilization consent form (https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/obstetrics-and-gynecology-clinical-coverage-policies)

h. Family Planning Services

i. These CPT codes should not be billed with a separate office visit: 11981. 11982, 11983, 57170, 58300, 58301. An office visit component is included in the reimbursement for the visit. However, if during the same visit, services are rendered for a separately identifiable service provided by the same provider on the same day of service, the provider may bill for the office visit and the IUD insertion or IUD removal. The providers documentation must support that the service rendered was a separately identifiable service.

ii. The provider may bill for the annual exam and the IUD insertion or IUD removal, if requested by the beneficiary, using an appropriate modifier with the annual exam code indicating that the service rendered was a separately identifiable service provided by the same provider on the same day of service.

iii. Family Planning Medicaid provides limited coverage to beneficiaries with MAFDN eligibility.
    1. Outpatient sterilization claims must be submitted with the appropriate family planning modifier (FP).
    2. Outpatient sterilization claims must be submitted with an appropriate family planning procedure code.
    3. A list of procedure and diagnosis codes covered by Family Planning Medicaid is available in Clinical Policy 1E-7 Family Planning Services where "Be Smart" is referenced.

i. Psychiatric Collaborative Care Management

i. In response to provider requests and to allow reimbursement for behavioral health integration in primary care settings, Medicaid is adding coverage for evaluation and management codes 99492, 99493, 94944, effective October 1, 2018.

ii. Psychiatric collaborative care management services must be rendered under the direction of a treating physician or non-physician practitioner (NPP), typically in a primary care setting when a beneficiary has a diagnosed psychiatric disorder and requires assessment, care planning, and provision of brief interventions.

iii. The American Medical Association (AMA) has defined the services and providers of psychiatric collaborative care management. See page 19 of the September Medicaid Bulletin.

iv. Psychiatric collaborative care management is billed once monthly and includes the services of the treating physician or NPP, behavioral health care manager, and the psychiatric consultant.

v. For additional billing guidance and information, see pages 20-21 of the September bulletin.

5. Provider Enrollment

a. Providers are required to update their enrollment record in NCTracks within 30 days of a change. This includes affiliation, taxonomy, and service location information. Providers should also confirm the accuracy of ownership and managing relationship information (dates of birth, social security numbers, etc). In addition, providers must update their expiring licenses, certifications, and accreditations.

i. The system currently suspends and terminates providers who fail to respond within specified time limits.

ii. To review the provider record, begin the MCR process to make necessary corrections and updates. If corrections are needed in fields that are not editable using an MCR, submit the correction, with proof of the correct information (i.e. driver's license, social security card) via the "Contact Us" link and email at the bottom of any NCTracks webpage.

6. Contacts

a. DMA Regional Managed Care Consultant, Melanie Whitener at 828-304-2345, melanie.whitener@dhhs.nc.gov.

b. CSRA (NCTracks) Call Center, 1-800-688-6696 (phone); 1-855-710-1965 (fax) or NCTracksprovider@nctracks.com.