Trillium HEALTH RESOURCES

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Clinical Communication Bulletin 69

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Subject: Hurricane Helene Policy Flexibilities to Support Providers and Members - Oct. 11, 2024

HURRICANE HELENE POLICY FLEXIBILITIES TO SUPPORT PROVIDERS AND MEMBERS

This bulletin contains information on updated flexibilities being implemented by NC Medicaid due to the Hurricane Helene Public Health Emergency. Trillium is working to update our behavioral health and physical health portals.

This bulletin replaces in full the Update on NC Medicaid Temporary Flexibilities Due to Hurricane Helene – October 1, 2024 bulletin.

New sections added from the previous bulletin are indicated with an asterisk (*)

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North Carolina Governor Roy Cooper issued Executive Order 315 on Sept. 25, 2024, which declared a state of emergency for North Carolina in anticipation of potential severe weather caused by the approach of Hurricane Helene.

NC Medicaid is committed to North Carolina's response to and recovery from Hurricane Helene. We are working with county and federal partners to make it faster and easier for beneficiaries to receive - and for health care professionals to provide - Medicaid care and services.

The flexibilities in this bulletin are effective from Sept. 26, 2024, through Dec. 31, 2024 (unless otherwise communicated by DHHS). Additional updates will be provided as they become available.

This bulletin contains several new clinical policy flexibilities which have been implemented due to the Hurricane Helene Public Health Emergency (PHE). The flexibilities listed in this bulletin are intended to benefit those members and providers

directly impacted by Hurricane Helene. These flexibilities are also intended to alleviate burden for providers who are supporting impacted members and/or have additional patients (patient surges).

It is recommended that providers only leverage the below listed flexibilities to support impacted beneficiaries or while impacted facilities and staff are recovering from Hurricane Helene. Providers should return to normal business operations as soon as possible to be compliant with NC Medicaid Clinical Coverage Policies (CCPs).

REMINDER: providers should always check NC Medicaid eligibility in NCTracks to confirm beneficiary enrollment in NC Medicaid, especially when the beneficiary presents without a Medicaid ID or their health plan ID card, to determine which health benefit the beneficiary is enrolled in and whether their eligibility remains current. Please see the Key Reminders for Providers > Information on Checking Beneficiary Eligibility section at the bottom of this bulletin for more details.

Disaster Relief Applications Available for Health Care Providers Not Currently Enrolled as a NC Medicaid Provider

NC Medicaid wants to ensure access to care for NC Medicaid beneficiaries and reimbursement to qualified providers for services rendered during the period of impact due to Hurricane Helene.

The Centers for Medicare & Medicaid Services (CMS) granted approval on Oct. 1, 2024, for NC Medicaid to implement a temporary, expedited enrollment process for health care providers to become a NC Medicaid provider due to a natural disaster. **This process is available to enroll with an automatic begin date of Sept. 25, 2024. The process will remain available through Dec. 31, 2024 (unless otherwise communicated by DHHS) and is not for providers who are already enrolled with NC Medicaid.**

Health care providers who will render services to NC Medicaid beneficiaries due to Hurricane Helene may apply through the NCTracks Provider Portal. See the NCTracks Provider homepage for more detail, as well as links to begin enrollment. Instructions are also offered in the Disaster Relief Provider Enrollment Application Job Aid (PRV703), which is available on the NCTracks Provider webpage as well as under Quick Links on the NCTracks Provider Enrollment webpage. **Be sure to review the job aid before applying as several preliminary steps are required.**

Although providers may select any Provider Enrollment Application Type as appropriate, they should select "Disaster Relief Provider Enrollment" on the Online Provider Enrollment Application page of the application to enroll using the temporary, expedited process.

Note: Disaster Relief provider enrollment is not for providers who see NC Medicaid beneficiaries on a regular basis. The expedited enrollment is not needed when a provider is already enrolled with NC Medicaid.

If you have questions, please contact:

- NCTracks Call Center:
  1-800-688-6696
- Provider Ombudsman:
  1-866-304-7062
  Medicaid.ProviderOmbudsman@dhhs.nc.gov

Reimbursement for Medically Necessary Services during Hurricane Helene

This section applies to NC Medicaid Direct and NC Medicaid Managed Care

NC Medicaid will reimburse providers for medically necessary drugs and services, equipment and supplies, provided during the Hurricane Helene emergency without prior authorization (PA) starting Sept. 26, 2024, through Dec. 31, 2024, (unless otherwise communicated by DHHS).

Medical documentation must support medical necessity. In addition, beneficiaries who have been evacuated out-of-state, voluntarily or involuntarily, can receive medically necessary services and/or care if needed and NC Medicaid Direct and NC Medicaid Managed Care will reimburse the out-of-state provider without PA.

Out-of-state providers must enroll as NC Medicaid providers, if not already enrolled with NC Medicaid. Please see the section of this bulletin "Disaster Relief Applications Available for Health Care Providers Not Currently Enrolled as an NC Medicaid Provider" for more details.

Providers are encouraged to request a PA if it is possible to do so (and normally required for the service). All claims are subject to audit.

Behavioral Health Services

This section applies to NC Medicaid Direct and NC Medicaid Managed Care.

NC Medicaid, in partnership with the DHHS Division of Mental Health, Developmental Disabilities and Substance Use Services (DMHDDSAS) and the Division of Health Service Regulation (DHSR), is temporarily modifying its Behavioral Health and Intellectual and Developmental Disability clinical coverage policies to better enable the delivery of care to NC Medicaid beneficiaries impacted by Hurricane Helene.

Behavioral health services must continue to be provided at an intensity and quality that meet the needs of the beneficiary and be consistent with goals and the intended outcomes of the service being provided. In addition, the service must be provided by staff at a ratio (as relevant) and with the expertise and scope necessary to meet the needs of each beneficiary.

The flexibilities listed in this bulletin are intended to benefit those members and providers directly impacted by Hurricane Helene. These flexibilities are also intended to alleviate burden for providers who are supporting impacted members and/or have additional patients (patient surges). It is recommended that providers only leverage the below listed flexibilities to support impacted beneficiaries or while impacted facilities and staff are recovering from Hurricane Helene. Providers should return to normal business operations as soon as possible to be compliant with NC Medicaid CCPs.

Behavioral Health Services delivered via telehealth or telephonically must follow the requirements and guidance in CCP 1-H, Telehealth, Virtual Communications, and Remote Patient Monitoring, at https://medicaid.ncdhhs.gov/. Services delivered via telehealth must have the GT modifier appended to the Current Procedure Terminology (CPT) or the Healthcare Common Procedure Coding System (HCPCS) code to indicate that a service has been provided via interactive audio-visual communication. Services delivered via telephonically must have the KX modifier appended to the CPT or HCPCS code to indicate that a service has been provided via telephonic, audio-only communication.

