



## May 2016 Medicaid Bulletin

In this Issue.....	Page
<b>All Providers</b>	
Change in Processing of Accounts Receivable.....	2
Payment Error Rate Measurement (PERM).....	3
Enrolled Practitioner Search Function.....	5
Out-of-State Provider Enrollment.....	6
Re-credentialing Due Dates for Calendar Year 2016.....	7
NCTracks Updates: 10 Percent Rate Increase for Private Duty Nursing.....	8
Auto-Assignment Initiative: Increased Enrollment of Medicaid and NCHC Beneficiaries with Community Care of NC (CCNC) Providers.....	9
Medicaid and N.C. Health Choice Provider Fingerprint-based Criminal Background Checks.....	11
<b>Hospital Providers</b>	
NCTracks Now Producing NC Health Choice Detailed PS&R Reports.....	12
<b>Nurse Practitioners</b>	
Additional Mid-Level Practitioner Taxonomy Codes Can Bill in NCTracks .....	14
Antihemophilic Factor VIII (Recombinant), lyophilized powder for solution for intravenous injection (Nuwiq®) HCPCS code J7199: Billing Guidelines.....	15
<b>Pharmacists and Prescribers</b>	
Prior Approval Requests for Select Hepatitis C Medications Now Online Only.....	17
<b>Physician Assistants</b>	
Antihemophilic Factor VIII (Recombinant), lyophilized powder for solution for intravenous injection (Nuwiq®) HCPCS code J7199: Billing Guidelines.....	15
<b>Physicians</b>	
Antihemophilic Factor VIII (Recombinant), lyophilized powder for solution for intravenous injection (Nuwiq®) HCPCS code J7199: Billing Guidelines.....	15
Ciprofloxacin Otic Suspension, for intratympanic use (Otiprio™) HCPCS code J3490: Billing Guidelines.....	19

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## Attention: All Providers

### Change in Processing of Accounts Receivable

Until recently, recoupment of system-generated Accounts Receivable (AR) began 30 days after the AR was established. **Beginning May 1, 2016**, recoupment of a system-generated AR will begin with the subsequent checkwrite after the system-generated AR has been established.

An AR is created in NCTracks when a provider does not have sufficient paid claims in the current checkwrite to satisfy a recoupment of funds, often related to claims reprocessing. Waiting 30 days to begin recoupment of the AR means the provider is subject to penalties and interest, based on state business rules. Commencing the recoupment of the AR in the next checkwrite helps providers avoid incurring penalties and interest.

A new letter has been created to inform a provider's chief executive officer (CEO) that money is owed to an N.C. Department of Health and Human Services (DHHS) payer. DHHS payers are the Division of Medical Assistance (DMA), Division of Mental Health (DMH), Division of Public Health (DPH) and Office of Rural Health (ORH).

The new letter will be titled *Notice of Balance Due the NC DHHS – First Demand*. A separate First Demand letter will be sent from each payer who is owed money. The First Demand letter will provide information regarding the potential for assessment of penalties and interest and instructions for repayment if the provider does not want to wait on recoupments through NCTracks.

**Note:** In some cases, checkwrite amounts are insufficient to completely collect the amount due from the provider whose National Provider Identifier (NPI) generated the AR. In that case, NCTracks will automatically seek to recoup the AR from other providers whose NPI shares the same IRS Tax Identification Number (TIN). The First Demand Letter will be sent to all providers who share the same IRS TIN.

If the AR is not satisfied within 30 days, a 30 Days Past Due Letter will be sent to the provider for whom the AR was established. It will not go out to other providers who share the same IRS TIN. The 30 Days Past Due Letter will include the penalty and interest owed on the AR.

If the AR is not satisfied within 60 days, payment will be suspended to the NPI for which the AR was established and other NPIs associated with the same IRS TIN. A 60 Days Past Due Letter will be sent only to the provider for whom the AR was established, not to any other providers who share the same IRS TIN. Providers are responsible for repaying the NC DHHS payer even if they are no longer filing claims to NCTracks.

