March 18 NCMT Hot Topics Fireside Chat
What Ifs

Q: Do I need an authorization to provide primary care for a member who is not assigned to me?

A: Members do NOT need an authorization to see an in-network PCP even if it is not the assigned PCP. We do encourage all PCPs to help members engage with their assigned practice or help members change their assignment.

Members WILL need a prior authorization to see a PCP who is NOT in network.

Q: How do I help a member change their assignment to my practice?

A: Member should call the members services number on their back of their cards and in their member handbook.

Q: How soon will the member's assignment be updated after a request by the member to change?

A: The member's assignment will change the first of the following month according to DHB policy. The member can still have services provided by that PCP prior to the reassignment without authorization as long as the PCP is in network

Q: How can I remove members from my panel if they will not engage with my practice?

A: PCP are encouraged to use their care management resources to help members with barriers to engage. PCPs should also work with their Health Plans to help members with barriers to engagement or to find a better PCP fit if all options have been exhausted.

Q: How do I get a list of my assigned members? How often do I get that list?

A: AMH Tier 3s will receive their member list monthly through the 834/Beneficiary File. All other PCPs will be able to log into each Health Plan's Provider Portal for a current monthly list.

DHB will continue to post member assignment lists in NCTracks for Medicaid Direct & all Health Plans (using data received from the Health Plans).

Q: Providers currently bill Medicaid on a weekly basis and receive payment weekly. Will the health plans follow the same model?

A: Each health plan follows their own schedule for payment, one health plan will pay twice a week while others will issue payment weekly.

Q: Is there a financial penalty for patients OR the provider if a patient sees a PCP different from the one assigned to them?

A: If you are not the assigned Primary Care Practice for the beneficiary but are in Network for the health plan, you can render and be paid for Primary Care Services.

If you are a non-participating provider for the beneficiary's Medicaid health plan, you may render services.

-Special protection is afforded non-network providers (see the Transition of Care section below)

-If a good-faith contracting effort has been made by the health plan and you declined to participate, then you are subject to receiving 90% of the Medicaid fee-for-service rate. If no good-faith contracting effort has occurred, or if it is in progress, then you are subject to receiving 100% of the Medicaid fee-for-service rate until the contracting effort has been resolved.

Q: Can a patient have Medicaid & private insurance at the same time? If so, is there ever a situation where we are expected to bill the Medicaid family for a co-pay or similar? What are the third-party liability (TPL) rules?

A: Yes, a patient may have Medicaid and private insurance at the same time. The PCP must follow the rules and regulations of the private insurance carrier, there may be instances where the private insurance carrier requires a co-payment, deductible or co-insurance from a Medicaid beneficiary. Whether the PCP charges a co-pay is a function of the contract with the private insurance carrier. TPL Rules; There is a requirement for the PCP to bill the private insurance carrier first. The PCP may then submit the claim to the PHP to determine if an additional payment will be made not to exceed the Medicaid allowed amount. The process ensures that Medicaid is the payer of last resort.

Q: Practices have to explain how they used the health equity payments. Will practices have to attest to how they used their Glidepath payments?

A: No, practices will not have to attest to how the glidepath funds were used.

Q: What should we do if we have already put in a change request for the patient, but it is not getting changed through NCTracks?

A: If you are referring to a PCP change request made to the local Social Service office that is not reflected in the NCTracks Recipient Eligibility Verification function, then there are some things to consider:

1. Was the "CCNC/CA Enrollment Form for Medicaid recipients" completed and signed by the patient? Social Service is only able to process PCP changes submitted on this form with the patient/caretaker's signature. NOTE: The form is at https://medicaid.ncdhhs.gov/providers/forms/community-care-nccarolina-access-forms (DHHS Provider webpage/Forms)

2. Has the month changed? PCP changes are always for the ongoing month pursuant to processing deadlines. For example, if the form was submitted in March and processed prior to March 30th, then the change will display in the NCTracks eligibility verification beginning April 1st. If processed on March 31st or in April, the change will not display until beginning May 1st.

3. If the answer to both of these questions is yes, the next best course of action is to request that the beneficiary contact their local Social Service office or the NC Medicaid Contact Center at 888-245-0179 to request a change.

4. Please note that PCP changes can be requested through this process for NC Medicaid Direct (FFS) beneficiaries. Beginning July 1, managed care enrolled beneficiaries will contact their health plan to request a PCP change.

