North Carolina Department of Health and Human Services

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

August 30, 2013

The Honorable Louis Pate
Joint Legislative Oversight Committee on
Health and Human Services
Legislative Building, Room 1028
Raleigh, NC 27601-2808

The Honorable Nelson Dollar
Joint Legislative Oversight Committee
on Health and Human Services
Legislative Office Building, Room 307B1
Raleigh, NC 27603-5925

The Honorable Justin Burr
Joint Legislative Oversight Committee on
Health and Human Services
Legislative Office Building, Room 307A
Raleigh, NC 27603-5925

Dear Senator Pate and Representatives Dollar and Burr:

Section 12.4.(g)(1) of Session Law 2013-360 requires the Department of Health and Human Services to provide a progress report on the implementation of the replacement MMIS, NCTracks, by September 1, 2013. That progress report is transmitted along with this letter.

The progress report contains information on several topics. The report details issues encountered after the go-live date of July 1, 2013 and solutions to those issues, manual work arounds and timelines for automated solutions, and the required capabilities that were not available at go-live. Information contained in this report is current as of July 31, 2013.

Should you have any questions, please contact Ed Riley at ed.riley@dhhs.nc.gov or 919.647.8326.

Sincerely,

Aldona Z. Wos, M.D.
Secretary

cc: Carol Steckel
Adam Sholar
Joe Cooper
Karlynn O'Shaughnessy
Pam Kilpatrick
Susan Jacobs
Patricia Porter
Brandon Greife
Legislative Library (1 hard copy)
Kristi Huff
Sarah Riser

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August 30, 2013

The Honorable Andrew Brock
Joint Legislative Oversight Committee on
Information Technology
Legislative Office Building, Room 521
Raleigh, NC 27603-5925

The Honorable Marilyn Avila
Joint Legislative Oversight Committee
Information Technology
Legislative Building, Room 2217
Raleigh, NC 27601-1096

The Honorable Jonathan Jordan
Joint Legislative Oversight Committee on
Information Technology
Legislative Office Building, Room 420
Raleigh, NC 27603-5925

Dear Senator Brock and Representatives Avila and Jordan:

Section 12.4.(g)(1) of Session Law 2013-360 requires the Department of Health and Human Services to provide a progress report on the implementation of the replacement MMIS, NCTracks, by September 1, 2013. That progress report is transmitted along with this letter.

The progress report contains information on several topics. The report details issues encountered after the go-live date of July 1, 2013 and solutions to those issues, manual work arounds and timelines for automated solutions, and the required capabilities that were not available at go-live. Information contained in this report is current as of July 31, 2013.

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Senator Pate

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Secretary DHHS

August 30, 2013

Art Pope, State Budget Director
Office of State Budget and Management
116 West Jones Street
Raleigh, NC 27603-8005

Dear Mr. Pope:

Section 12.4.(g)(1) of Session Law 2013-360 requires the Department of Health and Human Services to provide a progress report on the implementation of the replacement MMIS, NCTracks, by September 1, 2013. That progress report is transmitted along with this letter.

The progress report contains information on several topics. The report details issues encountered after the go-live date of July 1, 2013 and solutions to those issues, manual work arounds and timelines for automated solutions, and the required capabilities that were not available at go-live. Information contained in this report is current as of July 31, 2013.

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Ambassador (Ret.)
Secretary DHHS

August 30, 2013

Mark Trogden, Director
Fiscal Research Division
Legislative Office Building, Room 619
Raleigh, NC 27603-5925

Dear Mr. Trogden:

Section 12.4.(g)(1) of Session Law 2013-360 requires the Department of Health and Human Services to provide a progress report on the implementation of the replacement MMIS, NCTracks, by September 1, 2013. That progress report is transmitted along with this letter.

The progress report contains information on several topics. The report details issues encountered after the go-live date of July 1, 2013 and solutions to those issues, manual work arounds and timelines for automated solutions, and the required capabilities that were not available at go-live. Information contained in this report is current as of July 31, 2013.

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SL 2013-360, Section 12A.4.(g)(1) Replacement Medicaid Management Information System (MMIS) Full Implementation Progress Report to the North Carolina General Assembly

State of North Carolina

Department of Health and Human Services

August 30, 2013

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INTRODUCTION

In July 2013, the NC General Assembly passed Session Law 2013-360, Senate Bill 402, "The Appropriations Act of 2013", of which Section 12.4.(g)(1) required the Secretary of the Department of Health and Human Services to provide the NCGA with a progress report on the full implementation of the Replacement MMIS no later than September 1, 2013. The following were to be addressed in the report:

a. "Any issues encountered following the 'go-live' date of July 1, 2013, and how each issue was resolved.
b. Any system requirements for manual workarounds and the time line for implementing an automated solution for each manual workaround.
c. Required capabilities that are not available in the replacement MMIS on the 'go-live' date of July 1, 2013, with a date for the implementation of each."

In compliance with this legislation, these items are addressed below. Please note that the information provided in this report is current as of July 31, 2013.

ISSUES ENCOUNTERED POST GO-LIVE AND SOLUTIONS

As expected when transitioning to a new system(s) of the magnitude and complexity of the Replacement MMIS and its ancillary systems, technical issues arose following go-live. The table below reflects these issues at the time of this reporting submittal, as well as how each issue has been (or will be) resolved.

Business or System Function	Issue	Resolution
Capitation and Management Fee Claims Adjudication	Problems encountered in the early stage of operations included incorrect taxonomies, and the lack of or improper electronic fund transfer (EFT) authorizations.	Special communications to CCNC providers. Problems have been resolved. Approval rates and EFT are now at or near 100%.
Core System Stability	During the first few days of operations, there were system tuning issues and other defects. With a few defect fixes, the system performance improved quickly.	System tuning and application of defect fixes corrected the problems. Stability has been solid for two to three weeks.

Business or System Function	Issue	Resolution
Call Center Abandonment Rates	The Call Center was overwhelmed at the beginning, causing abandonment rates over 70% initially.	Additional staff has been deployed to meet the high call volume; hours of operation have been extended; provider communications regarding the key issues of taxonomies and ETFs have occurred; and agents and providers have gained experience. Abandonment rates are currently trending toward the State's Service Level Agreements (SLAs).
Call Center Time to Answer	The overwhelming volume of calls resulted in average call to answer greater than 60 minutes initially.	Additional staff has been deployed to meet the high call volume; hours of operation have been extended; provider communications regarding the key issues of taxonomies and ETFs have occurred; and agents and providers have gained experience. Current call-to-answer rates are trending toward the State's SLAs.
Call Center Average Call Time	Agent and provider inexperience with NCTracks and the lack of familiarity in key areas caused call times much longer than expected. Early call times were in excess of 18 minutes.	As agents and providers gain experience and knowledge, the time to provide resolution continues to drop. The time to handle calls has improved consistently since the third week of July.
Call Center Attrition Rates	The Call Center began the operations phase with extra agents due to the expectation that a certain percent of new hires would quit; however, attrition rates have been even higher than expected.	As new agents are hired and trained, CSC is backfilling positions. Attrition has stabilized.
Provider Portal Response	During the first few days of operations, the Provider Portal response time was slow.	System tuning, additional servers, and defect fixes have improved system capabilities and eliminated Provider Portal response problems.
Operations Portal Response	During the first few days of operations, the Operations Portal response time was slow.	System tuning, additional servers, and defect fixes have improved system capabilities and eliminated Operations Portal response problems.