Examples of the 30 and 60 Days Past Due Letters can be found on the [Provider Policies, Manuals, Guidelines and Forms web page](#) of the NCTracks Provider Portal. (The 30 and 60 Days Past Due Letters are not new, but the wording has changed). A list of Frequently Asked Questions (FAQs) regarding the AR process can be found on the [FAQ page](#).

**CSRA, 1-800-688-6696**

**Attention: All Providers****P**ayment Error Rate Measurement (PERM)

The Payment Error Rate Measurement (PERM) audit program was developed and implemented by the Centers for Medicare & Medicaid Services (CMS) to comply with the Improper Payments Information Act (IPIA) of 2002. The program examines eligibility determinations and claims payment made by Medicaid and Children's Health Insurance Programs (CHIP) for accuracy and ensure states only pay for appropriate claims. North Carolina's next PERM cycle is federal fiscal year 2016 (October 2015 – September 2016).

**Note:** N.C. Health Choice (NCHC) is North Carolina's CHIP.

**How PERM is implemented**

**Claims Review** – Claims are reviewed to determine if they were processed correctly and the services were provided, medically necessary, coded correctly, and properly paid or denied.

For the PERM cycle, CMS uses two contractors to perform claims reviews:

- **Statistical Contractor** – Collects universe claims data quarterly from states. Uses a stratified random sampling design to draw the sample for review.
- **Review Contractor** – Uses the sample list to request copies of medical records from providers and reviews them for medical necessity, correct coding, correct payment or denial of claims, and services provided.

The Lewin Group is the Statistical Contractor and A+ Government Solutions/CNI Advantage, LLC, is the Review Contractor for the FY 2016 PERM cycle. A+ served as the Review Contractor for the FY 2010 through FY 2013 PERM cycles so many of the processes states are accustomed to will continue into FY 2016.

Throughout the cycle, A+ will be responsible for collecting Medicaid and NCHC policies, conducting data processing reviews, requesting medical records from providers, conducting medical reviews, and hosting the State Medicaid Error Rate Findings (SMERF) website. The website allows state representatives to track medical records requests, view review findings, request different resolution/appeals on identified errors, etc.

**Where providers can find out more information**

- [CMS website](#)
- [CMS PERM "Providers" web page](#)
- [Central PERM email for providers](#)
- ["Provider Education Calls" to learn more about the PERM process and provider responsibility](#)

## Provider Education Webinar/Conference Calls

To access all of the meetings call **1-877-267-1577** and enter the **WebEx Meeting Number**.

- **June 21, 3 p.m. to 4 p.m.**
  - WebEx Meeting Number: 996 196 415
  - [Click here](#) to view the presentation online
- **June 29, 3 p.m. – 4 p.m.**
  - WebEx Meeting Number: 994 831 426
  - [Click here](#) to view the presentation online
- **July 19, 3 p.m. – 4 p.m.**
  - WebEx Meeting Number: 997 909 667
  - [Click here](#) to view the presentation online
- **July 27, 3 p.m. – 4 p.m.**
  - WebEx Meeting Number: 999 454 534
  - [Click here](#) to view the presentation online.

Presentation materials will be posted as downloads on the [Providers Tab of the PERM Website](#).

**Program Integrity**  
**DMA, 919-814-0000**

**Attention: All Providers****E**nrolled Practitioner Search Function

According to Federal Regulation 42 CFR 455.410, any physician or other practitioner who orders, prescribes, refers or renders services to N.C. Medicaid or Children's Health Insurance Program (CHIP) beneficiaries must be enrolled in those programs. In North Carolina, the CHIP program is called N.C. Health Choice (NCHC).

Therefore, for NCTracks to reimburse for services or medical supplies resulting from a practitioner's order, prescription, or referral, the ordering, prescribing, or referring provider must be enrolled in N.C. Medicaid or NCHC.