PCP changes are processed through the NC Medicaid beneficiary eligibility system and transmitted to NCTracks nightly to be displayed in the NCTracks Recipient Eligibility Verification function.

Q: How do practices cap the number of patients their practice or an individual provider is willing to accept? If governed by the health plans, will this vary?

A: The provider should refer to its contract with the PHP for this information and/or contact the contract specialist at the PHP about the PHP's process and requirements.

Q: How does a practice determine what tier status they are?

A: Practices have the ability to attest to an AMH Tier Status within NC Tracks. In 2019 any Carolina ACCESS 2 practice was grandfathered into the AMH program as a Tier 2. You can view this via the NC Tracks Provider Portal.

Q: Can a health plan set a minimum quality rating scale for the quality incentive payments and refuse to pay any incentives to a tier 3 practice who does not meet the minimum?

A: Yes, PHPs are able to set targets as they deem appropriate. DHB sets targets for PHPs.

Q: What if a patient has started prenatal care with us before Managed Medicaid, does not enroll and is auto enrolled in a plan we are not contracted with. Will we still get paid if we see this patient?

A: If a beneficiary comes to your practice and they are not enrolled with you, or with the health plans that you are contracted, you can still deliver the services they need.

The PHP will honor existing and active prior authorizations on file with the North Carolina Medicaid or NC Health Choice program for services covered by the PHP for the first 90 days after launch or until the end of the authorization period, whichever occurs first.

Q: Will women covered by Medicaid for Pregnant Women transition to managed care?

A: Most Medicaid for Pregnant Women (MPW) will enroll in managed care. If the pregnant woman is eligible for both Medicaid and Medicare, are eligible for tailored plans, are eligible for the Tribal Option, etc., then they may have other choices.

Q: Our Women's Health Department is considered a specialist and not considered a PCP. Will patients be required to obtain a referral from their PCP to continue receiving services from us?

A: If the provider in question is a women's health specialist AND is an in-network provider for the member's PHP, then according to federal regulation and the PHP Contract, the PHP shall provide female enrollees with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.

Q: Many pediatric patients will transition to adult providers at 18 years old. What is the process to ensure that the patient maintains coverage during the transition?

A: The PHP will support, as needed, the member's transition to an adult provider including assistance in identifying a new provider (through the Member Call Line or through care management supports) and ensuring that the member's health record is shared, as needed, in accordance with professional standards and state and federal law. If the member is transitioning between or to an AMH Tier 3 practice, the member's health plan will begin transmitting the member's claims and risk information to the new AMH prior to the transition.

Q: If we are contracted with all plans, can we still see members not assigned to our practice?

A: Yes, if you are not the assigned Primary Care Practice for the beneficiary but are in Network for the health plan, you can render and be paid for Primary Care Services.

Q: If a practice is not currently accepting new Medicaid patients, will they have to open this up for open enrollment?

A: That's a good question and something the practice needs to consider. Members may be choosing plans you have not contracted with, so you may lose patients from your panels and then not gain any through auto-assignment from the health plans you have contracted with. So, it's a decision left to the practice.

Q: If a practice is not currently accepting new Medicaid patients, will they have to open this up for open enrollment?

A: That's a good question and something the practice needs to consider. Members may be choosing plans you have not contracted with, so you may lose patients from your panels and then not gain any through auto-assignment from the health plans you have contracted with. So, it's a decision left to the practice.

Q: What if a patient's PCP is enrolled with their health plan but their dermatologist and pulmonologist are not in that network?

A: NC Medicaid Managed Care is designed to for members to access services through a network of providers contracted with their PHP. If a member chooses a PHP based on her primary care provider (i.e. the PCP is in-network for the chosen PHP), but other providers are not in-network, then the member will need to move to specialists who are in-network with her PHP. Note that periods of transition of care will permit a member to continue to see an out-of-network provider for a specific period of time until they transition to an in-network provider. Additionally, a member will have opportunity to switch their PHP through open enrollment and then 90 days following managed care launch.

Q: If there are no other specialists of my type in the local area and a patient is contracted with a health plan outside my network, will the patient have to travel to see an in-network specialist?