Note: While Tailored Plans and LME/MCOs provide all the services listed in this section Standard Plans only offer a subset of the below behavioral health services.

1915(b)(3) and 1915(i) Services

- Supported Employment for Individuals with Intellectual and developmental disabilities:
  - Service may be provided by two-way, real-time audio and video, as well as telephonically.
- Individual and Transitional Support:
  - Service may be provided by two-way, real-time audio and video as well as telephonically.
- 1915(b)(3) In-Home Skill Building and 1915(i) Community Living and Support:
  - Service may be provided by two-way, real-time audio and video.

Assertive Community Treatment (ACT)

CCP 8A-1

- Waive prior authorization and reauthorization request.
- Waive staff to beneficiary ratio of 1:8 for small teams and 1:9 for medium and large teams.
- Waive requirement that team must demonstrate fidelity to the latest tool for Measurement of ACT (TMACT) model of care.
- Waive median rate of service frequency and median rate of service intensity.
- Waive staff training requirements within 120 days of employment, if unable to be obtained during the state of emergency.
- Allow any agency-employed, licensed staff to provide supervision within scope if team lead is unavailable.
- Allow Associate licensed professional to have more than 30 months to become fully licensed.
- Allow supervision to occur virtually.
- Waive requirement that staff must be dedicated to the team.
- Service may be provided via real-time, two-way interactive audio and video telehealth.
- Service may be provided telephonically if telehealth is not accessible.

Ambulatory Withdrawal Management with Extended On-Site Monitoring (Ambulatory Detoxification)

CCP 8A-8

- Waive authorization requirement after the first three days of service has been provided.
- Waive staff training requirements for length of the state of emergency or unless otherwise notified.

Ambulatory Withdrawal Management (WM) without Extended On-Site Monitoring (Ambulatory Detoxification)

CCP 8A-7

- Waive requirement for authorization after the first three days of service has been provided.
- Waive staff training requirements for length of the state of emergency or unless otherwise notified

Child and Adolescent Day Treatment

CCP 8A

- Waive prior approval request and reauthorization request.
- Waive minimum of three hours of service per day.
- Allow service to be provided outside of the facility by telehealth, telephonically or in-person, including in the person's residence.
- Waive requirement that a maximum of 25% of treatment services may be provided outside of the day treatment facility.
- Waive staff-to-beneficiary ratio if provided outside of the facility.
- Waive requirements for staff training within 30 and 90 days of employment and follow-up, and ongoing continuing education requirements for fidelity of clinical models, if unable to be obtained during the state of emergency.
- Allow for supervision by any licensed professional, within scope, employed by the provider agency if team lead is unavailable.
- Allow service when school is not in operation.

Community Support Team

CCP 8A-6

- Waive authorization requirement after the 30-day pass-through.
- Waive reauthorization requirement.
- Waive requirement that staff must be dedicated to the team.
- Waive requirement that associate licensed professional team lead be fully licensed within 30 months.
- Waive maximum of eight units for first and last 30-day period for individuals transitioning to and from other services and allow for 40 units of service overlap.
- Allow team meetings to occur virtually.
- Waive requirement that 75% of the service must be delivered face-to-face and outside of agency.
- Waive Comprehensive Clinical Assessment beyond six months of treatment.
- Waive staff to beneficiary ratio of 1:12.
- Waive monitoring of delivery of service by team leader.
- Waive staff training requirements within 30 and 90 days of employment, if unable to be obtained during the state of emergency.
- Allow functional assessments and crisis interventions to be completed by telehealth or telephonic modalities, as clinically appropriate.
- Service may be provided via real-time, two-way interactive audio and video telehealth.
- Service may be provided telephonically if telehealth is not accessible.

Developmental and Psychological Testing

CCP 8C

Service can be provided via telehealth: CPT codes 96112, 96113, 96136, 96137, 96138, 96139

Diagnostic Assessment

CCP 8A-5

Waive prior authorization for additional units beyond one unmanaged Diagnostic Assessment per state fiscal year.

Facility-Based Crisis Services for Children and Adolescents

CCP 8A-2

- Waive requirement that authorization request must be submitted within two business days of admission.
- Waive staff training requirements if unable to be obtained during the state of emergency.
- Allow behavioral assessment to be completed by telehealth by the psychologist.

Intensive In-Home

CCP 8A

- Waive prior approval and reauthorization request.
- Waive staff training requirements within 30 and 90 days of employment, if unable to be obtained during the state of emergency.
- Waive the two-hour per day minimum service provision and reduce to one-hour per day to bill the service.
- Waive requirement that staff must be dedicated to the team.
- Waive requirements that 60% of contacts should be face-to-face and 60% of staff time should be spent outside of facility.
- Waive team-to-family ratio of 1:12.
- Allow for supervision by any licensed professional on the team or employed by the provider agency, within scope and training, if Team Lead is unavailable.
- Service may be delivered via real-time, two-way interactive audio and video telehealth.
- Service may be provided telephonically if telehealth is not accessible.

Medically Monitored Inpatient Withdrawal Management (non-hospital medical detoxification)

CCP 8A-11

- Waive requirement for authorization after the first three days of service have been provided.
- Allow LCAS and CCS to provide services by telehealth or telephonically in lieu of being provided in-person at the facility.
- Physician assessments may be conducted in-person or by telehealth.
- Waive staff training requirements for length of the state of emergency (SOE).

Medically Supervised or Alcohol and Drug Abuse Treatment Center (ADATC) Detoxification Crisis Stabilization

CCP 8A

- Waive authorization requirement after the first eight hours of service.
- Waive maximum of 30-days of treatment within 12 months.

Mobile Crisis Management

CCP 8A

- Waive concurrent review after the first 32 units of service have been rendered.
- Waive 80 percent of the service must be provided face-to-face.
- Waive staff training requirements within 90 days of employment, if unable to be obtained during the state of emergency.
- Waive concurrent review after the first 32 units of service have been rendered.
- Waive requirement that 80% of the service must be provided face-to-face.
- Service may be provided via real-time, two-way interactive audio and video telehealth.

Multisystemic Therapy

CCP 8A

- Waive prior approval and reauthorization request.
- Waive staff introductory and quarterly training requirements if unable to be obtained during the state of emergency.
- Waive minimum monthly contacts of 12 contacts in the first month
- Waive minimum monthly contacts of six contacts in the second and third month.
- Waive the three to five-month maximum duration of service.
- Allow supervision by another master's level qualified professional (QP) employed by the provider agency if team lead is unavailable.
- Waive requirements that 50% of face-to-face contact with beneficiary and family and 60% of staff time should occur outside of facility.
- Waive maximum of 480 units per three months.
- Service may be provided via real-time, two-way interactive audio and video telehealth.
- Service may be provided telephonically if telehealth is not accessible.