**Beginning Feb. 1, 2016**, claims are being edited to ensure the ordering, prescribing, referring or rendering provider are enrolled in the applicable programs. An informational Explanation of Benefits (EOB) stating that the ordering, prescribing, referring or rendering provider should enroll has been appearing on the billing provider's Remittance Advice (RA). **The edit disposition will change from "pay to report" to "suspend" beginning Aug. 1, 2016.**

Providers who render services or supplies should verify the enrollment of the ordering, prescribing, or referring practitioner before services or supplies are provided. **Beginning May 1, 2016**, a new "Enrolled Practitioner Search Function" will be available on the [NCTracks provider portal](#).

Additional information will be communicated to providers via NCTracks alerts and announcements. For additional assistance, providers can contact the NCTracks Contact Call at 1-800-688-6696.

**Provider Services  
DMA, 919-855-4050**

## Attention: All Providers

### **O**ut-of-State Provider Enrollment

**Notice:** This article was originally published in the [January 2016 Medicaid Bulletin](#).

Out-of-state providers are required to adhere to North Carolina rules, regulations, laws and statutes governing healthcare delivery under the N.C. Medicaid and the N.C. Health Choice (NCHC) programs. They are only eligible for time-limited enrollment under the following conditions:

- Reimbursement of services rendered to N.C. Medicaid or NCHC beneficiaries in response to emergencies or if travel back to North Carolina would endanger the health of the beneficiaries
- Reimbursement of a prior-approved non-emergency service, or,
- Reimbursement of medical equipment and devices that are not available through an enrolled provider located in North Carolina or within the 40-mile border area

Out-of-state providers must submit a **re-enrollment application** every 365 days in order to continue as N.C. Medicaid or NCHC providers.

Out-of-state providers must wait until the day after their current enrollment period ends – when their provider record is terminated – to begin the re-enrollment process. Many out-of-state providers are attempting to re-enroll using a Managed Change Request (MCR) prior to the end of their current enrollment period. This will not continue provider enrollment. MCRs are used to report changes to the provider record; they do **not** serve as re-enrollment applications.

Providers with questions about the NCTracks online enrollment application can contact the NCTracks Call Center at 1-800-688-6696 (phone); 919-851-4014 (fax) or [NCTracksprovider@nctracks.com](mailto:NCTracksprovider@nctracks.com) (email).

**Provider Services**  
**DMA, 919-855-4050**

**Attention: All Providers****Re-credentialing Due Dates for Calendar Year 2016**

**Notice:** This article was originally published as a [Special Medicaid Bulletin in February 2016](#).

**List of Providers due for Re-credentialing**

A list of providers scheduled for re-credentialing in calendar year 2016 is available on the [provider enrollment page](#) of the DMA website under the “Re-Credentialing” header. Providers can use this resource to determine their re-credentialing/revalidation due date, and determine which month to begin the re-credentialing process. Organizations and systems with multiple providers may download this spreadsheet, which includes NPI numbers and provider names, to compare with their provider list.

Providers will receive a notification letter 45 days before their re-credentialing due date.

**Providers are required to pay a \$100 application fee for re-credentialing/ reverification.** If the provider does not complete the process **within the allotted 45 days, payment will be suspended** until the process is completed. If the provider does not complete the re-credentialing process within 30 days from payment suspension and termination notice, **participation in the N.C. Medicaid and Health Choice programs will be terminated.** Providers must submit a re-enrollment application to be reinstated.

**Re-credentialing is not optional.** It is crucial that all providers who receive a notice promptly respond and begin the process. Providers will receive a notification letter 45 days before their re-credentialing due date. When it is necessary to submit a full managed change request (MCR), the provider must submit the full MCR prior to the 45th day and the application status must be in one of these status to avoid payment suspension:

- 1) In Review,
- 2) Returned,
- 3) Approved, or,
- 4) Payment Pending.

Providers are required to complete the re-credentialing application after the full MCR is completed. If the provider does not complete the process **within the allotted 45 days, payment will be suspended.** Once payment is suspended, the provider must submit a re-credentialing application or the full MCR before payment suspension will be lifted.

When the provider does **not** submit a re-verification application by the re-verification due date **and** the provider has an MCR application in which the status is In Review, Returned, Approved or Payment Pending, the provider’s due date will be reset to the current date plus 45 calendar days.