Business or System Function	Issue	Resolution
Institutional Claims Adjudication	Initial approval rates were around 50%.	System changes and taxonomy and EFT improvements have improved Institutional Claims adjudication. Approval rates are now close to 70%.
Professional Claims Adjudication	Initial approval rates were about 30%.	System changes and taxonomy and EFT improvements have enhanced Professional Claims adjudication; however, this function remains problematic. An ongoing outreach campaign continues to help. The current approval rate is approximately 60%.
Dental Claims Adjudication	Initial approval rates were around 45%.	System changes and taxonomy and EFT improvements have enhanced Dental Claims adjudication; however, this function remains problematic. An ongoing outreach campaign continues to help. The current approval rate is approximately 60%.
Prior Approval (PA)	There have been several problems with Prior Approvals, resulting in case backlog.	A "tiger team" was created to fix defects, identify problem areas, improve processes, and update user training. Additionally, providers have been (and continue to be) encouraged to use automated PA requests rather than paper entry. Automated methods have been identified to remove a large volume of PA requests from manual processing. While PA remains an issue, the backlog has stabilized.
Total Backlog	Several areas have experienced a backlog of work that has continued to increase. This backlog is made up of pended claims, prior approval requests, emails, faxes, escalations, provider enrollments, etc.	CSC has developed a work-off plan and assigned a team to address the backlog. Minor improvement has been seen in a few areas; however, the overall backlog continues to increase. The expectation is that a very significant improvement will soon be seen.

Business or System Function	Issue	Resolution
Taxonomy	Taxonomy is a new feature within NCTracks that has been misunderstood by providers since the beginning of the operations phase, causing large volumes of claims to be denied. Providers with training experienced a much better success rate.	NCTracks provider communications have helped with awareness and have resulted in significant improvements. Updated training, Webinars, and CBT training have also helped. CSC, OMMISS, and the business units implemented a provider outreach to help them understand taxonomy and correct claims entry. While much slower than preferred, improvements are being made. Most institutional providers' taxonomy problems have been eliminated. Some improvement has been seen with professional and dental claims.
Electronic Fund Transfer (EFT)	Large volumes of claims have pended due to missing or incorrectly entered electronic banking information. Additionally, CSC encountered an issue with EFT processing for a small volume of claims.	NCTracks provider communications have helped with awareness and have resulted in some improvement. An OMMISS team is reaching out to providers, especially institutional and high volume providers and trading partners, to assist them in correcting EFT problems. Paper checks are being issued to providers that continue to have issues with their bank information. Also, a defect affecting a small volume of claims was detected and is under investigation.
Report-2-Web (R2W)	The assignment of incorrect user role profiles has resulted in unnecessary staff access restrictions to the Report-2-Web, as well as report posting problems.	Corrections to user role profiles and defect resolutions have resolved a number of problems; however, Report-2-Web issues persist. Work toward full resolution to this issue continues.
HIPAA Transactions	Initially, there were a number of problems with HIPAA transactions involving providers and trading partners.	Defect corrections have resulted in the resolution of most of these problems.

Business or System Function	Issue	Resolution
Financial Balancing	Various problems balancing financial reports have occurred.	Team members from CSC, OMMISS, State Budget, and State Controller's office meet daily to resolve problems. The State is working towards closing the identified problems and others that are being discovered via the following process: 1. Identify the root cause of the problem 2. Development a detailed analysis to support manual journal entries to offset the impact of the problem until the root cause of the problem is corrected 3. Effect the permanent fix 4. Perform remediation of the transaction data affected by the problem to facilitate correct federal quarter-end processing
Software Defects	Initially, more software defects were being identified than were being fixed.	The rate of occurrence of software defects has slowed and the rate of defect correction has improved. To date, 1,057 defects have been identified and 674 have been fixed.

MANUAL WORKAROUNDS AND TIMELINE FOR AUTOMATED SOLUTIONS

Since there was a "freeze" period just before the new systems' go-live (during which no requirements updates could be made), some requirements necessitated manual workarounds. Manual processes for the following automated solutions are reflected below.

The Change Service Request (CSR) number assigned to the automation effort needed for each of the manual workarounds is noted below.

Because CSC and the State are focusing efforts and resources on prompt resolution of the defects/issues found after go-live, there is not yet an expected implementation date for automating these CSRs. Implementation dates will be provided as soon as possible.

CSR #	Title and Brief Description of Change
289	Add Health Net as a new benefit plan for the Office of Rural Health and Community Care (ORHCC)
404	Implementation of system functionality for Money Follows the Person Demonstration Grant
420	Managed Care (Community Care of North Carolina/Carolina Access [CCNC/CA]) Reporting Taxonomy
602	EVC Operating Reports analysis activities. This is to align with the revised business rules from DMA provider services
618	Update Edit 8550 to be used with additional provider types
651	Create New Report for three-way contract Prior approval/Expenditures
677	Creation of Recipient Profile History Report at county level
688	Implement Use of Standard Template Letters
703	Automate the Distribution of Provider Eligibility, Verification and Credentialing (EVC) Template Letters to Various State Users as required by DMA provider services business rules.
798	This CSR covers Pharmacy Pricing Methodology For NC Medicaid; two new pricing indicators added to the drug file; New Mercer file to provide the Expanded Maximum Allowable Cost (EMAC) at the National Drug Code (NDC) level; and Add EMAC to the lower of logic pricing reimbursement
883	Implementation of Critical Access Behavioral Health Agencies (CABHA) providers in NCTracks, which will allow CABHA adjustments on previously adjudicated claims, when necessary
899	Retro-Medicaid Voids for T1017-HE/H0032/H0038 which changes the criteria for the Retro-Medicaid process
904	Modify Retro-Medicaid Process for YP820/821 (to void any YP820/821 claims paid when client has received retro-Medicaid eligibility
915	Modify Retro Medicaid Extract Process to prevent claims for DMH clients that also have either Medical Assistance to Families, Medicaid Family Planning Waiver (MAFDN), or Medicaid for Qualified Beneficiaries (MQBxx) Medicaid eligibility from being extracted and voided

CSR #	Title and Brief Description of Change
916	State Children's Health Insurance Program (SCHIP) – Reporting Modification to show the recipient is HealthChoice on the claims that are identified through Retro-Medicaid
920	Deliver Nursing Facility rate and patient rosters to providers via NCTracks web portal
921	Secondary Coordination of Benefits Agreement (COBA) ID for North Carolina Community Care Networks (N3CN) Medicare Crossover Claims, which allows NCTracks to receive and pass claims from Global Health Initiative (GHI), the Medicare Fiscal Agent, to N3CN for the dual eligible grant project
922	NC Health Home Project. Health Home is a payment methodology that allows enhanced federal draw down. (90% versus 64%)
948	Medicaid EHR Incentive Payment System (MIPS) Financial Interface with Replacement MMIS
950	Local Management Entity - Managed Care Organizations (LME MCO) transition
960	DMH's use of CABHA's in NCTracks, which allows NCTracks to process fee-for-service claims for CABHA services
964	Send Public Consulting Group (PCG) - the DMA global recipient file daily
975	Report Modification for Retro-Rate Load Process Change to ensure that the Single Stream Funding (SSF) and zero paid claims that are part of the Retro rate process are being reported
978	Modify retro-Medicaid for CABHA Claims and create report for all CABHA claims that have been voided
987	Edit 230/ Revision to Edit 230 Bypass Criteria for Auto-Approval and Manual Review of Out-of-State Emergency Services
988	Develop MIPS interface to Build 5 (Provider) that replaces EVC Interface
995	End-date Recipient Opt-in (Global Limits) Program and the Monthly Prescription Limits - Batch and Point of Sale (POS)
997	Bypass Prior Approval/Preferred Drug List (PA/PDL) if Medicaid is Billed as Secondary for Pharmacy claims in POS and Batch
1000	DMA Pharmacy claims need to deny for recipients with living arrangement codes 16 and 17. This CSR implements system functionality for the pharmacy PDL program as well as revised edits for claim adjudication denials related to living arrangement codes and Medicare information on the recipient eligibility file

