

March 4 NCMT Hot Topics Fireside Chat

Q: When will we get specific information on how to request authorization for services for pt/ot/slp within all different carriers?

A: Information about each managed care plan's prior authorization requirements should be made available to providers as they enroll with each plan. For a list of managed care plans with contact information and provider manuals, please visit this webpage:

<https://medicaid.ncdhhs.gov/transformation/health-plans/health-plan-contacts-and-resources>. For additional information, please see the Feb 5, 2021 Medicaid Managed Care Provider Update article here: <https://medicaid.ncdhhs.gov/blog/2021/02/05/medicaid-managed-care-provider-update>.

Q: How can pregnant women get in the mandatory category?

A: Thank you for contacting the NC Medicaid Help Center. NC Medicaid is making every effort to ensure NC beneficiaries and providers receive the information they need. Pregnant women are included in the mandatory managed care population that will receive NC Medicaid through their chosen health plan beginning 7/1/2021. This will ensure that NC Medicaid beneficiaries receive care through the health plan that best fits their needs and services. If you have additional questions, please contact DHHS Local DSS offices for further assistance. There also many additional resources listed on the NC Medicaid Provider link.

Q: If I see a patient the Sunday of the Weekend of July 4th (when our practice is open) who has a plan I am not signed up with, will the enrollment broker change their PHP plan on Sunday so I can get paid for that visit Sunday? Or does the claim get rejected and the plan change is effective the next month?

A: If a patient comes to your office and they are enrolled with a plan that you are not contracted with, the Enrollment Broker will not change their health plan, unless requested by the patient. For a beneficiary to change to their plan, they should contact the Enrollment Broker. If they do not change their plan prior to the visit, you would be considered an Out-of-Network Provider. Out-of-Network Providers will file services covered under Medicaid Managed Care directly with the health plan. Out-of-Network providers are required to get a prior authorization from the assigned health plan before providing services and may need to complete a single case agreement to receive payment. If the provider has engaged in good faith negotiations with the health plan but failed to contract, the out-of-network provider will be paid at 90% reimbursement. If the health plan has not yet engaged in good faith negotiations, the provider would be reimbursed at 100%. Please refer to the appropriate health plan provider directories and websites linked above for additional details

Q: When I was assisting one of my Nurse Practitioners to do a Managed Change Request to update the hours of operation, we were being forced to address her DEA. She does not have a DEA. Is she required to have a DEA?

A: Designated prescribing providers are required to provide their Drug Enforcement Administration (DEA) certification on their initial enrollment, re-enrollment, or MCR applications. If the provider does not have a DEA number: A) 123456789 shall be entered on the application, B) the DEA Designation Form must be completed, and 3) Upload the form to the Upload Documents page under Status Management when submitting an application. -

<https://www.nctracks.nc.gov/content/public/providers/provider-communications/Provider-Announcements-2020-/2020-Announcements/Details-on-Prescribing-Provider-DEA-Requirements.html>

Q: The provider directory seems to be case sensitive. Will there be any change to make that not an issue with the tool?

A: Thank you for your question. The Medicaid and NC Health Choice Provider and Health Plan Lookup Tool, available at <https://ncmedicaidplans.gov/>, is available to be searched using all upper or lower case letters or a combination of both. In addition, all or part of the provider or organization name can be used in the search. This was retested today. If you are not receiving the expected results, please provide the specific search name, location, and other criteria you are using, as well as the expected result, so we may conduct further research. Thank you again. Have a great day.

Q: Everything on the website about the provider directory says, "primary care." This is a bit confusing to the other MDs and practitioners who need to be enrolled for network adequacy. IS the website and directory ONLY for PCPs? Also, is there an indication of the licensure of provider--MD, NP, PA, LCSW, ...?

A: The Tool contains all active Medicaid and NC Health Choice providers including primary care providers (PCPs), specialists, hospitals, and facilities. Beneficiaries required to enroll with a health plan and select a PCP will log in to an authenticated portal that only displays providers eligible for selection as their PCP.

Q: How can a practice indicate alternative locations that are not physical locations? We have 1 physical location but serve patients in their natural environment in 12 counties.

A: Practices shall only enroll their physical site locations.

Q: When you refer to "integrated primary care and behavioral healthcare," do you generally mean both types of care provided by one practice; or do you mean care that is coordinated but might be provided by 2 different providers (e.g., a PCP and a specialty BH provider)? Thanks.

A: This could be either, depending on the model of integrated care. Essential, it means that both the physical and the behavioral health need to be considered when treating the individual.

Q: My last question is will any of the Medicaid HMO's will they be coming around to the various offices to "check us out" visiting us?