A: A PHP must have a network of providers that is sufficient to ensure that all covered services are available and accessible to all members in a timely manner. If the PHP's network is unable to provide a covered service on a timely basis (without undue delay), then the PHP shall provide timely access to an out-of-network provider, and shall continue to provide the access to an out-of-network provider until the Network's deficiency is addressed. Please note that the PHP can require that this access be prior-approved as an out-of-network service.

Q: How is managed care going to impact provision of dental services? How will this impact beneficiaries trying to get dental services?

A: Dental services are carved out of Managed Care. Dental providers will continue to submit prior approval requests and claims for payment in NCTracks like they do today.

Beneficiaries will continue to select the dentist of their choice for dental treatment.

Q: Does a dental office need to sign up with the insurance company to get paid or will we still use NC Tracks?

A: Dental Services are carved out and not included in Managed Care. Dental providers will continue to submit prior approval requests and claims for payment through NCTracks as they do today.

Q: What is the difference between the health plans giving a standard authorization decision and an expedited authorization decision?

A: For expedited authorization decisions, the PHP will provide notice no later than 72 hours after receipt of the request for service. The PHP may extend the 72-hour time period by up to 14 days if the member requests the extension or if the PHP justifies a need for additional information and how the extension is in the member's interest. If the PHP extends the timeframe beyond 72 hours, the PHP will provide the member and provider with a written notice of the reason for the decision to extend the timeline and inform the member of the right to file a grievance if he or she disagrees with that decision.

For standard authorization decisions, the PHP will provide notice as expeditiously as the member's condition requires and no later than 14 calendar days after the receipt of the request of services. However, the PHP may receive a possible extension of up to 14 days if the member requests the extension or if the PHP justifies a need for additional information and how the extension is in the member's interest. If the PHP extends the timeframe beyond 14 days, the PHP will provide the member and provider with a written notice of the reason for the decision to extend the timeline and inform the member of the right to file a grievance if he or she disagrees with that decision.

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Questions

Q: I thought auto assignments was not happening until after open enrollment closed?

A: Beneficiaries will have the option to choose a health plan during the open enrollment period. As a provider, it is important that all office staff know which plans you participate in and to encourage your patients to self-select their health plan and primary care provider to avoid auto-assignment.

• Open enrollment will begin in all 100 counties on March 15, 2021 and ends statewide on May 14, 2021.
• Beneficiaries may choose a health plan based on personal preference, coverage options, value added benefits or whether their preferred provider(s) are in-network.
• If a beneficiary does not select a health plan by the end of open enrollment, they will be auto-enrolled into a health plan and the health plan will auto-assign them to a PCP. Auto-enrollment into a health plan will take current assignment into account if the current PCP is in network.
• Beneficiaries who do not actively choose a health plan will be automatically enrolled in a health plan based on an algorithm developed by NC Medicaid. Auto-enrollment is scheduled to begin on May 15, 2021.
• Auto-enrollment is based on:
  1. Where the beneficiary lives
  2. Whether he or she is a member of a special population
  3. Historical provider-beneficiary relationship and preference
  4. Health plan assignments of other family members
  5. Previous health plan enrollment within the past 12 months
  6. Equitable health plan distribution
• For a provider to be considered in the algorithm for health plan auto-enrollment, the provider needs to have signed and mailed their contract to the health plan by April 12, 2021.

Q: Did the beneficiaries that got reassigned, choose this change or was it done automatically for them?

A: Additionally, a PCP practice reassignment process occurred March 20 and 21, 2021 to be effective April 1, 2021. This impacted only beneficiaries who have not visited their current PCP in the last two years and have an active treatment relationship with a different PCP. The April Enrollee Report, available April 12, 2021, reflected any changes made during the reassignment. Please see the Primary Care Provider Practice Reassignment for Some Beneficiaries bulletin article at: https://medicaid.ncdhhs.gov/blog/2021/04/01/primary-care-provider-practice-reassignment-some-beneficiaries, for more information on that change.

Based on provider feedback regarding the AMH Medicaid Direct/Managed Care PCP Enrollee Report, NC Medicaid is in the process of updating functionality to include health plan members and the name of the health plan to which each is assigned. Although the timeline for the addition is still being determined, the report will only display the health plan name beginning in July 2021 when managed care assignments become effective.

Thank you for supporting NC Medicaid and the transition to managed care. Please proactively encourage patients to self-select their health plan and primary care provider by informing them of the health plans with which you participate so each one may make the best-informed choice during their transition to managed care.