CSR #	Title and Brief Description of Change
1002	Create CMS21 (CMS Report for Health Choice) data file and send to DMA for the SAS Forecasting tool
1007	Code Additions for Select Incontinence Products
1015	Revisions to the NCTracks Claims Pricing Manual for Pharmacy for Wholesale Acquisition cost (WAC) and EMAC pricing, and for removal of Average Wholesale Price (AWP)
1030	Bypass Recipient Co-Payment Edits for Visual Aid Claims for NCHC Recipients
1031	Replace 92004 & 92014 with S0620 & S0621. This CSR covers the paid history and AVRS response for the eye refraction rules
1044	Additional Correct Coding Initiative Edits
1046	Implementation of Institution for Mental Disease (IMD) Living Arrangement Code 18/Edit 99. This CSR implements recipient and claim logic to identify recipients based on living arrangement codes and deny claims for non-covered services
1047	Health Choice - Recipients in Extended Coverage Group (ECG) Claims Coded to Federal Rate Codes (FRC) that Do Not Draw Federal Dollars (this allows for system and mapping changes related to the federal draw down)
1061	Outpatient Pharmacy Coverage for IV Fluids > 500mls - manual review information
1064	Processing of Bariatric Providers' Proof of Bariatric Center of Excellence Certification
1079	NC Medicaid Pharmacy legacy program and edit changes legacy CSRs
1080	NC Medicaid Pharmacy Program Edit updates
1082	NC Dept of Justice - Payment Access
1083	Clean Up DMA Account Structure, which allows for system and mapping changes related to federal draw down of money
1084	Department of Correction - budget/billing reports for inmates
1085	Prompt Pay Requirements legacy report layout. This CSR implements the reporting rules and the monitoring of report creation
1086	Living arrangement code 16, 17, and 18 edit and buy in code changes, which add bypass criteria for recipients who are in the custody of the Department of Correction

CSR #	Title and Brief Description of Change
1087	NCHC Orthodontic Claims. This CSR allows for changes to the dental program to report on web inquiries and changes related to the recipients in the Health Choice benefit plan
1088	Billing Lower Level of Care beds which allows NC Medicaid Acute Hospital to bill Lower Level of Care (LLOC) beds for Medicaid recipients in their facilities awaiting placement into a nursing home
1090	Pricing rules for Interim Billing legacy provider types 065/068
1093	Update to Edit 0146 that relates to behavioral health services
1095	Allow bill type 89X to utilize special pricing when adjudicating claims
1098	Updates to Edits for the Addition of Pull-up Diapers for Home Health, Private Duty Nursing (PDN), and Community Alternatives Program (CAP) Providers
1099	Update to Edit 0036 for Vaccine Reimbursements
1102	Implements revised case management business rules from the Budget for CAP Children, Disabled Adults, HIV, Mental Retardation and Developmental Disabilities
1105	Implementation of Therapeutic Foster Care Level II Family Setting policy
1107	Multiple procedure code, benefit plan, and audit changes related to the CAP Children Waiver
1108	Update to Edit List 402 for Edit 0187 to add specific diagnosis codes to correct claim denials related to ventricular assist device policy
1113	This CSR covers Optical Program Changes per the 2012 Session Law and the annual procedure code update changes to edits and audits
1116	New and Modified Audits for Targeted Case Management/Developmental Disabilities (TCM/DD) Program to allow for claim adjudication edits and procedure codes
1117	Update to Edits 0311 and 0317 which will stop anesthesia claims denial for no Person Centered Plan (PCP) when a CRNA is the attending
1121	Modification to Edit 2202 to allow changes to the MedSolutions prior approval rules and procedure code updates
1122	Modifications to Money Follows the Person Waiver Program
1124	Timing Change regarding Creation of Health Check Management Fees, allowing for changes to letters and reports for Health Check and Managed Care programs

CSR #	Title and Brief Description of Change
1127	Dental Program Changes due to Appropriations 2011, which implements changes in the edits, audits, pricing/fee schedule, prior approval, and reporting based on the session law
1128	Edit 0164 Changes to Allow Reimbursement for Vaccines for 21 and Older
1131	April 2012 Poverty Level Amount Requirements MMA/Part D File, which adds these amounts for determining eligibility
1134	Changes to reimbursement of Home Health T1999 billing
1135	Federal Aids Drug Assistance Program (ADAP)Changes to allow for compliance with the HRSA grant rules
1137	Payee Modification to the existing practice of paying the individual Community Care of North Carolina networks
1140	Add Data Elements to CMS64 Reporting Extract for SAS Forecasting to the CCNC Network Level
1142	Mental Health/Substance Abuse Targeted Case Management for enrolling CABHA providers to provide this service
1143	Procedure Code Change for HIV TCM from T1017 to G9012 related to HIV case management business rules
1148	Recipient Lock-in. Include Recipient Management (for Controlled Substances) Lock-in info in Eligibility Requests
1151	Revision of Co-Pay for Health Choice Recipients. Corrects Procedure codes that should not be subject to co-pays for SCHIP
1155	Separation of Outpatient Unmanaged Visit for Health Choice Recipients
1166	New Drug Rebate Report 340B - Use of AMPs and URAs
1186	Revision to MFP AB Report to add 2 procedure codes
1191	Coverage of Omontys in Dialysis Facilities through the Physician's Drug Program
1200	Implement federal requirements for Infant Toddler Program Payment and Fees
1211	Removal of PA from Kidney Transplants
1139/ 1103	Edit 2600/ Update to Edit Lists 310, 330, and 325 for Family Planning Waiver