A: There are no requirements for the PHPs to do office visits during this time. PHPs will be doing provider education, AMH validation or other provider relation activities, but they do not need to be conducted in person

Q: Many clinical coverage policies have been updated to include telehealth- when will clinical coverage policy 10A and 10B updated to include telehealth? Hopefully this will be completed before July transformation? (10c and 10d are already updated)

A: As of Jan 1, 2021, psychological and counseling treatment codes 90832, 90834, 90837, 90847 and 90853 were permanently activated for telehealth as part of policy 10C. Also as of Jan 1, 2021, respiratory therapy codes 94664, 94760 and 99504 were permanently activated for telehealth as part of policy 10D. We are currently drafting updates for speech and language therapy telehealth in policies 10B and 10C. Please check for proposed policies posted for public comment monthly on this webpage:

<https://medicaid.ncdhhs.gov/meetings-notice/proposed-medicaid-and-nc-health-choice-policies>.
Thank you.

Q: Are family planning services been added for PrEP under Family planning benefit only for offices or does it cover the hospital as well?

A: No, Comprehensive Metabolic Panel (effective 12/1/2020) for monitoring HIV prophylactic medications given through Ready Set PrEP programs are only covered in the office/clinic setting for FP Medicaid beneficiaries. The only services covered in the registered outpatient hospital setting for Family Planning Medicaid are sterilization procedures. Inpatient services are not covered at all under Family Planning Medicaid.

Q: For AMH status, who provides cultural competency training?

A: Health plans are required to show care management competency in cultural competency and several other specific knowledge areas. Requirements for this training are found in the Provider Manual. AMH providers are encouraged to connect with the health plans with which they have contracted regarding the cultural competency and other required staff trainings.

Q: What training and preparation is being done with the local DSS offices?

A: NC Medicaid held NC Medicaid Managed Care Training for DSS staff in January and February. This included information related to Managed Care, EBCI Tribal Option, DSS role in Managed Care, and the Enrollment Broker. The training modules have been posted to the DSS Learning Management System for county use. The County Playbook, a collection of Fact Sheets and other materials, is also available on the NC Medicaid website as a resource for DSS staff. A dedicated DSS Support Line is available for DSS staff to ask questions related to NC Medicaid Managed Care.

Q: Who will be responsible (DSS / adoptive family) for enrolling children who move from foster care (NC Medicaid Direct) to adoption (needing a PHP plan)?

A: Thank you for contacting the NC Medicaid Help Center. NC Medicaid is making every effort to ensure NC beneficiaries and providers receive the information they need regarding NC Medicaid Managed Care. Both foster care and adoption children are temporarily excluded from NC Managed Care and will not have to enroll with a health plan at this time. The transition of care team is carefully reviewing processes for these children and will provide a plan once finalized.

If you have additional questions, please contact <https://www.ncdhhs.gov/divisions/social-services/local-dss-directory> for further assistance. There also many additional resources listed on the <https://medicaid.ncdhhs.gov/providers> webpage.

NC Medicaid Help Center Response Team

Q: Does any of the lab CPT codes been added to family planning cover labs done under an ourpatient center at the hospital?

A: The only service that added in the December 1, 2020 update for coverage by FP Medicaid in a registered outpatient hospital setting is CPT 58661 (Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)) when performed as bilateral

salpingectomy for a sterilization procedure. Inpatient services are not covered at all under Family Planning Medicaid and the only registered outpatient hospital services covered are for sterilizations.

Q: But when I asked a local LME about tailored plans, they said they were subcontracting with the standard plan- how is it integration when it is still two different payors?

A: Legislation requires the Behavioral Health I/DD Tailored Plans to contract with an entity that holds a PHP license that covers the services that are required to be covered under the Standard Plan contract. By partnering with a PHP the Behavioral Health I/DD Tailored Plans will be able to meaningfully leverage the PHP's expertise to increase the Behavioral Health I/DD Tailored Plan capabilities and to ensure readiness.

Q: Do PCPs need to obtain an auth if the patient is enrolled with a plan that the PCP is not contracted with?

A: Yes, if the patient is enrolled with a health plan that a provider is not contracted with, the provider is considered an Out-of-Network Provider. Out-of-Network Providers will file services covered under Medicaid Managed Care directly with the health plan. Out-of-Network providers are required to get a prior authorization from the assigned health plan before providing services and may need to complete a single case agreement to receive payment. If the provider has engaged in good faith negotiations with the health plan but failed to contract, the out-of-network provider will be paid at 90% reimbursement. If the health plan has not yet engaged in good faith negotiations, the provider would be reimbursed at 100%. Please refer to the appropriate health plan provider directories and websites linked above for additional details.