Q: I attested for glidepath; how do I go about seeing this in NC Tracks?

A: If you mean how to view the payment, then you can look at your remittance notice (RA).

Q: How do we verify on NC Tracks if it was successfully attested?

A: Those who successfully attested will receive a payment in the second check write of the month (check your RA). If you are denied payment, you will receive notification from NCTracks.

Q: How do I find out what tier if any that my provider is in for the AMH?

A: If you are a provider you can check your status on NCTracks.
https://medicaid.ncdhhs.gov/blog/2021/02/01/advanced-medical-home-tier-3%E2%80%9Cglidepath%E2%80%9D-payments

Q: For optical, will the billing go through NC Tracks or individual insurance companies and will payments be processed through Nc tracks?

A: For beneficiaries who enroll with a managed care health plan (PHP) that the provider is also enrolled with, all billing (including eyeglasses dispensing fee) will be through the health plan. However, for eyeglasses, whether FFS or PHP, providers will continue to follow current Clinical Coverage Policies 6A and 6B references to eyeglasses, obtain PA through NCTracks, and receive eyeglasses from Nash Optical Plant. The only thing that will change about the eyeglasses process is providers will bill the health plan if the beneficiary is a member of the health plan.

Q: Does this webinar address all specialties or only PCP?

A: These webinars are catered to all providers

Q: Who do we contact if PHP does not follow policy protocol?

A: The provider ombudsman

Q: In your song what are all the abbreviations?

A: Here are all the meaning of the abbreviations in the song:
BH: Behavioral Health
MH: Mental Health
SUD: Substance Use Disorder
ASD: Autism Spectrum Disorder
CME: Child Medical Evaluation
OTC: Over the Counter
PDP: Physician Drug Program

Q: Will all PHP's reimburse both medical and routine diagnosis on the same visit? Everyday scenario in pediatric ophthalmology: child with accommodative esotropia H50.43 presents for exam, requires

sensorimotor measurements (92060) for eye muscle misalignment, requires refraction (92015) with refractive diagnosis to provide glasses to align eye and prevent amblyopia, visit coded with appropriate E/M and medical diagnosis.

A: Health plans must meet the floor of current Medicaid Clinical Coverage Policies (CCP). Current Medicaid Clinical Coverage Policies 6A and 6B state in Attachment B.B.1.c. "General ophthalmological exams and office visits must not be billed by the same provider on the same day as a routine eye exam (S0620 or S0621) or a refraction only (92015)". Since Medicaid CCP does not require payment of medical and routine vision services on the same day by the same provider, health plans are not required to cover both on the same day by the same provider, either. This does not prevent health plans from covering both services on the same day by the same provider, but they are not required to do so.

Q: We have been told specialty providers who are OON with a PHP after July 1 can get reimbursed if they see patients who need care in the first 90 days – is this reimbursement at 100% Medicaid rate or is it reduced because they are OON?

A: Out-of-network providers will file services covered under NC 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 below for additional details.

- AmeriHealth Caritas of North Carolina: https://www.amerihealthcaritasnc.com/provider/forms/index.aspx
- Blue Cross and Blue Shield of North Carolina | Healthy Blue: https://provider.healthybluenc.com/north-carolina-provider/resources
- Carolina Complete Health: https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs
- WellCare of North Carolina: https://www.wellcare.com/en/North-Carolina/Providers/Medicaid/Claims
- DHHS: https://medicaid.ncdhhs.gov/providers/claims-and-billing

Q: How much of a difference in Rx between the eyes does the patient need to have to qualify for medically necessary contacts?

A: In accordance with current Clinical Coverage Policies 6A and 6B, Subsection 5.9, there is not a dioptric power criterion for medically necessary contact lenses. A diagnosis indicating medical necessity is required, such as keratoconus or anisometropia (this list of examples is not all inclusive). Each request for medically necessary contact lenses is reviewed on a case-by-case basis.

Q: When a patient is seen in June 2021 and orders glasses through the state that do not arrive until July 2021, who do we bill the dispensing fee to? Policy is to bill service date as date glasses dispensed. And if it is the new PHP what if the provider is not contracted with the PHP?

A: Yes. No matter the PHP, providers will continue to enter all Medicaid and Health Choice eyeglasses prior approval requests into NCTracks and Nash Optical will continue to fabricate and mail to providers. The only thing that changes about eyeglasses process, is that providers will bill health plans for the dispensing fee if the beneficiary is enrolled in a managed care health plan.