Opioid Treatment Program

CCP 8A-9

- Waive requirement for prior authorization and concurrent reviews after the 90-day pass-through.
- Waive requirement that a licensed professional shall complete a CCA or DA within 10 calendar days of the admission, to determine an ASAM level of care for discharge planning.
- Waive requirement for clinical staff to be available five days per week to offer and provide counseling.
- Waive requirement for medical provider staff to be available five days per week to provide methadone and buprenorphine inductions and beneficiary care.
- Waive requirement for In-Clinic Dosing Services to be available at least six days per week, 12 months per year, for a beneficiary who is in the induction phase or who is not stable enough for unsupervised take-home doses. Daily, weekend and holiday medication dispensing hours must be scheduled to meet the needs of the beneficiary.
- Waive requirement for the supervising RN, physician, NP, or PA to be available by phone immediately and physically arrive within one hour and be present on site in a timely manner as much as needed to address beneficiary assessment and care needs.
- Waive Monitoring drug testing, to be conducted at least one time per month.
- Waive requirement for a biopsychosocial assessment if unable to complete at intake.
- Waive staff training requirements for the length of SOE or unless otherwise notified.

Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers

CCP 8C

Waive initial and reauthorization.

Partial Hospitalization

CCP 8A

- Waive prior approval requirement and reauthorization requirements

- Waive requirement of minimum service availability of four hours a day five days per week.
  - Service must be provided for a minimum of 10 hours of treatment per week to bill for the service.
- Allow service to be provided outside of the facility by telehealth, telephonically or in-person, including in the person's residence.

Peer Support Services (PSS)

CCP 8G

- Waive the requirement for telehealth or telephonically, audio-only communication be limited to 20% or less of total service time provided per beneficiary per fiscal year.
- Waive staff-to-beneficiary ratio.
- Waive staff training requirements unable to be obtained during the state of emergency within 30 and 90 days of employment.
- Waive initial authorization and reauthorization.

Professional Treatment Services in Facility-Based Crisis Program

CCP 8A

- Waive per person maximum of 45 days of treatment per calendar year.
- Waive prior approval requirement and reauthorization requirement

Psychiatric Residential Treatment Facility for Children under the Age of 21

CCP 8D-1

- Allow psychiatrist to provide services via telehealth instead of providing on-site at the facility.
- Allow licensed therapist(s) to provide services via telehealth instead of providing on-site at the facility.

Psychosocial Rehabilitation

CCP 8A

- Waive prior authorization and reauthorization request.
- Waive requirement for a minimum of five hours per day, five days a week of service availability.
  - Service must be available a minimum of 10 hours per week.

- Waive staff ratio of 1:8 only if provided by telehealth or telephonic modalities.
- Allow service to be provided outside of the facility by telehealth, telephonically or in-person, including in the person's residence.

Research Based – Behavioral Health Treatment (RB-BHT)

CCP 8F

- Waive concurrent authorization under Medicare authorities.
- If two-way audio-visual options are not accessible to the beneficiary, the following services may be offered by telephonic modality: CPT codes 97151, 97152, 97153, 97154, and 97155.

Residential Treatment Services Level I and II – Family Type

CCP 8D-2

- Allow QP, licensed professional, psychologist, psychiatrist to provide treatment and consultation by telehealth and/or telephonically, as clinically indicated and based on level of expertise, instead of providing on-site at the facility.
  - All supervision and daily structure services must be provided in-person by the appropriate staff.
- Waive reauthorization.
- Waive staff training requirements unable to be performed during the state of emergency, except sex offender specific training.

Residential Treatment Services Level II –- Program Type

CCP 8D-2

- Waive staff training requirements if unable to be obtained during the state of emergency, except for sex offender specific training.
- Allow sex offender training to occur virtually.
- Allow QP, social worker, psychologist or psychiatrist to provide treatment, services and consultation by telehealth and telephonically, as clinically indicated and based on level of expertise, instead of providing on-site at the facility.
- Waive reauthorization.

Residential Treatment Services Level III

CCP 8D-2

- Allow QP, social worker, psychologist or psychiatrist to provide treatment, services and consultation by telehealth and telephonically, as clinically indicated and based on level of expertise, instead of providing on-site at the facility.
- Waive staff training requirements if unable to be obtained during the state of emergency, except for sex offender specific training.

Residential Treatment Services Level IV

- **CCP 8D-2**
- Waive staff training requirement if unable to be obtained during the state of emergency except for sex offender specific training.
- Allow sex offender training to occur virtually.
- Allow social worker, psychologist or psychiatrist to provide services via telehealth instead of providing them in-person at facility.
- Waive opportunity for individual inclusion in community activities.

Substance Abuse Comprehensive Outpatient Treatment (SACOT)

CCP 8A

- Waive reauthorization after the initial 60-day pass through.
- Waive the required for minimum service availability of four hours per day, five days per week.
  - Service must be provided for a minimum of two hours of treatment per day, five days per week to bill for the service.
- Waive Urine Drug Screening requirements.
- Waive requirement for family counseling if family is unavailable or unwilling to participate in telehealth or telephonic interventions.
- Allow service to be provided outside of the facility by telehealth, telephonically or in-person, including in the person's residence.
- Waive beneficiary-to-staff ratio if provided outside of the facility.
- Waive requirement that certified clinical supervisor (CCS) or licensed clinical addiction specialist (LCAS) must be on-site but must be available virtually a minimum of 90% of the hours the service is in operation.

Substance Abuse Intensive Outpatient Program (SAIOP)

CCP 8A

- Waive reauthorization after the initial 30-day pass through
- Waive the required minimum service availability of three hours per day, three days per week.
  - Service must be provided for a minimum of 1.5 hours of treatment per day, three days per week to bill for the service.
- Waive beneficiary to staff ratio if provided outside of the facility.
- Waive Urine Drug Screening requirements.
- Waive requirement for family counseling if the family is unavailable or unwilling to participate in telehealth or telephonic interventions.
- Allow service to be provided outside of the facility by telehealth, telephonically or in-person, including in the person's residence.
- Waive requirement that the CCS or LCAS be on-site 50% of the hours open; but must be available virtually.

Substance Abuse Medically Monitored Community Residential Treatment

CCP 8A

- Waive prior authorization and reauthorization request.
- Allow LCAS and CCS to provide services by telehealth or telephonically in lieu of being provided in-person at the facility.
- Allow supervision of QP, Associate Professional (AP) to occur virtually.

Substance Abuse Non-Medical Community Residential Treatment

CCP 8A

- Waive prior authorization and reauthorization request.
- Allow LCAS and CCS to provide services by telehealth or telephonically interventions in lieu of being provided in-person at the facility.

Therapeutic Leave for Psychiatric Residential Treatment Facilities for Children under the Age of 21 and Residential Treatment Services Levels II-IV

CCP 8D-1 and CCP 8D-2

Allow an increase of Therapeutic Leave days from 45 days to 90 days.