**Note:** Providers must thoroughly review their electronic record in NCTracks to ensure all information is accurate and up-to-date, and take any actions necessary for corrections and updates.

Re-credentialing does not apply to time-limited enrolled providers, such as out-of-state providers. Out-of-state providers must complete the enrollment process every 365 days. Providers with questions about the re-credentialing process can contact the CSRA (formerly CSC) Call Center at 1-800-688-6696 (phone); 919-851-4014 (fax) or [NCTracksprovider@nctracks.com](mailto:NCTracksprovider@nctracks.com) (email).

**Provider Services**  
**DMA, 919-855-4050**

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### **Attention: All Providers**

## **NCTracks Updates: 10 Percent Rate Increase for Private Duty Nursing**

As required by the N.C. Session Law 2015-241, the N.C. Department of Health and Human Services (DHHS) submitted N.C. State Plan Amendment (SPA) 16-001 to the Centers for Medicare & Medicaid Services (CMS) requesting approval for a 10 percent rate increase for Private Duty Nursing (PDN) with an **effective date of Jan. 1, 2016**. CMS approved this SPA on April 14, 2016 and the rate was implemented in NC Tracks on April 21, 2016. Beginning April 21, 2016, claims for PDN will be reimbursed at the lessor of this new rate, \$9.90 per 15 minutes, or billed charges. Providers are reminded to bill their usual and customary charges.

Claims with dates of service Jan. 1, 2016 through April 21, 2016 will be systematically reprocessed at a later date. N.C. Division of Medical Assistance (DMA) will provide updates and additional details on the reprocessing in upcoming Medicaid bulletins.

**Provider Reimbursement**  
**DMA, 919-814-0060**



**Attention: All Providers****Auto-Assignment Initiative: Increased Enrollment of Medicaid and NCHC Beneficiaries with Community Care of NC (CCNC) Providers**

**Notice:** This article was originally published as a [Special Medicaid Bulletin in September 2015](#).

N.C. Division of Medical Assistance (DMA) launched a statewide effort to increase the number of Medicaid and N.C. Health Choice (NCHC) beneficiaries enrolled in the Community Care of North Carolina (CCNC) managed care program. An eligible population of Medicaid and NCHC beneficiaries will be auto-assigned to a CCNC Primary Care Provider (PCP) when the beneficiary has not made a choice and when there is no valid reason for exemption from the program. Beneficiaries will be sent a letter with instructions on how to change their assigned PCP if desired. Eligible Medicaid and NCHC beneficiaries were assigned to a CCNC PCP in their county of residence **beginning** September 2015.

CCNC is an enhanced primary care case management program that provides patient-centered, community- and evidence-based healthcare. DMA strongly supports this special program's goals to improve quality and access to care; manage appropriate utilization of services; and maintain cost-effectiveness through care coordination with medical homes.

It is expected that providers work together to ensure access to care for assigned beneficiaries during this initiative. CCNC PCPs must remember that they are contractually obligated to coordinate care for assigned beneficiaries. This may include providing services or authorizing another provider to treat assigned beneficiaries. There will be instances in which a beneficiary is not assigned to the correct PCP.

To ensure that auto-assigned Medicaid and NCHC beneficiaries receive medical care without delay, consider the following guidelines:

- For beneficiaries newly linked to the practice, PCPs are reminded of the appointment availability expectations for all participating CCNC providers.
- For beneficiaries who will be changing their assigned PCP, consider giving a CCNC/Carolina Access (CA) Referral Authorization for needed medical services until the assignment is corrected.
- Providers are reminded that DMA policy allows use of the NPI of the beneficiary's assigned CCNC PCP as the CCNC/CA Referral Authorization on a claim. Entering the referral in NCTracks is allowed, but not required at this time.
- **If the beneficiary has been assigned to the wrong PCP, refer them to the DMA Call Center at 1-888- 245-0179 to correct the assignment.**

**Community Care of NC/CA Override Reminders**

- If providers are unable to obtain a CCNC/CA Referral Authorization from the assigned PCP of record prior to rendering treatment, an override may be requested.
- The assigned PCP should be contacted prior to requesting the override.