Q: Can PCPs hire therapists and bill for Psychotherapy without a need to be credentialed through Alliance?

A: If providers are billing outpatient codes, it needs to be billed to the MCO and the therapist would be credentialed by the MCO.

Q: Will the dispensing reimbursements change for Medicaid?

A: The dispensing fees are defined by the Department and will be consistent across the Managed Care Plans. All 5 plans have indicated they will pay the flat dispensing fee as defined by the State, rather than the Tiered Dispensing Fee based on the generic dispensing rate.

Q: When a pediatric ophthalmologist sees a newborn preemie in the NICU and later finds out that the infant was placed in a PHP they do not participate with, you say they will get paid EITHER for 90 days OR until the child is enrolled (which could be less than 90 days). Is their office obligated to help family find a participating specialist for continued screening for ROP until fully developed? (MD is liable once sees infant).

A: The plan holds the responsibility and should assist with providing a participating specialist. The provider would be paid, whether it is within the 90 days at full rate or out-of-network rates.

Q: Are all eyeglasses ordered thru Nash Optical no matter the PHP?

A: Yes. No matter the PHP, providers will continue to enter all Medicaid and Health Choice eyeglasses prior approval requests into NCTracks and Nash Optical will continue to fabricate and mail to providers. The only thing that changes about eyeglasses process, is that providers will bill health plans for the dispensing fee if the beneficiary is enrolled in a managed care health plan.

Q: How do we know if we are "in the network" for the health plan?

A: A provider must have a written agreement with a prepaid health plan (PHP) to be considered "in network". If you (or your staff) handle your own contracting directly, then you should have those written agreements and other communications from those PHPs with whom you have contracted. If you are a member of a practice, group, or system where contracting is handled through a centralized point for a number of providers, then contacting that area for the information about the contracting with PHPs would be appropriate. Another alternative would be to check each PHP's provider directory found on the PHP's website.

Q: For those therapy disciplines that require an MD order for a prior auth for treatment, how can therapy providers get MD orders while beneficiary's have not yet been seen by their new PCP?

A: We are not aware of a managed care requirement for specialized therapy orders to be issued only by PCPs. Moreover, the PHPs are required to honor exiting PAs for the first 90 days after managed care launches July 1. The PHPs are also required to work with out-of-network providers as if they are in-network for the first 60 days after launch. Thank you.

Q: Do you know if the timely filing will be the same with the health plans as traditional Medicaid?

A: Health plans are responsible for claims processing and timely payments to providers for claims submitted within 180 days of the date of service. Health plans must, within 18 calendar days of receiving the Medical claim, notify the provider whether the claim is clean or request all additional information needed to timely process the claim. If the claim is clean, the health plan must pay or deny within 30 days of receipt. Health plans will be required to act on additional information that is submitted by a provider within the required timeframe. Health plans that do not pay claims within the required timeframe according to prompt pay requirements will bear interest at the annual rate of 18 percent beginning on the date following the day on which the claim should have been paid or was underpaid. In addition to interest, a health plan shall pay the provider a penalty equal to one percent of the claim per day. Providers do not have to make separate requests to the health plan for interest or penalty payments and are not required to submit another claim to collect the interest and penalty. Link to Prompt Payment Guidance Fact Sheet: https://files.nc.gov/ncdma/NCMT-Provider-FactSheet-Playbook-Provider-Payment-20200331.pdf

The Department offers additional information in the "Prompt Payment" fact sheet available at https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care/fact-sheets, or in the DHB PHP contract available at https://medicaid.ncdhhs.gov/transformation/health-plans. Health plans also offer claim submission and processing information in their Provider Manual. The Department offers links to each health plan's Provider Manual on the Health Plan Contacts and Resources webpage at https://medicaid.ncdhhs.gov/transformation/health-plans/health-plan-contacts-and-resources.

Q: As an optometrist we are having issues with responses from the additional health plans associated with the managed care. What is the problem?

A: Many of the Prepaid Health Plans (PHPs) have made arrangements with vision network subcontractors who will manage the PHP's vision network. You may use the information at this website (https://medicaid.ncdhhs.gov/transformation/health-plans/health-plan-contacts-and-resources) to reach out to each PHP and request to be contact relating to contracting. If you continue to experience issues with non-response from the PHPs (or their subcontractors), please reach out to the Department again through the Provider Ombudsman.