Dental

This section applies to NC Medicaid Direct only.

NC Medicaid Direct is implementing the following flexibilities to support providers during the Hurricane Helene PHE:

- **Coverage for Teledentistry for Provider to Patient Visits (D0999):**
  - CDT code D0999 (Telephonic Encounters Without Live Video, Recorded Video and/or Digital Photos) is added for telephone or audio-only encounters between providers and patients that do not result in a diagnosis.
  - Telephonic encounters billed with D0999 are not allowed to be reported with any other service. Providers should not bill D9995 or D9996 for telephone or audio-only interactions, as these codes require the use of video or photos.
- **Coverage for Teledentistry for Provider to Patient Visits (D9995)**
  - Expanding CDT code D9995 (Teledentistry – synchronous; real-time encounter) for provider to patient encounters using real-time video.
  - This is reported in addition to other procedures, e.g., diagnostic, delivered to the patient on the date of service). A dentist is not required to be present with a patient during provider-to-patient synchronous teledentistry encounters.
    - Note: This code can be billed for both provider to provider and provider to patient encounters.
- **Coverage for Teledentistry for Provider to Patient Visits (D9996)**
  - Allowing CDT code D9996 (Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review) for provider to patient encounters using recorded video or photos.
  - This is reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service. A dentist is not required to be present with a patient during provider-to-patient asynchronous teledentistry encounters.

        - Note: This code can be billed for both provider to provider and provider to patient encounters.
    - There is a frequency limit applied the use of this code; for both provider to provider and provider to patient asynchronous teledentistry encounters, providers may not bill this code more than once per week, per patient.

- **Allowing overrides of radiographic images**
    - Allowing an override of the one-year limit for bitewing radiographic images (D0270-D0272-D0273-D0274) and the five-year limit for panoramic radiographic images (D0330) by submitting a retroactive prior approval request in the NCTracks PA Portal with documentation about previous radiographs lost in Hurricane Helene.
    - Instead of overrides for Intraoral complete series of radiographic images (D0210), providers should bill D0220 (Intraoral periapical first radiographic image) and D0230 (Intraoral periapical each additional radiographic image) and the NCTracks system will allow the maximum allowed reimbursement for D0210 for bitewings and periapical films billed.
    - Reminder: Most providers have digital radiographs that should be available with office computer backup requirements.
- **Allowing overrides for partial and complete denture replacement**
    - Allowing an override of the 8-year limit on partial dentures and the 10-year limit on complete dentures for appliances lost in Hurricane Helene with documentation from the Federal Emergency Management Agency (FEMA), the American Red Cross, or a homeowners insurance claim indicating loss of possessions.
- **Fluoride Varnish Flexibilities**
    - Allowing the topical application of fluoride varnish (D1206) for all ages.
    - Under this clinical policy modification, NC Medicaid is also allowing the topical application of fluoride varnish (D1206) once per three calendar month period (approximately every 90 days) for patients at high risk for caries (active disease or previous caries related treatment).

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

This section applies to NC Medicaid Direct and NC Medicaid Managed Care

In addition to the removal of PA requirements as listed in the "Reimbursement for Medically Necessary Services During Hurricane Helene" section at the top of this bulletin, NC Medicaid has added:

- DMEPOS coverage for HCPCS code A4928 – surgical mask, per 20, effective Sept. 26, 2024, through Dec. 31, 2024 (unless otherwise communicated by DHHS)
- If medically necessary, this item may be provided to NC Medicaid beneficiaries without prior authorization.

Family Planning

This section is applicable to NC Medicaid Direct Family Planning (MAFDN) Beneficiaries.

NC Medicaid Direct has temporarily modified its Family Planning CCP, 1E-7 to better enable the delivery of remote care to Medicaid beneficiaries. Both new and established MAFDN-eligible beneficiaries may receive family planning services, including a new patient visit, in-person or via telemedicine, and an annual exam is not required.

Innovations and Traumatic Brain Injury (TBI) Waiver

This section applies to NC Medicaid Direct and NC Medicaid Managed Care

These flexibilities below are intended for NC Innovations and TBI Waiver beneficiaries in NC Medicaid Direct and NC Medicaid Managed Care who were impacted by the hurricane either directly or due to staff impacted and unable to provide services and effective Sept. 26, 2024, through Dec. 31, 2024, (unless otherwise communicated by DHHS). **They are not intended to be utilized by every waiver beneficiary.** Tailored Plans and LME/MCOs should assess the continued need for these flexibilities case-by-case.

NC Medicaid will seek approval for Appendix K authority for the following Innovations and TBI Waiver Flexibilities. NC Medicaid is evaluating the need for additional flexibilities and as more flexibilities are approved that information will be published via an updated NC Medicaid Bulletin.

The flexibilities below are specific to beneficiaries directly impacted by Hurricane Helene.

NC Medicaid will allow, and providers can implement the following flexibilities:

- Allow Relatives of adult waiver beneficiaries, minor waiver beneficiaries, and Employer of Record (EOR) who reside in the home and out of the home to provide services.
  - Relatives of adult waiver beneficiaries and minor waiver beneficiaries may provide Community Living and Supports, Supported Employment and Supported Living. This should only be used for cases when direct support staff is impacted by Hurricane Helene and not able to provide services.
- Additional services hours may be provided without PA due to issues related to Hurricane Helene. This should only be in cases where additional hours are needed by the beneficiary because of the hurricane, and either the beneficiary could not reach the provider to notify them of this need or the provider did not have the time/ability to submit a PA.
- Allow replacement or repair of existing home and vehicle modifications damaged by Hurricane Helene when cost of repair or replacement will exceed the Innovations/TBI Waiver limit.
- Innovations/TBI waiver services may be provided out of state without PA by the Tailored Plan and LME/MCO when the Innovation/TBI Waiver beneficiary is displaced and requires out of state shelter. Respite may also be provided out-of-state for individuals who have been displaced due to Hurricane Helene.
- Allow direct service hours to be provided in alternatives settings: hotels, shelter, church, or alternative facility-based setting or the home of a direct care worker due to Hurricane Helene-related impact.
- Allow respite to be provided when the beneficiary family is out of state, due to evacuation or displacement, until they return home.
- Allow prior approval to be waived up to 60 days, when beneficiaries are displaced out of state by Hurricane Helene. Or the individual must transfer to a new provider for delivery of services.
- Allow Annual reassessments of level of care that exceeds the 60-calendar-day approval requirement beginning on Sept. 25, 2024, to remain open, and services will continue for three months to allow sufficient time for the Tailored Care managers to complete the annual reassessment paperwork. Additional time may be awarded on a case-by-case basis when conditions from Hurricane Helene impedes this process. Annual reassessments of level of care may be postponed by 90 calendar days to allow sufficient time to complete the annual reassessment and accompanying paperwork.