### Submitting an Override Request

- **Telephone** – The provider can call the NCTracks Call Center at 1-800-688-6696 to request an override for future dates of service, or if the beneficiary is in the provider's office waiting for treatment.
- **Fax** – The provider can fax the Override Request Form to NCTracks at 1-855-710-1964. Providers may fax the override request form for past dates of service
- A copy of the DMA CA Override Request Form can be found on the [NCTracks Provider Policies, Manuals, Guidelines and Forms](#) page.
- Providers may contact the NCTracks Call Center at 1-800-688-6696 to check on the status of a pending override request.

### Provider Record Reminders

- Providers who are listed as accepting new patients in NCTracks are likely to receive auto-assigned beneficiaries.
- Providers are encouraged to verify that the information on their provider record is up-to-date and accurate, including counties served, enrollment limits, and other restrictions.
- If changes need to be made, providers may submit a Managed Change Request in NCTracks.
- For more information on submitting Managed Change Requests, review the [Provider User Guide and Training section](#) of the NCTracks website.
- [Regional consultants](#) can also provide guidance on submitting Managed Change Requests.

With cooperation in the provider community, beneficiaries will have access to quality medical services through care coordination with medical homes. For more information on CCNC/CA, visit DMA's [CCNC/CA web page](#) or contact a [regional consultant](#).

**Note:** Due to auto assignment, a patient may be assigned to a new practice. If you are contacted by the new provider's office for an authorization, please provide authorization to the new practice. This will reduce the need for providers to contact DMA and request an override.

**CCNC/CA Managed Care Section  
DMA, 919-855-4780**

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### **Attention: All Providers**

## **M**edicaid and N.C. Health Choice Provider Fingerprint-based Criminal Background Checks

In accordance with [42 CFR 455.434\(b\)](#), Medicaid and Children Health Insurance Program (CHIP) providers designated as a “high” categorical risk by the federal government soon will be required to submit a set of fingerprints to the N.C. Division of Medical Assistance (DMA) through its enrollment vendor, CSRA, as a part of the federally mandated provider screening process.

**Note:** N.C. Health Choice (NCHC) is the North Carolina’s CHIP.

High-risk providers are listed under [42 CFR 424.518\(c\)](#) and [N.C.G.S. 108C-3\(g\)](#). The requirement for fingerprint-based criminal background checks applies to both:

- High-risk providers and,
- Any person with a 5 percent or more direct or indirect ownership interest in the organization, as those terms are defined in 42 CFR 455.101.

Providers will be notified of all locations in North Carolina where fingerprinting services will be offered.

Providers required to submit fingerprints will be notified in writing of the requirement. A deadline for compliance will be established. Providers who fail to meet the deadline will be denied participation in the N.C. Medicaid and N.C. Health Choice (NCHC) programs. Providers who have already undergone fingerprint-based criminal background checks for Medicare or another State’s Medicaid or CHIP program are **not** required to submit new ones to enroll in N.C. Medicaid and NCHC.

Additional information will be provided in future Medicaid bulletins. Questions regarding this new requirement or requests for additional assistance can be directed to the NCTracks Call Center by phone at 800-688-6696, or by email to [NCTracksprovider@nctracks.com](mailto:NCTracksprovider@nctracks.com)

**Provider Services  
DMA, 919-855-4050**

## Attention: Hospital Providers

### **N**CTracks Now Producing NC Health Choice Detailed PS&R Reports

Provider Statistical and Reimbursement (PS&R) reports accumulate statistical and payment data for hospital providers. The PS&R reports are used to help complete the annual cost reporting submitted by hospital providers participating in the N.C. Medicaid and N.C. Health Choice (NCHC) programs.

NCTracks is now producing NCHC detailed PS&R reports. The reports are similar in format to the existing Medicaid detailed PS&R reports on NCTracks.

The reports can be requested for any 12-month time period, including prior to the implementation of NCTracks. Although the legacy system was substantially different than NCTracks, the new detailed PS&R reports are designed to provide accurate reporting of data accumulated from both systems.