CSR #	Title and Brief Description of Change
1183/ 1267	Podiatry Services System Changes for Medicaid & NC Health Choice Recipients/ POST GO LIVE: Implement legacy Edit 247 for Podiatry to limit services to only individual provider types and require specific diagnosis codes
730/ 1035	Implement Pregnancy Home Model for the Pregnancy Home case management Per Member Per Month (PMPM) program
File Maintenance	Buy-In TXN for Retro buy-in period for part B
N/A	Edit 8606 to prevent payment of CST (H2015:HT) by B-Suffix Provider
N/A	Create Edit 8637 to prevent 074/113 from T1017
N/A	Edit 355, which adds rate references for certain drugs
N/A	Edit 9934 for Point of Sale for SCHIP recipient delinquency indicator check
N/A	Edit 9935 for Point of Sale to deny N1/N2 transactions for SCHIP recipients
N/A	Edit 9936 for Point of Sale, SCHIP third party suspect
N/A	Edit 9942 for Point of Sale to require A+ Kids registry
N/A	Edit 174 to add SCHIP bypass criteria
N/A	Edit 306 to deny SCHIP claims if provider is type 093 (LEA) or 099 (DSS Case Management)
N/A	Edit 361 to add SCHIP bypass criteria
N/A	Edit 355, which adds rate references for certain drugs/injections
N/A	Edit 153, which adds diagnosis codes
N/A	PMPM payments for Value Options (VO)
N/A	Edit 146, to deny claims for 1/1/2012 dates of service for some procedure codes
N/A	Edit 818, 819, 820
N/A	Edit 149, which adds dental procedure codes
N/A	Revision of the Due Process Instructions in letters
N/A	Edit 197, which adds diagnosis codes 631.0 and 631.8 to edit lists 159 and 160
N/A	Edit 353, which adds statement to deny claim for billing type 098, TOS9 when the attending is other than type 088, TOS9

REQUIRED CAPABILITIES NOT AVAILABLE AT GO-LIVE

Replacement MMIS capabilities that were not available at go-live are each associated with a particular Change Service Request (CSR) and are noted below. The CSRs not available for go-live for which workarounds are being performed are reflected in the table above to avoid duplication.

Because CSC and the State are focusing efforts and resources on prompt resolution of defects/issues found after go-live, there is not yet an expected implementation date for automating these CSRs. Implementation dates will be provided as soon as possible.

CSR #	Title and Brief Description of Change
113	De-scoping Reports from MMIS Contract. The state is removing the RFP requirements for 227 of the reports currently listed in the Consolidated List of Reports shown in Appendix 40 Attachment G of the Replacement MMIS RFP
211	Modifying RFP Requirements for Build 16.1 Health Check. Due to policy changes regarding Health Check Coordinators, DMA has requested changes in the replacement MMIS
242	Modify NCHC Recipient Reimbursement Requirement 40.8.1.384. Provides capability to reimburse NCHC recipients for eligible out of pocket claims payment. Modification is to build the capability, but not to implement at this time
253	Revision to RFP 40.12.2.19 The State needs to revise the requirement to read differently
270	External User Interface for General Public to Search for a Provider. The State requires the functionality for external users to search for a provider via the NCTracks web portal
305	Community Care of North Carolina/Carolina ACCESS (CCNC/CA) and CA Provider Referral Affiliations. This CSR will establish that CCNC/ CA Provider Referral Affiliations will allow Primary Care Providers (PCPs) to designate certain peer primary care and urgent care providers to render services to their enrolled recipients without a specific referral for each visit during a specific period of time
306	Add Service Utilization & Referral Utilization Data to the Referral Web Entry & Referral/Override Web Inquiry Pages. This CSR relates to a new requirement #40.7.1.70
316	Remittance Advice - Add Provider Location Code Break. DMA is requesting that the financial build include the billing provider location code information into the remittance advice to allow providers use of that information to filter/separate different locations that are under the same National Provider Identifier (NPI) and Tax ID
323	Delete individual MARS Financial Participation Reports (FPR) as replaced with single combined Report HMER5811. This report will provide the information needed for reporting on the CMS64.

CSR #	Title and Brief Description of Change
383	Additions/Enhancements For The Electronic Verification System (EVS) Provider And Recipient Response Pages. This CSR created as a result of CSR 320, where analysis was performed
396	Managed Care Referral Messages 40.7.1.65. Provides capability for NCTracks to return on-line, real-time, user friendly messages to Medicaid & NCHC providers when web-entered managed care referral requests are denied. Responses will be based on managed care referral edits in the PA subsystem
412	Remove Medicare User Interface (UI) and associated table from NCTracks. The State no longer supports a Medicare cross reference once needed in the legacy system
418	DHSR Interface - Replacement MMIS impacts on Build 5 and Build 100. Fiscal Agent Operations will be impacted by the Build 5 comment that the interface to DHSR will not be built and the process will remain manual
421	Managed Care Requirement Updates. A number of Managed Care requirements need to be either deferred or updated
424	Replacement MMIS - Automate the generation of email notification as defined in business rules. Per DMA Provider Business Rule PSBRA15A, distribution of general provider correspondence needed to meet this business rule should be automated
434	Recipient Visit Limit/Threshold and Notification Review. Session Law 2007-323 Provider visit limits [10.36(e)(2)] establishes that reimbursement is available for up to 30 visits per recipient per fiscal year for various professional services. Recipients that have reached 15 mandatory visits within a fiscal year will be included within monthly reports. The recipient's visits will be calculated from the paid claims processed within the NCTracks. The report will include two sections: Carolina ACCESS II and NON Carolina ACCESS II recipients
446	Allow Clozaril to Bypass Prescription Limit if Multiple Fills in Same Calendar Month. Pharmacies are required to bill Clozaril in weekly increments and this can cause problems with the prescription limit. The POS system needs to be changed so that if multiple fills of Clozaril are paid during the calendar month that only one is counted toward the prescription limit. All dispensing fee and co-pay rules remain the same
453	Change Criteria for How Monthly Prescription Count is Determined. Currently the MMIS counts each paid prescription during the month as one prescription regardless if it is a unique fill or not. The MMIS and POS systems should be changed to count only unique fills toward the limit (similar to how Clozaril is working today). The monthly systematic review process of the lock-in file will also need to be changed to account for this different methodology of counting prescriptions. DMA would like this change implemented by January 1, 2008
454	Edit 946 Overrides on POS. The Fiscal Agent has experienced several issues regarding errors in the buy-in file from CMS. This directly impacts recipients trying to obtain drugs covered by Medicare part B, since there is no longer an override available at Point of Sale (POS) for these situations

CSR #	Title and Brief Description of Change
471	Update to Instructions for Distribution of Correspondence - Build 5 Impact of CSR213. The updates will align NCTracks with a number of DMA Provider Business Rules and will facilitate communication between CSC and Medicaid providers
475	Estate Recovery Invoicing Changes. This change will correct the problem of living arrangement codes that are being used to generate estate recovery invoices that are inaccurate, resulting in under billing, especially for the nursing home room and board that represent the largest item in estate recovery invoicing
488	Medicare and Third Party Liability (TPL) By-Pass. This will allow NCTracks to by-pass the TPL and Medicare editing for Facility Based Crisis and Mobile Crisis
510	Pharmacy Global Limits. The current monthly limit on prescriptions needs to be updated with a number of criteria
517	Piedmont Benefit Package Modifications. Two changes need to be made to the Piedmont benefit package, including both Per Capita Prepaid Benchmark (PCPB) and Per Capita Prepaid Cost (PCPC) effective July 1, 2010. The changes have been approved by CMS
518	New CAP MR/DD Waiver. To implement in NCTracks 2 new waivers as specified in CSR 180
552	Medicaid Statistical Information System (MSIS) Modifications for Federal Fiscal Year 2009. The changes would align NCTracks with NPI related MSIS record changes that were to be effective with Federal Fiscal year 2009
570	FORM CMS-416: Annual EPSDT Participation Report. Will create a new report to meet CMS' criteria for the FORM CMS-4l6: ANNUAL EPSDT PARTICIPATION REPORT. This report will exist in addition to the current 5901 Legacy Report
583	PEGA - Update to business rule for Caller Confirmation Aligns NCTracks with an update to DMA Provider Business Rule PSBRA17 that indicates the EVC Call Center staff *shall* request the last four digits of the caller's tax identification number (SSN or EIN) to confirm that the caller is the actual enrolled provider or an authorized agent of the enrolled provider that he/she is presenting himself/herself to be
624	Long-Term Solution for End-dated Budget Criteria. This change modifies NCTracks so that adjustments processing against end-dated budget criteria will place the recouped funds back into the associated account as long as the original claim was paid within the current fiscal year
669	Business Rule Updates, PSBRM5, E18, E4, and E9, 20101202 - Build 5 analysis of CSR391. This CSR communicates changes that were made to the DMA Provider Business Rules during the months of October 2010 and November 2010. These changes were made to align with current requirements or to add clarification only