For provider inquiries, concerns, complaints regarding health plans
Medicaid.ProviderOmbudsman@dhhs.nc.gov
Phone: 919-527-6666

Q: When do we get the glidepath payment?

A: Enhanced payments for eligible practices will automatically be added to monthly Carolina Access payments (and Advanced Medical Home glidepath payments for qualifying practices) for April – June 2021. Practices receiving enhanced payments must complete a practice survey following this health equity initiative; failure to complete the survey may result in NC DHHS recouping payments. The survey will be provided by email and will seek to understand how the payments advanced health equity for the practice and will inform future initiatives. Practices are directed to use these funds to enhance primary care medical home services to support beneficiaries to ultimately address health equity.

Q: How will children enrolled in the CDSA Infants Toddler Program be transitioned to the managed care plans?

A: The guardians of children who are eligible for Standard Plan participation will be notified by NC Medicaid of how to enroll in a Standard Plan. IFSP Services provided and billed by the CDSAs will be provided under Medicaid Direct. Services on the IFSP not provided and billed by the CDSAs as well as all other Medicaid services will be provided by the managed care plan.

Q: On July 1, 2021, an uninsured pregnant client present to a health department for prenatal care. We complete a Medicaid Presumptive Eligibility (MPE) and submit to DSS for review and approval. Client is approved for MPE from 7/1/21 to end of August. My understanding is that MPE remains w/ traditional Medicaid. Correct? What coverage will client have on September 1st?

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. Presumptive Eligibility for Pregnant Women only covers ambulatory prenatal services including prescriptions provided by a Medicaid enrolled provider. The presumptive provider should advise the pregnant women to apply for NC Medicaid by the last day of the month following the month she is determined presumptively eligible. If the pregnant woman applies for Medicaid within the time frame, she remains presumptively eligible for Medicaid until the county makes a determination on her Medicaid application. If the pregnant women fails to apply for Medicaid, she is only eligible for Presumptive Medicaid for Pregnant Women through the last day of the month following the month she is determined presumptively eligible.

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 webpage.

Q: Can you all provide a virtual presentation/overview for agencies? If so, who do we contact?

A: NC Medicaid has hosted several webinars for our community partners. Recordings of each webinar, along with the slide deck, are available on our website on this page https://medicaid.ncdhhs.gov/transformation/more-information (you will need to scroll down to the bottom of the page).

If you would like to be notified of upcoming webinars or are interested in hosting a presentation, please send an email to Medicaid.NCEngagement.dhhs.nc.gov

Q: For the glidepath payment, does the practice have to test and have a contract with the same health plan - OR can the contracts be with different health plans than those who were tested with.

A: The contract and testing should be with the same two health plans.

Q: NC Medicaid does not currently require prior auth on some DME/enteral nutrition HCPCS, but some of the PHPs will now require prior auth on those same HCPCS effective 7/1. Will there be a grace period to service existing patients already on service for these HCPCS after 7/1 until we obtain auth from the PHP?

A: Please inform the person asking this question that it appears at least some of the PHPs will allow flexibility on PA for nutritional items during the 90-day crossover period. To be safe, we would recommend contacting each PHP's call center to confirm this understanding. You might also consider shipping extra nutritional supplies before the managed care launch while Medicaid fee-for-service quantity limits on these items remain suspended for the public health emergency. See COVID-19 Special Bulletin #69 here: https://medicaid.ncdhhs.gov/about-us/covid-19-guidance-and-resources/providers/covid-19-special-medicaid-bulletins. Thank you.

Q: Is there a contact for us to engage if we have contracted over 14 days ago and our providers are still not listed as enrolled with the PHPs within the provider lookup tool?

A: NC Medicaid encourages providers to reach out to the Provider Ombudsman. These types of inquiries, concerns or complaints can be submitted to Medicaid.ProviderOmbudsman@dhhs.nc.gov, or through the Provider Ombudsman line at 919-527-6666. The Provider Ombudsman contact information is also published in each health plan's provider manual.

Q: When can we expect the Local Health Dept Program Guide?