- Allow Community Living and Supports to be provided in acute care hospital or short-term institutional stay, when the waiver beneficiary is displaced from home due to injury from Hurricane Helene and the waiver participant needs direct assistance with ADLs, behavioral supports or communication supports on a continuous and ongoing basis and such supports are otherwise not available in these settings.
- Allow beneficiaries to receive fewer than one service per month during this amendment without being subject to discharge.
- Allow in person face- to- face monthly/quarterly Tailored Care Manager or Care Coordinator monitoring requirements with the beneficiary to be waived when the beneficiary is not physically accessible. In these cases, virtual and telephonic monitoring will be conducted in accordance with HIPAA requirements.
- Allow Support Intensity Scale (SIS) to be waived. The SIS can be completed virtually when appropriate and accessible.

Tailored Plans and LME/MCOs must provide an assessment of the health and well-being status of each impacted Innovations and TBI waiver beneficiary to NC Medicaid at the conclusion of the state of emergency.

LONG TERM SERVICES AND SUPPORTS (LTSS)

Community Alternatives Program for Children (CAP/C) and Community Alternatives Program for Disabled Adults (CAP/DA)

These CAP/C and CAP/DA flexibilities are for NC Medicaid Direct beneficiaries only.

A critical role for case management entities serving Community Alternatives Program for Children (CAP/C) and Community Alternatives Program for Disabled Adults (CAP/DA) beneficiaries is to provide support to ensure the health, safety and well-being of all CAP beneficiaries in the preparation for, during and immediately after, a natural disaster. To fulfill this requirement, NC CAP case management entities (CMEs) are directed to assist their assigned CAP beneficiaries in activating their emergency and disaster plans in preparation for the unknown impact of Hurricane Helene.

When helping CAP beneficiaries activate their plans, it is imperative to emphasize checking and updating disaster kits. ReadyNC.gov is a valuable resource to use for additional information and assistance to stay informed. Providers should encourage beneficiaries to register with their special needs' registry in their county. Please

coordinate with local county emergency management departments if assistance is needed.

NC Medicaid has requested from case management entities, in the impacted counties, an assessment of the health and well-being status of each CAP beneficiary. Case management entities, in impacted counties, are required to complete in the eCAP systems the Disaster Wellness Check Documentation related to the health and well-being status of the CAP beneficiaries they serve. NC Medicaid will seek approval for Appendix K authority, more information will be provided on the flexibilities of service utilization and the effective period of Appendix K when available. Below is the information that must be included in the Disaster Wellness report.

- Name of contact person for questions regarding the report
- Status of beneficiary (safe, sustained impact, unknown)
- Beneficiary current location (home, shelter, facility, relative – in/out of county/state)
- Beneficiary contact information, if displaced from home
- Documentation if the current service plan meets the needs of the beneficiary because of Hurricane Helene
- If it does not, specify what additional or replacement services are needed through a plan revision.

Additional flexibilities allowed:

- In-home aide, pediatric nurse aide, attendant nurse care, personal assistance services, and coordinated caregiving can be authorized to be administered in a different residence or alternative setting in the event the waiver participant is displaced from their home.
- CAP/C and CAP/DA waiver beneficiaries in impacted areas who cannot receive their in-person scheduled assessment or a required in-person monitoring visit, a telephonic assessment or monitoring visit may be conducted. Annual assessments and new and annual service plans during the hurricane recovery period, can be postponed until safe contact can be arranged to complete these assessments and service plans.
- Case management entities, for CAP/C and CAP/DA waiver beneficiaries, can conduct quarterly telephonic contact with waiver beneficiaries and quarterly telephonic contact with service providers to monitor the impacted member's service plan, other essential case management needs and initial and annual telephonic assessments of level of care and reasonable indication of need.

- CAP/C and CAP/DA home and community-based services that are identified from the CAP emergency and disaster plan assessment may be implemented and a retroactive approval may be granted. The assessed need for the home and community-based service must be documented in the emergency and disaster plan or evidence of the need if access to e-CAP is not available.
- CAP/C and CAP/DA waiver beneficiaries in impacted areas, who lost access to their direct care worker due to the impact of Hurricane Helene, may temporarily select a live-in family member/caregiver, legally responsible person, close kinship relative, family friend, or an identified direct care worker as a qualifying extraordinary condition as described in the CAP waiver applications during the first 90 days of recovery efforts, beginning Sept. 25, 2024, through Dec. 23, 2024.

To seek technical assistance in managing a waiver beneficiary's recovery from Hurricane Helene, contact the CAP unit at medicaid.capc@dhhs.nc.gov or medicaid.capda@dhhs.nc.gov. CAP/C and CAP/DA case management entities should contact NC Medicaid at 919-855-4340 to provide updated contact information, if current contact information is temporarily inaccessible.

Home Health

This applies to NC Medicaid Direct and NC Medicaid Managed Care

In support of the Hurricane Helene PHE, NC Medicaid Direct and NC Medicaid Managed Care is implementing the following flexibilities effective Sept. 26, 2024, through Dec. 31, 2024, (unless otherwise communicated by DHHS):

- Waive Home Health Nursing and Home Health Aide Visit Limits: CCP 3A, Home Health Services, limits a beneficiary's annual nursing visits to 75 per year and home health aide visits to 100 annually. To support Home Health beneficiaries remaining in their residence and to lift the administrative burden for the providers during the Hurricane Helene PHE, the visit limit is temporarily being lifted.
- Waive On-site Supervisory Visits for Home Health: Waiving the CCP 3A Section 6.1.1 requirement for a nurse to conduct onsite supervisory visits every two weeks.
  - Allowing visits to be conducted utilizing eligible technologies that allow the supervising Registered Nurse (RN) to remotely communicate and evaluate services rendered. Supervisory visits can be delivered via any HIPAA-compliant, secure technology with audio and video capabilities including (but not limited to) smart phones, tablets and computers.

- Requiring if remote technology is used, that it be real-time. The use of remote technology and patient consent should be properly documented in the participant's medical record.

- No PA for Home Health Skilled Nursing Visits: Due to the Hurricane Helene PHE and to expedite a hospital's ability to discharge patients to a lower level of care when medically appropriate, Medicaid beneficiaries who would require medically necessary Home Health Skilled Nursing visits post-hospitalization do not require prior authorization. This applies to members receiving services under both NC Medicaid Direct and NC Medicaid Managed Care. NC Medicaid Managed Care plans may require notification within three calendar days of Home Health admission to facilitate care management and care transitions. Home Health providers can begin services with verbal orders from the physician or as per CMS Interim Final Rule 42 CFR 440.70, licensed practitioners, as defined by CMS.

