

ACMESA Meeting - Questions

1. Do we honor waiver 1135? These are the COVID Flexibilities set forth by the State. **Carolina Complete Health follows state guidance regarding COVID flexibilities.**
2. Will we consider honoring lifetime oxygen authorizations for members? There is a major concern with the 90 day grace period ending and providers having to scramble to get authorizations for a large number of members who need these services/care. **We will do year-long Oxygen authorizations for those that qualify for O2. Due to the need of these members likely having complex care issues and the expectation of the state's care management model and required annual member assessment at minimum– we would expect the engaged CM/AMH to be coordinating in advance of the annual expiration to ensure all needs are met not just oxygen and renewing any all service needs and potentially requesting others.**
3. Will we load all taxonomy codes that are in NC Tracks or just the primary? **The answer today is we enroll the taxonomies the providers advises. Therefore, if they advise only one taxonomy we only load the one after verifying the state files. We will load additional per network or provider's request to meet adequacy needs.**
4. If the providers are submitting batch claims with multiple line items that are billed with different taxonomy codes – will our system recognize the taxonomy code on the line item detail or will it pull from the batch line taxonomy? If it is pulling from the batch line, will this result in a rejection? **There can only be one taxonomy billed per claim – it would likely pull off from the first line billed.**
5. Providers are having concerns for Carolina Complete Health about if the DME fee schedule was loaded correctly into our system because there are a number of providers who are not being paid at the Medicaid rate – they are wanting us to check that this is correctly loaded and if this is a global issue. **The DME reimbursement rate has been updated to 100% Medicaid Fee Schedule based on the State's floor rate...and should be paying correctly.**
6. Providers are needing clarification on the use of the local codes that the state uses or the HCPCS codes – seeing the local codes being rejected. **Per the Carolina Complete Health Billing Manual Page 30: When reporting claims for DME Miscellaneous services, providers must submit both the National DME Miscellaneous and corresponding Local W Code based on the chart below. When both codes represent miscellaneous services, e.g. E1399 and W4047, a description of the product/service must also be included. If the provider submits a claim without both the National DME Miscellaneous and corresponding Local W code the claim will be DENIED.**
7. How will we go about authorizing items that are over quantity limitations and pricing overrides? **Providers may submit prior authorization requests for this and it is based off**

of medical necessity. And do we how follow EPSDT? For EPSDT, we should follow the clinical policies set forth my NC DHHS.