NCTracks Communications and Updates

October 28, 2015

NCTracks Updates for Nov 1

There are several enhancements to NCTracks being implemented on November 1, 2015, many of which are described in this newsletter. A second newsletter will be sent at the end of the week with the remaining updates. Providers are encouraged to read this information to understand the changes and how they affect provider enrollment, prior approval, and claim processing in NCTracks.

Reminder of NCTracks Re-credentialing Process

The Centers for Medicare and Medicaid Services (CMS) requires that all Medicaid providers are re-credentialed. (This process is also sometimes referred to as re-verification.) The N.C. Division of Medical Assistance (DMA) is reviewing the status of enrolled providers to ensure compliance. This is a reminder and update to the announcement posted on August 24, 2015.

Providers will receive a re-credentialing notice posted to their Message Center Inbox on the secure NCTracks Provider Portal when re-credentialing is due. Due dates for re-credentialing are specific to each provider. All providers will not receive re-credentialing notices at the same time. Providers have 45 days after notification to complete the re-credentialing process. As a reminder, North Carolina session law 2011-145 Section 10.31(f)(3)requires that providers pay a $100 fee for Medicaid re-credentialing.

It is crucial that all providers who receive a notice promptly respond and begin the online re-credentialing process. All Medicaid providers

that receive a re-credentialing notice are required to re-credential as part of the NCDHHS Provider Administrative Participation Agreement.

Re-credentialing is not optional.
Providers who do not complete the re-credentialing process on time will receive a letter notifying them that they are suspended from participation in the Medicaid program. The suspension letter is posted to their Message Center Inbox on the secure NCTracks Provider Portal and mailed to the provider in an envelope marked "Important" in red letters. Providers have 30 days following notification of suspension to complete re-credentialing. Providers who do not complete the re-credentialing process within that time frame will be subject to termination from the Medicaid program.

Note: Re-credentialing does not apply to any time-limited enrolled providers such as out-of-state (OOS) providers. OOS providers must continue to complete the enrollment process every 365 days.
To assist providers with the re-credentialing process, a new webpage is available on the NCTracks provider portal at https://www.nctracks.nc.gov/content/public/providers/provider-recredentialing.html. Providers are encouraged to consult the new webpage for information regarding the online re-credentialing process in NCTracks, as well as links to Provider Announcements, User Guides, and Frequently Asked Questions.

Billing Update for Procedure Code T1999
As of November 1, 2015, procedure code T1999 (Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified) will have new service limitations applied.

The following rules will be applied to any T1999 dollars used since the beginning of the current State Fiscal Year (SFY) on July 1, 2015:

- No PA is required for total dollars used up to $250.00
- A PA is required for total dollars used from $250.01 to $1,500.00

- For recipients under age 21, a PA is required for total dollars used from $250.01 to the amount specified on the PA
- Claims with total dollars exceeding $1,500.00 will be denied
- For recipients under age 21, claims with total dollars exceeding the maximum amount identified on the PA will be denied
- EPSDT recipients under age 21 may exceed the $1500.00 limit if there is a validated need
- For recipients over age 21, no more than $1500.00 per recipient per SFY may be billed, with or without prior approval

The provider taxonomy codes listed below will be subject to these restrictions when billing procedure code T1999:

- 251E00000X Home Health
- 261QF0400X FQHC Clinic
- 261QR1300X Rural Health Clinic
- 251J00000X Nursing Care
- 251B00000X Case Management
- 253Z00000X In Home Supportive Care
- 385H00000X Respite Care
- 333300000X Emergency Response System Company
- 332B00000X DME and Medical Supplies
- 332U00000X Home Delivered Meals

Prior Approval (PA) requests will only be accepted via the NCTracks secure Provider Portal. Prior Approval requests will not be accepted via fax, phone or mail. Providers will be able to verify service limit amounts via the Automated Voice Response System (AVRS), the NCTracks secure Provider Portal and X12 270/271 transactions.
Please refer to DMA Clinical Coverage Policy 3A, Home Health Services for additional information, which can be found on the DMA website. Also refer to the October 2015 DMA Special Bulletin titled "Updated Bill Type for Home Health Provider."

Note: T1999 services will be measured in dollars while Home Health Aide or Skilled Nurse services will continue to be measured in visits.

Service Limits Available Nov 1 in Eligibility Verification Response
Beginning November 1, 2015, DMA service limit data will be more readily available to providers. NCTracks will provide used and available service limit amounts on the eligibility verification response for the Automated Voice Response System (AVRS), the NCTracks secure Provider Portal, and the 270/271 X12 transaction for services used in the current fiscal year.

This new enhancement will allow providers to access the service limit amounts for the following services: Skilled Nursing visits, Home Health Aide visits and procedure code T1999 (Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified). Procedure code T1999 will have new limitations applied beginning November 1, 2015. Providers can refer to DMA Clinical Coverage Policy 3A, Home Health Services for additional information, which can be found on the DMA website.

Note: If an eligibility verification response does not return service limit data, it indicates that within the current fiscal year July 1-June 30, services with limits have not been used or claims with services limits have not been paid at the time of the inquiry.