Nursing Facilities

This applies to NC Medicaid Direct and NC Medicaid Managed Care

Expediting Nursing Home Admissions for Individuals Displaced due to Hurricane Helene

NC Medicaid Direct and NC Medicaid Managed Care will allow expedited nursing home admissions for individuals displaced by Hurricane Helene effective Sept. 26, 2024, through Dec. 31, 2024, (unless otherwise communicated by DHHS).

For NC Medicaid Direct, providers should upload the signed Physician Signature form with their portal submissions to NCTracks. NCTracks is designed to receive long-term care PA information in the FL2 format. Medicaid has suspended the requirement of a Pre-Admission Screening and Annual Resident Review (PASSR) number on the PA. Providers should note on their portal submissions the PASRR is unavailable due to Hurricane Helene emergency placement. In addition, providers should add all pertinent information about the recipient's levels of care needs in their portal submission on the long-term care FL2. For individuals displaced from an adult care home (ACH), on line 15 of the FL2, requested level of care should be "Nursing Facility" and on line 16 notate "Temporary Placement due to Hurricane Helene." Additional questions can be directed to the NCTracks service line at 800-688-6696.

For NC Medicaid Managed Care, providers should contact the provider service line (numbers are listed in the Contact Information under the Health Plan Provider Service Lines section at the bottom of this bulletin) to confirm if additional documentation or

processes need to be completed to allow for expedited nursing home admissions for individuals displaced due to Hurricane Helene.

Temporary PASRR Procedures Due to Hurricane Helene

NC Medicaid Direct and NC Medicaid Managed Care will not require Level I and II Preadmission Screening and Resident Reviews (PASRRs) for new admissions effective Sept. 26, 2024, through Dec. 31, 2024, (unless otherwise communicated by DHHS).

For NC Medicaid Direct:

- If the individual is expected to remain in the nursing facility beyond Dec. 31, 2024, a notice of the need for a PASRR review should be submitted via NCMUST.
- Individuals transferred from one nursing facility to another nursing facility because of Hurricane Helene will not be considered a new admission and will not need a PASRR.
- The transferring nursing facility must ensure that all copies of the resident's PASRR paperwork (including any Level II information) is transferred with the individual.
- From Sept. 26, 2024, through Dec. 31, 2024, (unless otherwise communicated by DHHS) NCTracks is authorized to suspend the requirements of a PASSR number on the PA. Providers should note on their portal submission that the PASRR is unavailable due to Hurricane Helene emergency placement. A Level I and II PASRR for new admissions will not be required during this period.

For NC Medicaid Managed Care:

- Providers should contact the provider service line (numbers are listed in the Contact Information under the Health Plan Provider Service Lines section at the bottom of this bulletin) to confirm if additional documentation or processes need to be completed for individuals expected to remain in the nursing facility beyond Dec. 31, 2024.
- For individuals receiving specialized services, the nursing facility should focus on promoting the basic health and safety of individuals who had been receiving specialized services in the nursing facility before the crisis or who were receiving specialized services in another nursing facility before the transfer.
- The admitting nursing facility is responsible for submitting a claim for payment. Those nursing facilities serving as an emergency shelter due to Hurricane Helene cannot submit a claim for payment.
- The safety of nursing facility staff and the NC Medicaid members served by nursing facilities and/or agencies are of prime importance. Any nursing facilities impacted by Hurricane Helene, please follow the instructions of the local

emergency operations in your area located at ncdps.gov/our-organization/emergency-management/county-emergency-management-agencies and implement the facilities emergency plan.

Additional Nursing Facility Flexibilities

This applies to NC Medicaid Direct and NC Medicaid Managed Care

NC Medicaid is implementing additional flexibilities:

- Waiving the requirement for a 3-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay to provide temporary emergency coverage of SNF services without a qualifying hospital stay and for those people who need to be transferred as a result of the effect the Hurricane Helene public health emergency.
- Coverage for certain beneficiaries who recently exhausted their SNF benefits will be renewed without first having to start a new benefit period.
- Waiving SNF Minimum Data Set (MDS) Assessment Transmission Timeframes: NC Medicaid also is waiving the SNF MDS transmission timeframe requirements.

Personal Care Services

This applies to NC Medicaid Direct and NC Medicaid Managed Care

Conditions from the impact of Hurricane Helene may present situations where NC Medicaid Direct and NC Medicaid Managed Care beneficiaries in impacted areas cannot receive their scheduled in-person personal care new or annual assessment. In those situations, a telephonic assessment, if attainable, may be conducted from Sept. 26, 2024, through Dec. 31, 2024, (unless otherwise communicated by DHHS).

To ensure the health and well-being of impacted individuals who meet medical necessity for PCS and expedited or abbreviated initial assessment may be conducted from Sept. 26, 2024, through Dec. 31, 2024. From Sept. 26, 2024, all existing PAs will be continued through the duration of the PHE. During the hurricane recovery period, providers and beneficiaries are asked to call NCLIFTSS at 833-522-5429 to provide new contact information, if applicable to maintaining consistent communication.

NC Medicaid Direct and NC Medicaid Care beneficiaries who are displaced from their homes or facilities may continue to receive their PCS in their relocated settings. The flexibilities below are specific to beneficiaries impacted by Hurricane Helene.

NC Medicaid will allow the following flexibilities:

- Use of telephonic assessments in place of in-person assessments for initial PCS requests
- Use of virtual real-time supervisory visits for In-Home PCS in place of in-person
- Use of telephonic mediation and appeal resolution (when resumed)
- Extension from 90 days to 120 days for the requirement to meet with practitioner in the preceding period for new referrals.
- Authorization for In-Home PCS delivered in a temporary alternate primary non-institutional location
- In situations where beneficiary or legally responsible person's written consent cannot be attained, acceptance of a "verbal signature" or "verbal concurrence".

For NC Medicaid Direct, NCLIFTSS will work with individuals in impacted areas to reschedule in-person assessments as telephonic assessments.

For NC Medicaid Managed Care, providers can contact the provider service line (numbers are listed in the Contact Information under the Health Plan Provider Service Lines section at the bottom of this bulletin) to confirm if additional steps need to be completed for individuals impacted and are scheduled for in-person assessments.

Private Duty Nursing

This applies to NC Medicaid Direct and NC Medicaid Managed Care

Private Duty Nursing (for pediatric and adult beneficiaries) may be provided without prior authorization (PA) for NC Medicaid Direct and NC Medicaid Managed Care beneficiaries, effective Sept. 26, 2024, through Dec. 31, 2024 (unless otherwise communicated by DHHS).

For NC Medicaid Direct:

NCTracks is authorized to suspend the standard PA requirements per PDN CCP, 3G-1 and 3G-2. Medical documentation must support medical necessity, and providers are encouraged to obtain PA if possible (as required under normal policy). All claims are subject to audit. Additional questions can be directed to the NC Tracks service line at 800-688-6696.

For NC Medicaid Managed Care:

Providers can contact the provider service line (numbers are listed in the Contact Information under the Health Plan Provider Service Lines section at the bottom of this bulletin) to confirm if additional steps are needed for individuals needing PDN.