A: The guide is currently posted.
https://files.nc.gov/ncdma/documents/Providers/Programs_Services/care_management/Program-Guide-High-Risk-Pregnancy-and-At-Risk-Children-11072018.pdf

Q: When will I know if my practice will get glidepath payments?

A: Enhanced payments for eligible practices will automatically be added to monthly Carolina Access payments (and Advanced Medical Home glidepath payments for qualifying practices) for April – June 2021. Practices receiving enhanced payments must complete a practice survey following this health equity initiative; failure to complete the survey may result in NC DHHS recouping payments. The survey will be provided by email and will seek to understand how the payments advanced health equity for the practice and will inform future initiatives. Practices are directed to use these funds to enhance primary care medical home services to support beneficiaries to ultimately address health equity.

Q: Can you confirm that April Glidepath payments will be in the April 13 check write?

A: Yes

Q: Is there a central search location to determine which plan patients are enrolled in at the time of service?

A: The Recipient Eligibility Verification function of NCTracks has been modified to include managed care enrollment information. In addition, functionality is being added to review eligibility for the following month. This will allow you, for example, to verify the projected eligibility and managed care assignment information for the month of July during the month of June. Please understand that eligibility and assignment may change before the first of the following month and for this reason, Medicaid coverage must always be verified prior to rendering services.

Thank you for your inquiry and for supporting NC Medicaid and the transition to managed care. Have a great day.

Q: Cumberland DSS is telling patients and care management for patients to call the EB number for the change forms. Is this correct?

A: There is a health plan change request form that is currently being finalized by NCDHHS. Beneficiaries can complete that form to request a health plan change (that form will only be needed after the 90-day choice period, so starting October 1, 2021). That form will be available on the ncmedicaidplans.gov website.

As far as PCP changes go, after a beneficiary has enrolled with a health plan, they will need to contact their health plan to change their PCP. There is not a form for beneficiaries to complete to change their PCP.

Q: Did I understand that a private practice cannot discharge a patient if they're having issues with them?

A: PCP are encouraged to use their care management resources to help members with barriers to engage. PCPs should also work with their Health plans to help members with barriers to engagement or to find a better PCP fit if all options have been exhausted.

Q: Where can we find PCP change request forms?

A: The health plan change request form is still in being finalized by the Department. Once finalized, it will be available on ncmedicaidplans.gov.

Q: For optical coverage, where/how are frames/ lenses supplied?

A: All frames and lenses will continue to be supplied through Nash Optical (for beneficiaries who remain Fee-for-Service [FFS] and beneficiaries enrolled in managed care health plans). For all Medicaid and NC Health Choice eyeglasses, providers will continue to enter eyeglasses prior approval requests into NCTracks, and Nash Optical Plant will continue to fabricate and deliver the eyeglasses to the provider. If the beneficiary is FFS, the provider will bill the dispensing fee to NC Medicaid. If the beneficiary is enrolled in a health plan, the provider will bill the dispensing fee to the health plan.

Q: Right now, if a patient has a private insurance showing on the plan, but the private policy has termed we send an update to HMS. Do we still do that with the PHP Plans?

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. You will continue to follow the same process you currently follow for reporting patients terminated insurance. If that process changes you will be notified.

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 webpage.

Q: For clarity, who will dental services be billed to?

A: Dental services are carved out of Managed Care. Dental providers will continue to submit prior approval requests and claims for payment in NCTracks like they do today. Dental providers (with the

exception of oral and maxillofacial surgeons who bill on the medical CMS-1500 format with CPT codes) will NOT need to be contracted and credentialed with the PHP plans.

Managed Care Benefits and Services

https://ncmedicaidplans.gov/learn/benefits-and-services

There are some services each health plan does not provide.

You can get these services from a provider outside of the health plan's network, as long as the provider takes Medicaid:

- Dental services
- Services provided by local education agencies
- Services provided by children's developmental agencies that are included in your child's Individualized Family Service Plan
- Fabrication of eyeglasses, including complete eyeglasses, eyeglass lenses and ophthalmic frames

Q: Will we need to continue completing Carolina Access forms after July?

A: Only for members in Medicaid Direct.

Q: When will patients begin to receive their new cards? Will it show my practice as PCP?

A: Health plan members will begin receiving Medicaid cards after auto-enrollment (May 15, 2021). Medicaid cards will include the PCP's name and phone number.

Q: Will we be able to see the PHP selected by the member in NC Tracks prior to July 1 go live date?