CSR #	Title and Brief Description of Change
679	Out-Of-State Provider Welcome Letter Changes. When a re-enrollment packet has been completed, the CSC credentialing coordinator creates a PS101 (Reactivation and Reenrollment Letter) which is sent to the provider as notification. The PS101 template will need to be revised to include the enrollment end date, too
709	Provider DDI Build Out for Bad Debt Processes. Provider Build 5 requires changes in the design to accommodate the bad debt process for certain accounts receivables processes
716	Modify Automated Voice Response System (AVRS) response for recipient service limits and insurance data. Updates AVRS to allow DMA Medicaid and NCHC (North Carolina Health Choice) recipients and providers to inquire on service limits/services
717	Modify Electronic Verification System (EVS) response for recipient service limits and insurance data. Allows DMA Medicaid and NCHC (North Carolina Health Choice) recipients and providers to inquire on service limits/services in the EVS
734	EPSDT Reviews by CSC for Prior Approval. RFP requirement 40.7.2.13 lists the PA services the fiscal agent will adjudicate. Completing the EPSDT portion of the review for adjudication is not listed; however, it is needed and will be added to NCTracks with this CSR
763	Modifications Required Supporting Cost-Sharing for Health Coverage for Workers With Disabilities. These changes are required for NCTracks to support cost-sharing processes for Medicaid Health Coverage for Workers with Disabilities (HCWD)
767	Delete reports from CSC Master Report Spreadsheet (32 total reports). Ensures business requirements for report production are current, with no report duplication between Legacy and new reports, as well as no duplication with reports scheduled for production in the Reporting & Analytics project
770	Provide capability for DMA recipients to view EOB's via the secure NCTracks web portal. Increased visibility by recipients of their claims for services will help identify provider fraud. New federal and State regulations require State Medicaid agencies to use all available means to combat fraud and abuse
785	End Date Migrant Health as an ORHCC benefit plan. The Migrant Health Program was closed by the Office of Rural Health and Community Care effective 6/30/11; NCTracks needs to be updated to end this benefit plan effective 6/30/2011
791	Develop Process to Adjust Claims in a Program Integrity Case for Which a Reimbursement Has Been Received. This CSR requests that CSC develop a process to include the claims involved in a PI case on the AR form and to systematically (automatically) adjust the PI related claims for the amount of the reimbursement via a history-only adjustment
801	1099 Suppression Indicator. The suppression indicator functionality build out will ensure that 1099's are not produced for tax exempt organizations and filed with the IRS by the State of NC. This is a requirement from the State Controller's Office
810	1099 Reporting/Pay To Address. The current process in finance for the selection of a 1099 reporting address does not meet the State's needs. The 1099 address for reporting and pay to needs to be added

CSR #	Title and Brief Description of Change
811	EIN duplicate check between individual and organization records. The current duplicate check for enrolling individuals checks for duplicate SSN and NPIs, not EIN. The coding for web pages and/or Pega workflow will be changed to enforce these rules
813	Change of Ownership (CHOW). Aligns NCTracks with Provider Services Business Rule PSBRM1 which defines the rules for when organizations obtain a new TIN without actually experiencing a change of ownership. IRS allows an organization to get a new EIN without experiencing a total change of ownership
822	Health Care Reform Implementation Requirements Analysis. Identifies the specific changes that will be required in the MMIS and creates a timeline that integrates efficiently with the MMIS DDI effort. The timeline should result in work being completed by the fall of 2013. This CSR should have a final deliverable consisting of a Basis of Estimate, schedule, and total cost for this effort
831	Suppress the Production, Printing and Distribution of Identification Cards for DPH/ORHCC. DPH/ORHCC eligibility determination will move to NCFAST. NCTracks will not need to produce, print or distribute DPH/ORHCC ID cards
835	Enhancements to Consent Form Workflow. This CSR carries out the changes the State and CSC have identified that will make the workflow more efficient in terms of CSC processing time and more compliant with State rules for creating consent form denial letters
836	Add Advanced Medical Prior Approval interface to PA functional area. The Advanced Medical interface was listed in Appendix H of the RFP; however, it was determined during design that the interface was not needed. The need has since been confirmed. This CSR adds the interface to NCTracks
838	De-scope the report FR18200-R0010. This CSR will eliminate the report from Legacy CSR 642
840	Build 18 AVRS Requirement Re-mapping for Currently Enrolled Providers. Requirement 40.1.2.51 will be mapped to Build 18 - AVRS, and the 47 test cases will be aligned under this CSR
841	Delete Community Alternative Program/Family Pay Part (CAP-FPP) from recipient premium processing. DMA has determined that Medicaid recipients cannot be charged premiums. This CSR deletes all requirements and business processes related to recipient premium process for CAP-FPP
848	Add edit 0259 to NCTracks. This edit will post to pharmacy claims when the recipient is identified as having third party coverage, but the submitted claim does not have on other payer amount paid. Bypass and override conditions apply to the edit
849	Enable NCTracks to enroll Physician Assistant: Changes will enable NCTracks to enroll Physician Assistant providers
852	Change the Claims Timely Filing Dates for Medicare Recovery. CMS has changed the time period for filling Medicare FFS claims to implement the Patient Protection and Affordable Care Act (PPACA) Section 6404. This CSR aligns NCTracks with this change
855	Prohibition of payments to institution or entities located outside USA. Implements Business Rule PSBRA28 to deny enrollment application where applicant has indicated an accounting/billing address that is located outside of the United States
859	Cash Receipt Reversal Requirement. This CSR will provide the system with the capability to reverse Cash Receipts dispositioned against Accounts Receivables to satisfy Requirement 40.14.1.94 which identifies the Medicaid Accounting System (MAS) business rules & requirements