Obstetrical Services

This applies to NC Medicaid Direct and NC Medicaid Managed Care

NC Medicaid Direct and NC Medicaid Managed Care encourages local health departments to provide maternal support services in-person when it is safe to do so; however, if an in-person or home visit is not feasible, eligible providers may conduct maternal support services with new or established patients via telemedicine (two-way real-time, interactive audio video). Maternal support services conducted via virtual patient communication (telephone, virtual portal communications, etc.) will not be eligible for reimbursement.

Eligible maternal support services include:

- Home visit for newborn care and assessment (CPT code 99501)
- Home visit for postnatal assessment (CPT code 99502)

Eligible providers include local health departments whereby the service is rendered via telemedicine by:

- A registered nurse (for home visit for newborn and postnatal assessment, only); or,
- A certified childbirth educator (for childbirth education classes, only).

For the newborn and postnatal assessments, providers must document on the assessment tool that the service was conducted via telemedicine.

For further details and guidance regarding the delivery of these services, see the following NC Medicaid CCPs:

- 1M-2, Childbirth Education
- 1M-4, Home Visit for Newborn Care and Assessment
- 1M-5, Home Visit for Postnatal Assessment and Follow-up Care

Providers are not required to obtain prior authorization prior to receiving services via telemedicine.

Outpatient Specialized Therapies

This applies to NC Medicaid Direct and NC Medicaid Managed Care

Due to the impact of Hurricane Helene, NC Medicaid Direct and NC Managed Care will allow temporary telehealth flexibilities for the delivery of select outpatient specialized therapies (OST) evaluation and treatment services. Telehealth/Teletherapy refers to the

use of two-way real-time interactive audio and video to provide and support health care when participants are in different physical locations; audio-only interactions are not considered teletherapy. All services must be medically necessary and are subject to audit. Documentation must support medical necessity.

For a listing of services approved in permanent policy for telehealth delivery, refer to the following CCPs:

- 10A, Outpatient Specialized Therapies
- 10B, Independent Practitioners
- 10C, Local Education Agencies
- 10D, Independent Practitioners Respiratory Therapy Services

The following temporary telehealth flexibilities have been enabled to support providers in response to the Hurricane Helene PHE. Please see the CPT codes for each therapy type:

- Audiology: 92630 and 92633
- Speech-Language Pathology: 92630, 92633, and 96125
- Occupational Therapy: 97165, 97166, 97167, 97168, 97750, 92065, 92526, 97110, 97112, 97116, 97530, 97533, 97535, 97542, and 97763
- Physical Therapy: 97161, 97162, 97163, 97164, 97750, 97110, 97112, 97116, 97530, 97533, 97535, 97542, 97763, and 95992
- Respiratory Therapy: 94010, 94060, 94150, 94375, and 99503
- School Psychology and Counseling: 96110, 96112, 96113, 96130, and 96131

NC Medicaid Direct: Existing authorizations for in-person care may be used for services delivered via telehealth. Providers do not need to submit new PA requests for service delivery via telehealth. Retroactive prior authorization will not be needed for services provided during the Hurricane Helene PHE timeframe starting Sept. 26, 2024 – Dec. 31, 2024 (unless otherwise communicated by NC DHHS).

- The GT modifier must be appended to the CPT code to indicate that a service has been provided via telehealth. For services delivered via telehealth that are not approved in permanent policy, the CR Modifier (catastrophe/disaster related) must also be appended to the CPT codes to indicate that the service was provided per temporary flexibilities due to the impact of the Hurricane Helene PHE.

NC Managed Care: Providers should contact the NC Managed Care plan(s) for additional instructions on prior authorization and claims for individuals displaced due to Hurricane Helene.

PHARMACY

Medication PA overrides due to Hurricane Helene

This applies to NC Medicaid Direct and NC Medicaid Managed Care

Impacts from Hurricane Helene may present situations where NC Medicaid beneficiaries in impacted areas may have difficulty obtaining necessary PA for certain medications, including beneficiaries who may have traveled out of state to seek safety. Therefore, NC Medicaid enrolled pharmacy providers have been approved to override PA requirements for people impacted by the storm, starting Sept. 26, 2024, through Dec. 31, 2024, (unless otherwise communicated by DHHS). This override of PA is being allowed to ensure Medicaid beneficiaries have access to necessary medications.

Out-of-state pharmacy providers, who may be serving beneficiaries who have been displaced, must enroll as NC Medicaid providers. Please see the section of this bulletin "Disaster Relief Applications Available for Health Care Providers Not Currently Enrolled as an NC Medicaid Provider" for more details about expedited enrollment available during the State of Emergency.

As a reminder, per CCP 9, a provider cannot refuse to provide services if a beneficiary cannot pay a copay at the time of service.

For NC Medicaid Direct, NC Medicaid enrolled pharmacy providers should resubmit these claims with "09" (Emergency Preparedness) in the PA Type Code field to override a denial for PA required. Do not place any values in the Submission Clarification Code field. Additional questions can be directed to the NCTracks service line at 800-688-6696.

For NC Medicaid Managed Care, providers should contact the pharmacy service line (numbers are listed in the Contact Information under the Health Plan Pharmacy Service Lines section at the bottom of this bulletin) to confirm if additional documentation or processes need to be completed to allow for PA overrides due to Hurricane Helene.

EARLY PRESCRIPTION REFILLS DURING THE GOVERNOR'S STATE OF EMERGENCY DECLARATION

This applies to NC Medicaid Direct and NC Medicaid Managed Care

Conditions following Hurricane Helene may present situations where NC Medicaid beneficiaries in impacted areas, including beneficiaries who may have traveled out of state to seek safety, may require an early refill of their medications. NC Medicaid enrolled pharmacy providers have been approved to fill these prescriptions early. Co-pay is not waived for early refills. Effective Sept. 26, 2024, through Dec. 31, 2024, (unless otherwise communicated by DHHS) the early refill is being allowed to ensure Medicaid beneficiaries have access to necessary medications.

Out-of-state pharmacy providers, who may be serving beneficiaries who have been displaced, must enroll as NC Medicaid providers, if not already enrolled in NC Medicaid. Please see the section "Disaster Relief Applications Available for Health Care Providers Not Currently Enrolled as an NC Medicaid Provider" at the top of this bulletin for more details about expedited enrollment available during the State of Emergency.

As a reminder, per CCP 9, a provider cannot refuse to provide services if a beneficiary cannot pay a copay at the time of service.

For NC Medicaid Direct, NC Medicaid enrolled pharmacy providers should resubmit these claims with "09" (Emergency Preparedness) in the PA Type Code field and a valid value for an E.R. override in the Reason for Service, Professional Service and Result of Service fields to override a denial for an early refill. Do not place any values in the Submission Clarification Code field. This allows the beneficiaries to receive their medication during an emergency without using either of their limited-use Submission Clarification Code overrides. Additional questions can be directed to the NCTracks service line at 800-688-6696.