Important: Accumulation of service amounts
Also beginning November 1, NCTracks will post a "pay and report" edit to the paper Remittance Advice (RA) every time a service subject to limitations is paid. The edits posted are the same ones currently used to indicate that the service limit has been exceeded. However, instead of posting only when the service limit is exceeded, the edits will now post every time a service subject to limitations is adjudicated, whether paid or denied. To determine whether the edit has posted as "pay and report" or a denial, the provider will need to check the paid amount for that claim line item.

The edits affected are:

Edit 44890 - EXCDS LMT FOR MANDATORY SRV FY (EOB 09825 - EXCEEDS LEGISLATIVE LIMITS FOR PROVIDER VISITS FOR FISCAL YEAR)

Edit 44900 - EXCDS LMT FOR OPTIONAL SRV FY (EOB 09825 - EXCEEDS LEGISLATIVE LIMITS FOR PROVIDER VISITS FOR FISCAL YEAR)

Edit 55100 - HHPA REQD T1999 > $250 IN SFY (EOB 55100 - HOME HEALTH PA REQUIRED FOR T1999 WITH ACCUMULATED SERVICES GREATER THAN $250 WITHIN THE SFY. PLEASE REQUEST HOME HEALTH PA.)

Edit 55110 - SVCS FOR T1999 > $1500 IN SFY (EOB 55110 - EXCEEDS $1500 MAXIMUM LIMITATION ALLOWED PER STATE FISCAL YEAR)

Edit 54810 - FISCAL YEAR LIMIT (EOB 02476 - SERVICE DENIED. EXCEEDS THE LIMITATION OF UNITS ALLOWED PER STATE FISCAL YEAR)

Edit 53150 - UNIT LIMITATION EXCEEDED FOR SFY (EOB 02476 - SERVICE DENIED. EXCEEDS THE LIMITATION OF UNITS ALLOWED PER STATE FISCAL YEAR)

271 Health Care Eligibility Benefit Response: A number of segments in the 271 Health Care Eligibility Benefit Response, Loop 2110C, will be used for service limits. Trading Partners should refer to the *270/271 Health Care Eligibility Benefit Inquiry and Response* Companion Guide on the Trading Partner Information page of the NCTracks Provider Portal for additional information on service limits.

Note: T1999 services will be measured in dollars while Home Health Aide or Skilled Nurse services will continue to be measured in visits.

Update to Bill Type for Home Health Services

Effective November 1, 2015, providers should no longer submit original claims for home health services using Bill Type 33X. Providers

should use Bill Type 32X or 34X instead. Bill Type 33X will be discontinued per the Centers for Medicare & Medicaid Services (CMS) and the National Uniform Billing Committee. No reprocessing will occur as a result of this implementation.

For more information, refer to the October 2015 Special Bulletin "Updated Bill Type for Home Health Providers" on the DMA website.

New Features for DME and Home Health Prior Approval

For Prior Approval (PA) requests for Durable Medical Equipment (DME) and Home Health services, a signed and completed certificate of medical necessity (CMN) is required. Currently in NCTracks, it is submitted using the paper CMN available on the NCTracks website or by having the prescribing provider sign the system generated document when a PA request is submitted via the secure Provider Portal.

Beginning November 1, providers requesting DME and Home Health services can route through NCTracks a PA request to the recipient's (beneficiary's) prescribing provider for review. The prescribing provider can approve and electronically sign the request using their PIN, then submit to NCTracks for review. If the prescribing provider does not agree with the service request, the record can be returned back to the requesting provider to review and correct as applicable. Per DMA policy, a prescribing provider is defined as a physician, physician assistant or nurse practitioner. A new NCTracks user role has been developed for this group to access the routed records - PrescribingProvider. The Office Administrator (OA) for the NPI must assign the appropriate authorized users this new user role in NCTracks to access records routed for review.

The paper CMN will remain available after November 1, but the online routing of the request can help expedite the submission of PA requests for DME and Home Health providers.

It is important to note that until a signed PA request is successfully submitted to NCTracks, it is not visible to the Call Center or the NC Division of Medical Assistance (DMA). Call Center Agents and DMA will have no information to tell providers if they are calling about a record that is being routed between the requesting and prescribing providers. The two provider groups (prescribing provider and service provider) must communicate with each other if there are any questions on the status of one of these PA records.

Additional Options

Providers also have the new option of 'N/A' for describing the recipient's living arrangement/support system and skin condition. This addition is being made to the Request for Prior Approval CMN/PA Form (DMA 372-131) and the PA entry pages in the secure Provider Portal. This information is required as part of the PA request process. An attestation statement is also being added below the signature section on the form. The updated form has been posted to the NCTracks Prior Approval webpage.

Training Available

Training for Office Administrators regarding the assignment of user roles in NCTracks is available in Skillport, the NCTracks Learning Management System. In addition, there will be an instructor-led course and job aid developed to assist providers with taking advantage of this new functionality. More information will be posted on the provider training as soon as it is available.

Thank you,
The NCTracks Team

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