CSR #	Title and Brief Description of Change
862	Change Application Process Flow for Rendering/Attending Providers and New Edit for Manage Change Request CCNC/CA Provider Terminations. This CSR will update the Provider application flow process to follow the current CCNC/CA application process for Organizations enrolling in Carolina Access
863	Endorsement Changes made EVC - DDI Impact. Endorsement changes made to the EVC system as defined in EVC CSR 63 will be converted to NCTracks
891	Programming Changes to HMFR5801 & HMFR5802. This CSR will make programming changes to the Audit Summary Reports for Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) Providers
912	Modify IPDR4471 WHP due to all LMEs changing to Single Stream Funding (SSF). This is per DMH policy
923	Allow Metabolic formulas to process on National Council for Prescription Drug Programs (NCPDP) D.0 (real time POS) transactions. The metabolic formulas need to be reimbursed at the same rate that applies under the Durable Medical Equipment fee schedule
924	Change to Admission date and statement coverage period rules from National Uniform Billing Committee (NUBC). CMS is altering the data elements to match the UB04 definitions and DMA is requesting that all edit/audit logic be verified for correct application of these data elements and system changes necessary to comply with the UB04 claim rules
925	Prior Approval Process for Transplants. This CSR covers the requirements for the administrative process for transplant prior approval reviews
930	Void and Reversal Functionality. The system must provide window(s) that allow the user to reverse an accounts receivable invoice on line if other items have been cross referenced to the voucher and return all cross referenced items to their original status when an invoice is reversed
932	NCFast Integration with NCTracks (DMA/EIS Interfacing with NCTracks). This CSR provides the scope of work to design the integration of NCFAST with the Replacement MMIS. In addition, the realignment of eligibility requirements currently within NCTracks to NCFAST will be planned
934	Provider dba (doing business as). Changes needed per business rules
939	Dental and Optical Benefit Limitation Web Inquiries. The purpose of this CSR is to define the online HIPAA-compliant inquiries of dental, eye refraction, and visual aid benefit limitations by enrolled Medicaid and NCHC providers
946	Provider Enrollment Application Cloning for DDI, to allow providers who are enrolling to save the common data electronically via a cloning process
951	Attending/Rendering Providers on Local Health Department (LHD) and FQHC/RHC claims. Under the 2012 State Budget item to eliminate incident 2 billing, and for the EHR Incentive program with the NC HIE, NC DMA has advised LHD and FQHC/RHC providers to put the actual attending/rendering providers on the claims. Future editing, history editing, and pricing could utilize this information under NC DMA policies. NC DMA is requesting CSC to review the NCTracks system and identify areas of concern and resolutions related to this claim change
952	Format Changes to Managed Care Letters to benefit the counties and allow the case worker to obtain the correct mailing address for the recipient
961	DMH Changes due to 1915 b/c/ waiver (Partially Implemented at Go Live), so that spacers be allowed to process under the pharmacy POS system
962	Adding spacers to pharmacy point of sale (for asthma inhalers)

CSR #	Title and Brief Description of Change
968	Report IPPR2417 - Eliminate Repetitious Listings of the same Pricing /Codes
969	Retro Medicaid to Use Submitted Billing Provider to ensure DMH claims pay properly
971	Validation of PA Requests for Out of State Specialty Equipment Providers
972	Transformed MSIS (T-MSIS) to support the CMS pilot for a T-MSIS. NC is one of eleven states participating in the pilot
977	Create new Audit for Peer Support H0038 to align with DMH policy
984	MIPS Document upload Interface with Filenet to provide communication storage for post-payment audits
992	Update Reports for Block Grant Attending Provider Changes to support a State auditor request to DMH to implement stronger controls in the claims payment system to only allow providers identified as Block Grant providers to receive block grant funds
993	Add Medicaid Data to report IPKR3841. Add the Medicaid ID and Medicaid Program Code as requested by the LMES
996	Re-instate edit 1222 due to code changes for the Immunization Admin Reimbursement
1001	Early refill override with change in therapy indication to support Session Law budget cost reductions and pharmacy policy changes
1005	NCHC Provider Enrollment for CCNC/CA (Implementation of CSR 473) to allow NCHC providers the ability to enroll in CCNC/CA without being a Medicaid enrolled provider
1016	DMH - Retroactive Medicaid Eligibility with Medicaid Encounter Claims if the claim denies because an encounter should have been submitted, the DMH paid claim is still voided
1017	POS Patient Residence, NCPDP Patient Residence field 384-4X, This CSR is to source all data from the Patient Residence rather than from the Place of Service (field 307-C7)
1018	Health Check Supervisor/Director County Assignment to allow the Sup/Dir to have access in the event there is no HCC within the CCNC Network.
1029	Add an On-Demand Letter - Recipient with no PCP and ER Visit. This change is for the Health Check population that is not required to have a PCP and has received non-emergency treatment from the emergency department
1045	Update the Fund Used for Program Integrity (PI) Activity Run Through NCTracks to capture all PI Activity in Fund 1330 instead of Fund 1310 to ensure that funds for PI are separated from other recoupments per Federal regulations
1049	Create "Core Indicators Survey for Clients of MR for Benefit Plan CDSN" Report
1051	Add NC Health Choice Fee Schedule Reimbursement to TCM Adults and Children per Session Law
1056	Editing for Prior Approval for Medicaid for Pregnant Women to support DMA's policy requirement for prior approval of a service/procedure/product that is not part of the Medicaid for Pregnant Women benefit plan when it is required for a pregnancy-related condition
1057	Inclusion of CAP for Children in MFP Service Package. This will allow related waiver services to be funded at an enhanced federal match the first year of participation.
1058	Create New Edit to Deny SCHIP Claims When Non-covered OB Diagnosis Codes are Billed

CSR #	Title and Brief Description of Change
1070	Prior Approval Requirements for NCHC Dental Services. Providers must document why approval is needed (pain, swelling, infection, previous antibiotic therapy, etc.) for the extraction of impacted teeth including the third molars and provide evidence that the removal of unerupted, impacted teeth is medically necessary
1072	SCHIP Claims Bypass Family Planning Edit to ensure that all family planning services are identified in claims processing
1073	Addition of Diagnosis Codes for Folotyn, Healthcare Common Procedure Coding System (HCPCS) Code J9307, in accordance with approved indications
1076	Modifications to Edit 349 to meet objectives for inclusion and exclusion of providers and procedure codes in the Managed Care Organizations (MCO) benefit plan
1077	RHC/FQHC changes to audit summary to support NC DMA policy ID-3 regarding core services for federally qualified health centers and rural health clinics
1078	Pharmacy program and edit changes from legacy HPES CSRs for Ad hoc reports for prodigy diabetic supply; Recipient Narcotic Lock-in Process for POS and Batch; D/C Form Management fees and lock in letters; Bypass new prescriber lock in edit; PDL update frequency from daily to weekly; and Update report HMPR2981 to list updates versus errors
1089	Grouper 27 and 28 with Managed Care Entity (MCE) Implementation documentation to allow for CSC to address conversion and other potential claim processing changes created from the implementations of these two versions of the Grouper
1091	DMA Rehab Pricing Rule revision to price all claims for border area and out of state special hospitals with the taxonomy 284300000X based on accommodation code 94 regardless of the associated Diagnosis Related Group (DRG)
1092	Implementation of Family, Infant, and Preschool Program (FIPP) Fee Schedule per session law
1094	Apply Alien Pricing Logic for recipients with 4th digit aid program categories of H and R
1096	Updates to Edit 0158 to comply with CMS Change Request 7266
1101	Update to Edit 0177 for HCPCS Code J0636 to comply with CMS guidelines
1106	Legacy Edit 1230 for CAP/MR-DD Indicator to comply with CMS requirements
1109	Prior Approval is required for capsule endoscopy. Based on Session Law 2011-145 HB 200, DMA is mandated to require limitations on the use of capsule endoscopy effective with date of service 10/1/11
1111	Update to Diagnosis List 45 for Edit 0153 to remove coverage for newly diagnosed breast cancer recipients for Avastin that impacted Diagnosis List 45 for Edit 0153 effective with date of service 3/31/12
1112	Prior Approval Requirements for Ophthalmic Ultrasounds. Effective with date of service 10/1/11, DMA removed prior approval for certain ophthalmic ultrasounds
1115	Establish New Waiver Year Parameter for CAP/MR-DD. Based on CMS approval, DMA implemented a new waiver year period for CAP/MR-DD as of 11/1/08 through 10/31/11
1118	Medicare Bypass for Residential Treatment Facility Services. This allows the system to bypass data processing requirements for Medicare
1119	New Edit for LME Medicaid Denials to deny claims billed with Provider Type/Specialty 074/113 for procedure code S5145 or any "H" outpatient procedure code when the attending Provider Type is 112, 109 or 020
1120	Implement New and Revised Edits for Provider 7705128 to prevent the provider from billing anything other than procedure code Y2200