For NC Medicaid Managed Care, providers should contact the pharmacy service line (numbers are listed in the Contact Information under the Health Plan Pharmacy Service Lines section at the bottom of this bulletin) to confirm if additional documentation or processes need to be completed to allow for emergency prescription refills during the state of emergency.

Additional Pharmacy Flexibilities due to Hurricane Helene

This applies to NC Medicaid Direct and NC Medicaid Managed Care

To ease burden to providers and beneficiaries impacted from Hurricane Helene, NC Medicaid Direct and NC Medicaid Managed Care will implement the below flexibilities effective Sept. 26, 2024, through Dec. 31, 2024, (unless otherwise communicated by DHHS). These flexibilities are being allowed to ensure that impacted Medicaid beneficiaries have access to necessary medications. No action is required from the pharmacy for these flexibilities.

The additional flexibilities that NC Medicaid Direct and NC Medicaid Managed Care will implement for pharmacy are:

- Suspend pharmacy clinical behavioral health edits to reduce barriers to necessary behavioral health medications.
- Allow for up to a 90-day supply of schedule 2 stimulants and buprenorphine products used for Medication Assisted Treatment (MAT), when indicated by the prescriber.

For NC Medicaid Direct, NC Medicaid enrolled pharmacy providers there is no action needed. Additional questions can be directed to the NCTracks service line at 800-688-6696.

For NC Medicaid Managed Care, providers should contact the pharmacy service line (numbers are listed in the Contact Information under the Health Plan Pharmacy Service Lines section at the bottom of this bulletin) to confirm if additional documentation or processes need to be completed to allow for these additional flexibilities due to Hurricane Helene.

Swing Beds: Expanded Ability for Hospital Swing Beds

This applies to NC Medicaid Direct and NC Medicaid Managed Care

A swing bed hospital is a hospital or critical access hospital (CAH) participating in Medicare with CMS approval to provide post-hospital skilled nursing facility care.

Effective Sept. 26, 2024, through Dec. 31, 2024, for all NC counties, to support providers during Hurricane Helene, the eligibility requirements at 42 CFR 482.58(a)(1)-(4), "Special Requirements for hospital providers of long-term care services (swing-beds)" have been waived. This allows hospitals to establish skilled nursing facility (SNF) swing beds payable under the SNF prospective payment system (PPS) to provide additional options for

hospitals with patients who no longer require acute care but are unable to find placement in a SNF.

The flexibility is for NC Medicaid Direct and NC Medicaid Managed Care. For information on billing for lower-level of care beds/swing beds, please review CCP 2A-1.

KEY REMINDERS FOR PROVIDERS

Hospital at Home Program Remains Active

This applies to NC Medicaid Direct and NC Medicaid Managed Care

As a reminder, NC Medicaid continues to allow coverage of the Acute Hospital at Home (HaH) program. This program is designed to provide relief to hospitals with limited bed capacity and can be leveraged by hospitals during Hurricane Helene. NC Medicaid continues to cover Acute HaH under the existing DRG methodology through Dec. 31, 2024, when CMS Medicare Waiver flexibility is scheduled to end. To bill for Acute HAH, providers should bill DRG claims using revenue code 0161 for room and board and occurrence span code 82.

More information on the Acute HaH program can be found in the Hospital at Home Program Re-Launching for NC Medicaid bulletin.

INFORMATION ON CHECKING BENEFICIARY ELIGIBILITY

This applies to NC Medicaid Direct and NC Medicaid Managed Care

Eligibility can be validated through the NCTracks Recipient Eligibility Verification methods outlined below.

There are three methods of Recipient Eligibility Verification available: via the NCTracks Secure Provider Portal: (1) Real Time Eligibility Verification and (2) Batch Eligibility Verification and (3) via the NCTracks Automated Voice Response System verification. As a reminder, these methods can be used for current eligibility information and one-month future eligibility.

- Real Time Eligibility Verification Method
  - Log into the NCTracks Provider Portal
  - Follow the Eligibility > Inquiry navigation
  - Populate the requested provider, recipient, and time-period information
- Batch Eligibility Verification Method
  - Log into the NCTracks Provider Portal

- Follow the Eligibility > Batch verify
- Upload the file by selecting browse > Load from file

- NCTracks Automated Voice Response System
  - Call 800-723-4337
  - Reference the Automated Voice Response System Job Aid under Quick Links for additional details

Note that future eligibility is subject to change and should be confirmed again in the current month.

Reminder to Provide Services Regardless of Copayment

This applies to NC Medicaid Direct and NC Medicaid Managed Care

NC Medicaid requires, per requirements of 10A NCAC 22J .0106, that providers do not refuse to provide services or supplies to a NC Medicaid beneficiary due to a beneficiary's inability to pay the copay for that medication or service. Providers enrolled in NC Medicaid agree to abide by this requirement as part of their NC Medicaid enrollment. This is especially important during this time when members may not have cash due to the impacts of Hurricane Helene and providers may have limited abilities to process bank and credit cards.

A provider may not willfully discount copays for a Medicaid beneficiary, and an individual's inability to pay does not eliminate their liability for the cost sharing charge. The provider should open an account for the beneficiary, collect the amount owed at a later date, and document all attempts to collect the copay. If the account has not been paid, the provider may, due to normal accounting principles, write-off the charges and stop monitoring the claim.

Contact Information

Health Plan Provider Service Lines

Standard Plans

- AmeriHealth Caritas: 1-888-738-0004 (TTY: 1-866-209-6421)
- Carolina Complete: 1-833-552-3876 - Option 3
- Healthy Blue: 1-844-594-5072
- United Healthcare: 1-800-638-3302
- WellCare: 1-866-799-5318

Tailored Plans and LME/MCOs

- Alliance Health: 1-855 759-9700
- Partners Health Management: 1-877-398-4145
- Trillium Health Resources: 1-855-250-1539
- Vaya Health: 1-866-990-9712

Health Plan Pharmacy Lines

Standard Plans

- AmeriHealth: 1-866-885-1406
- Healthy Blue: 1-833-434-1212
- Carolina Complete: 1-833-992-2785
- United Healthcare: 1-855-258-1593
- WellCare: 1-866-799-5318, option 3

Tailored Plans

- Alliance Health: 1-855-759-9300
- Partners: 1-866-453-7196
- Trillium: 1-866-245-4954
- Vaya Health: 1-800-540-6083

Thank you for your attention to this communication. All questions related to this Clinical Communication Bulletin can be sent to UM@TrilliumNC.org. Questions will be responded to as quickly as possible. We are working to address other questions and concerns as quickly as possible. Thank you for your patience while we transition to a Tailored.