A: The Recipient Eligibility Verification function of NCTracks has been modified to include managed care enrollment information. In addition, functionality is being added to review eligibility for the following month. This will allow you, for example, to verify the projected eligibility and managed care assignment information for the month of July during the month of June. Please understand that eligibility and assignment may change before the first of the following month and for this reason, Medicaid coverage must always be verified prior to rendering services.

Thank you for your inquiry and for supporting NC Medicaid and the transition to managed care. Have a great day.

Q: If someone has Medicaid as secondary insurance to Medicare, will they be going on a managed care 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. At this time beneficiaries in NC that receive both Medicaid and Medicare are temporarily exempt from enrolling in a managed care health plan. They will remain in NC Direct with Medicaid as the last pay source.

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 webpage.

Q: Will you be able to bill well visits in addition to another visit on same day?

A: Yes here's how: How to code for a well visit with a sick visit

From a pure coding perspective, the guidelines for billing an E/M service in addition to a preventive service are spelled out under the Preventive Medicine Services section in the CPT book. The guideline state; "If an abnormality is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate Office/Outpatient code 99201-99215 should be reported. Modifier 25 should be added to the Office/Outpatient code to indicate that a significant, separately identifiable Evaluation and Management service was provided by the same physician on the same day as the preventive medicine service."
The key to adding an E/M service to a preventive service is the significance of the problem, the amount of work required at that visit to deal with the problem, and how clearly this is documented in the patient chart.
1. Acute visit, Minor problem combined with well visit.
a. Bill only the preventive well-child visit.
b. Documentation is the key to whether or not the additional work during the preventive visit qualifies for an additional E/M visit code.
c. Keep in mind, that insignificant or minor problems that does not require additional work-up should not be reported separately.
d. Example of when not to use the E/M code with modifier 25:
§ During an acute visit for a 12 month old child the physician notes diaper rash in the chart and writes a prescription for the rash, during the visit he also becomes aware that the child has not been in for a well visit since the child was 6 months old. The physician decided to conduct a well-child visit during the acute visit. Do not count this visit as a sick visit since the problem (diaper rash) was an insignificant or minor problem. So, code the visit as a well visit only. Also, the well child visit will go toward the pay for quality program.
§ Diagnosis Code: V20.0 (Routine infant or child health check)
§ CPT Code: 99392 (Established Preventative Medicine Services Code for child age 1 through 4)
§ Documentation requirements:

-Must document all components for well child visit during the above visit;
-A comprehensive health and developmental history – physical health, mental health, development, and nutrition;
-An unclothed physical exam with height, weight, and head circumference;
-Health education or anticipatory guidance

2. Acute visit with a significant problem combined with well visit.
a. Bill both preventive well-child visit and all services rendered during sick visit.
b. If the provider encounters a significant new problem or a preexisting problem that requires a significant work-up including, the ordering of additional tests, consultation with other specialists, and/or further follow up care, then the appropriate level of E/M for the additional work should be coded.
c. Example of when to use an E&M code with modifier 25:
§ A four-year-old child comes in for follow-up visit for asthma and the provider noted that the child is wheezing. He sends the child for an x-ray and gives a nebulizer treatment. While reviewing the chart the provider also notes that the member has not been in for a well visit since age 2. The provider decides to conduct a well-child visit during the acute visit. Because the problem/abnormality is significant enough to require additional work to perform the key components of a problem – oriented E/M service, then the appropriate Office/Outpatient code 99201-99215 should also be reported. Modifier 25 should be added to the Office/outpatient code to indicate that a significant, separately identifiable Evaluation and Management service was provided by the same physician on the same day as the preventative medicine service.
§ Diagnosis Code: V20.2 (Routine Infant or child health check)
493.00 (Asthma, unspecified)
§ CPT Code: 99392 (Established Preventive Medicine Services Code for child [age 1 through 4])
99214 (E/M for established patient), with modifier 25
771010 (chest, single view)
Code for nebulizer treatment
§ Documentation requirements:
1. Must document all components for well child visit during the above visit;
2. A comprehensive health and developmental history – physical health, mental health, development, and nutrition;
3. An unclothed physical exam with height, weight, and head circumference;
4. Health education or anticipatory guidance
5. In addition to the well visit documentation, the provider must include the additional work that was conducted for the asthma follow-up visit in the documentation.