CSR #	Title and Brief Description of Change
1123	Change Report HMLR6201 Health Check Management Fees to report these fees to the CCNC network (by CCNC network) in a different manner
1125	Outreach & Suspension for Non-Responsive Medicaid & NC Health Choice Providers. The two parts to this CSR are (1) Creation of new provider action reason codes (ARC's) and (2) conversion of an EVC crosswalk table of provider types & specialties with provider associations. There is also an NCTracks operational component for generating & mailing letters to provider associations
1130	PR File Change Requested by Physicians Advisory Group (PAG). The DMA Medical Director and the physicians' advisory board decision to change policy
1133	Changes to CAPCH Waiver (Yrs 07/01/10-06/30/15): Creation of Prior Approval for P Codes and Addition of P Codes to the Waiver
1138	Changes to Prior Approval and to Audit Related to Change to PDN Policy per session law
1144	CAP-MR/DD Report as implemented in legacy
1145	Stop Running HMKR3701 and HMKR3702 reports due to Medicaid eligibility policy changes
1147	March 26, 2012 business rule updates for PSBRC1, PSBRM3, PSBRM5 and PSBRM6
1157	Botulinum Toxin Policy Revisions to comply with 45CFR 162.1002
1167	MFP "Pre-Transition Case Management Demonstration Service" for CAP DA and CAP CHOICE Case Managers. This CSR is to enable CAP DA case managers and CAP Choice Care Advisors to bill for up to eight hours of assessment and planning conducted up to 60 days prior to an MFP participant's transition date, without it impacting their annual 42 hour allotment
1169	Addition of Limit information to AVR and web based system. Because of new visit limitations and prior approval components in the Home Health policy, DMA needs a way for providers to be able to determine where a recipient stands against those limits so they know whether they need prior approval or whether they can provide services
1181	E-Check Configuration within the PayPoint Application. This requirement is based on the mandate from the NCDHHS Office of the Controller in accordance with G.S. 147-86.22 and the State Cash Management plan, stating that NCDHHS will accept electronic payments for all divisions to the maximum extent possible
1183	Podiatry Services System Changes for Medicaid & NC Health Choice Recipients per a legislative change
1187	Align system to support PAG approved policy
1188	Special Ophthalmological Services. This CSR covers multiple changes to CPT codes, Audits, Diagnosis editing per new policy
1189	Add F2 Medicare Suspect Override Indicator to Nutrition Codes (B Codes) to ensure that providers who provide oral nutritional formulas (a non Medicare covered service) can submit their claims and receive reimbursement without denial issues
1192	Revised version of the 1500 Health Insurance Claim Form (version 02/12) as mandated by CMS

CSR #	Title and Brief Description of Change
1197	AOC records to support Intellicorp for background checks. In 2011 the North Carolina AOC made an administrative decision to discontinue supplying full record case extracts to licensed vendors. While records which existed prior to this decision continue to include complete criminal case details, AOC record results generated after 07/18/2011 have been reduced to basic data elements only (name, date-of-birth, county, case type, file date, and case number). The charge/description of the crime and the disposition of the case have been removed. Because of state & federal mandates related to Medicaid/NCHC provider enrollment & screening requirements, DMA must find another source to obtain the information above that is no longer provided to vendors by the NC AOC.
1207	Implement the CMS mandate for enumeration of a unique standard Health Plan Identifier (HPID). The final rule CMS-0040-F, may be viewed at www.ofr.gov/inspection.aspx
1227	10.9e SL Medicaid Option/ Special Care and Memory Care. This CSR is for the implementation of SL 10.9E for special care memory units
1275	Update to Revenue Code 636 to Allow Billing by Dialysis Providers
1336	Prior Approval Signatory Work Around the Electronic PIN. This CSR is to provide the capability to have a clinician signature on the PA forms when it is required
1340	Create DMA Credit Balance Refund Form. Providers are required to submit this form when sending in a refund check with a credit balance report

Additionally, issues were identified during UAT which were not resolved by go-live. The list of these issues follows:

As with the CSRs listed in the tables above, no expected implementation date has yet been established.

Issue Synopsis
The Emergency User role was not created for Health Check
UI - Global Help system does not meet requirements or standards for self help
UI - Global Reference Expand/Collapse row indicator missing OPS_SUPER35
Web Standard Discrepancy on PA Drugs and Criteria Web Page
Web Standard Discrepancy
Services Tab- Languages Supported- Conversion Not Defaulted to English
UI - Skillport user manuals and training not available
Zoom feature of the provider Portal UI does not work
UI - Recipient NCTRACKS Training not available
UI - Liquid layout not present in screen design
UI - Verify Patient Entry boxes in Foxfire minimized
UI - Verify Provider Information Entry boxes in Foxfire minimized
The order of the menu is not in alphabetic order
PA Page Not Displayed for Out of State Location

Issue Synopsis
Tab Sequence in PA entry incorrect
System not Updating Upon Submission
Hover Over Information on Budget Criteria Detail UI is Incorrect
Deceased Provider Still Active-Allowed to Re-enroll and MCR
Deceased Providers Converted Incorrectly
Empty Space Selectable and Hover over
A different carrier is displayed in the search section when a new carrier is add
Gender Converted Incorrectly when blank in EVC
Data Presented to Providers After Conversion is Inaccurate/Incorrect
Unable to sort columns
UI - Taxonomy Crosswalk Search Qualifier field not displayed as DED described
Delete Staff with current date shows Active
UI - Taxonomy Crosswalk Search Help file is not sufficient
Can't create Drug Rebate or Bed Assessment AR without period code & CAC code.
Cosmetic Issues with the Dental Remittance Advice
Drop Down Box for Staff Type contains Emergency User
NCTracks' Edit numbers should be displayed first and separated from Legacy edits
Grandfathered Providers of End Dated Taxonomies that are Still Active
Clinical Information Questions are not showing required
Default the Claims Attachment question to NO on Attachments tab
Sort order for report Fr18105-R0010 needs to be corrected
Dental Paid History Screen - Recipient Name and Eligibility Information
State COS/NCAS Acct. combinations invalid. Mthly Expend overstated COS 100 & 120
COS/NCAS Acct. combinations invalid. Monthly Expenditures overstated
COS appear multiple times inappropriately. NCAS Account expenditures overstated
State COS/NCAS Acct. combinations invalid. Monthly Expenditures overstated
State COS/NCAS Acct. combinations invalid. Monthly Expenditures overstated
Number of Eligibles understated. Number of Participants overstated.
Missing/Incorrect premiums/expenditures
CR40031-R0001 report issue
CR40031-R0002 report issue
Expenditures exceed that shown in CSC load of the CLOB in MR41100-R0015
Alternate Flow State Review Background Inconsistent System Response
Claim PAID should have Denied; Inconsistency of data to Financial Reporting
R2W: TMO03302-R3085-Report title and heading are different
Benefit Plan Determination for Orthodontic Claims
Referrals not Location Specific
Benefit Plan Determination for Orthodontic Claims/ Not Eligible
Printing Dental Claim from Operations Portal

Issue Synopsis
Monthly Accounting of Activities Report (MAAR)UI shouldn't be displayed for Super/Dir/HCC
FR33000-R0010 Report Title is incorrect
Audit History is not functioning - all fields are blank
Recipient Reports displayed in R2W do not Match the Functional Area Master (FAM)
Provider Portal Dental History, Optical Refraction Confirmation, DME PA
DPH -Issues for updated records
Report FR18100-R0030 Not Being Created Correctly
Title of Report FR88200-R0030 Contains the Name of the Legacy System
Report doesn't accurately depict the multiple changes made to the policies
Can't change a pended Buy-In segment
FR88200-R0030 Total Description Incorrect
HCPCS and CPT Periodic Update Change Report is not comparing Resource-Based Relative Value Scale (RBRVS) values
Family Planning Waiver Benefit Plan (MAFDN)
County code is required in Financial Account Receivable Detail page when Updating
837P UI test case: Create Professional Claim failed upon SUBMIT- system message
CSR 309 - Validation of 40.8.1.80-1.15 issues
On Claim Edit Detail, the Edit Manual "view" link is not working
Provider Accept As Code (Provider Portal)
Dental Service Page - Unable to see Service Line Info (Provider Portal)
Error Message Received when Attempting to Submit a Managed Change Request
Recipient Data Not Restricted/Displayed Correctly Based on User Roles
FP Edit 01800 is being associated with MFP EOB 08029
5010 X12 837I raw data does not comply with CG values
Primary Location Indicator Set for End Dated Converted Address
National Standards Format (NSF) letter - Salutation does not adhere to Specs
DMA Conversion-Recipient Eligibility and Enrollment-Errors
Pending Transactions approved though System Error
Provider Enrollment - Error Message
276 UI Search Arguments not used correctly
The printed RA has the correct NPI, but the RA lists it as "Attending Provider ID"
Raw 835 Adjustment Reason Code field should match the printed RA value
Submitted CEP applications not displayed on Status Management Page
Re-enrollment work item in Pega cannot proceed
Major Provider Concerns regarding the format and sizing of the paper remittance
MCR to end date Only Taxonomy Will Not Submit
Re-verification process does not display Review Application Page
FR19200-r0010 Column Headers do not match
MCR to End Date all Health Plans; Incorrectly created work item in Pega
MCR to End Date all Taxonomies; Incorrectly created work item in Pega

Issue Synopsis
Not Able to Wildcard Search a Provider Name
Directions for Re-enrollment Incorrect
Note Type & Internal Comments are marked as * required on PA UI
Provider Portal Prof Claim Entry Rendering Atypical not available defect
Provider Portal Prof Claim Entry Rendering Address defect
Provider Portal Prof Claim Entry Rendering Taxonomy not allowing entry defect
Provider Portal Prof Claim Entry Other Payers Paid Date defect
Provider Portal Prof Claim Entry Services tab, Prescription # and Date defect
Provider Portal Prof Claim Entry Prescription Date showing a Time defect
Provider Portal Prof Claim Entry Claim Service Line Quantity Type defect
Provider Portal Prof Claim Entry Line Item Control Number display is limited
X12 277 Claim Response did not include NUBC Revenue Code
Report should only show "system receivables"
Deferred Repayment Plan Report Amounts at top of page are split
AR Aging Report; AR reporting under incorrect Company
EIS Case Termination Did Not Terminate Recipient's Case
Initial entry date of a policy is not captured in the Audit Icon
Required fields on NCTracks Contact Us and Report Fraud page
Subscription Preferences on Provider Portal are not saving when changed/edited
of Letters/DCNs not calculated correctly
Changing the NCID user id results in bad Audit information and no access to Pega
Provider Pharmacy External User login fails
Provider Portal - Dental Benefit Limitation - inaccurate error message displayed
Expiration Date Hover Over for Accreditation and Certification
Legacy Consent Forms Not Converted or Not Mapped Correctly to NCTracks Fields
277P Transaction - EJ qualifier indicates Patient Control Number
Edit Criteria 00259 is only displaying criteria for Pharmacy but not medical
Problems with R3098 - List of Buy-In Actions Recd From CMS
Search on Recipient ID failed
Prof/Inst claims via Portal or X12 not capturing Line Item Control Number
X12 277 Response Claim Status Code D0|21 requires one more Status Code returned
MR53100-R0050 Perm Balancing Expenditures not expected result
NH Crossover Claim Suspended
FR19100-R0010 Accounts Receivables Aged Over Sixty Days
FR19300-R0120 Medicaid Accounting Adjustment Register - Monthly
FR19300-R0130 Medicaid Adjustment Recap Register
FR33000-R0010 AR Finance Interest Charges Process Summary
On Demand Letters: (01-30Day SUSP, 02-60Day SUSP, 03-30Day NRP, and 004-RTRN)
On Request Summary Report 'AM08000-R0702' has no data.

Issue Synopsis
5010 X12 837 Prof TR3 compliance error-not allowing ",", "-", in AN (string) field
5010 X12 837 Prof Data Element type Decimal not allowing decimal
5010 X12 Prof Claim Entry error in NPI being erased erroneously
5010 X12 Prof Claim Entry bug in adding Drug NDC row
5010 X12 Prof Claim Entry bug in Service Detail Line CAS adjudication entry
Once a FMR is requested there is no approval process built into the application
5010 Prof & Dental Claim Entry Other Payer row delete bug
Got logged out of session with message: "Please Login (message#07)"
Unable to Access Move-It
Provider Relations Read- Provider Accreditation Page- unable to access Audit log
Logged in as DMA-NC DHHS Recipient Pega User and no Tabs or options are available
Consent form page must not be available when logged in as DPH user
Provider Accreditation Page - Unable to access Audit Log
Manage online COCC, ID Cards and Booklets Request Page available for DMH Recipient
D0003 dated 06-05-2013 notes column conflicts with additional required column
Recipient Cross-Reference/Combine Data not displayed consistently
Data converted for Finance Payments are duplicative and incorrect
Invalid Checkwrite Date showing for Provider Payment information
Provider History Search data differs from Provider Payment Search data
Portal Dental Claim - Cannot Correct Billed Amount
Inconsistent use and results with cross reference ID's
Co-pay amount is not evident on RA
Not All Service Facility Information Populates When Selecting From Favorites
Ability to collect Recipient TPL information at the county DSS for new or existing recipient that should be entered in /sent to NCTracks
Calculate Estate Recovery of applicable Medicaid monies from a recipient estate after death
Medicare Recovery – recoup funds paid by Medicaid when Medicare is applicable
Credit Balancing, which means to collect and apply provider overpayments discovered when other third party criteria surface after payment
Not all Service Facility information populates when selecting from favorites

End of Report