#### **Ordering PS&R Reports from CSRA**

The CSRA PS&R Detailed Report Request Form, which can be found under the heading **Provider Forms** on the [Provider Policies, Manuals, Guidelines, and Forms page](#) of the NCTracks Provider Portal, has been modified to facilitate ordering PS&R reports for either NCHC or Medicaid.

**Note:** Only one NCHC or Medicaid report can be requested on each form. Service dates must be limited to a 12-month time period. Payment dates can be for a longer period of time.

1. Mail the completed form with a certified check to NCTracks according to the instructions on the form. There is no limit to the size of the report or the number of reports a provider can request.
2. **Each request must be submitted on a separate form.**
3. Multiple forms can be submitted with a single certified check.
4. The detailed PS&R report will be generated in PDF format within one checkwrite of receiving the request. It will be delivered on Password Protected CD via Federal Express to the provider correspondence address.
5. A signature will be required for the package.
6. The provider must then call the NCTracks Call Center to request a password. The Financial Team will call to provide the password within one business day.

This approach helps ensure that the report is only accessible to the provider requesting the report.

**Note:** NCTracks is also now producing NCHC summary PS&R reports, which are delivered electronically to the provider Message Center Inbox on the secure provider portal, as explained in an NCTracks [Aug. 6, 2015, announcement](#).

Those with questions about requesting detailed PS&R reports can see the [PS&R Frequently Asked Questions](#) (FAQs). Two new questions have been added to these FAQs.

**Q – Can I use the form to request both Medicaid and NCHC reports?**

A – Yes, but only one report can be requested per form. If a provider wants both Medicaid and NCHC reports for a given NPI, two forms are required. However, both forms can be submitted with a single certified check.

**Q – Can I use the old form?**

A – The previous PS&R Report Request Form can still be used to request Medicaid PS&R reports, but the new form is required to request NCHC PS&R reports. It is recommended that the new form be used for all PS&R report requests from now on.

**CSRA, 1-800-688-6696**

**Attention: Nurse Practitioners****A**dditional Mid-Level Practitioner Taxonomy Codes Can Bill in NCTracks

As of April 18, 2016, (date of processing) mid-level practitioners with the following nurse practitioner taxonomy codes can bill for the same services associated with the nurse practitioner (363L00000X) and physician assistant (363A00000X) taxonomy codes:

- Adult Health – 363LA2200X
- Community Health – 363LC1500X
- Acute Care – 363LA2100X
- Critical Care Medicine – 363LC0200X
- Family – 363LF0000X
- Gerontology – 363LG0600X
- Perinatal – 363LP1700X
- Neonatal – 363LN0000X
- Neonatal, Critical Care – 363LN0005X
- Obstetrics & Gynecology – 363LX0001X
- Occupational Health – 363LX0106X
- School – 363LS0200X
- Pediatrics – 363LP0200X
- Pediatrics, Critical Care – 363LP0222X
- Primary Care – 363LP2300X
- Psychiatric/Mental Health – 363LP0808X
- Women’s Health – 363LW0102X

Over the past year, CPT codes have been added to the list of codes that can be billed to NCTracks by mid-level practitioners. These additional codes are posted on an [N.C. Division of Medical Assistance \(DMA\) web page](#). This list is updated periodically as new CPT codes are added to the system.

**Note:** The taxonomy codes added apply to all the services that are covered as of April 18, so providers can go back and bill for services prior to April 18.

**CSRA, 1-800-688-6696**

**Attention: Nurse Practitioners, Physician Assistants and Physicians****Antihemophilic Factor VIII (Recombinant), lyophilized powder for solution for intravenous injection (Nuwiq®) HCPCS code J7199: Billing Guidelines**

**Effective with date of service Jan. 1, 2016**, the N.C Medicaid and N.C. Health Choice (NCHC) programs cover antihemophilic Factor VIII [recombinant] (Nuwiq) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J7199 (Hemophilia clotting factor, not otherwise classified). Nuwiq is currently commercially available as single-use vials in nominal potencies of 250 IU, 500 IU, 1,000 IU and 2,000 IU of Factor VIII potency.

Nuwiq is indicated in adults and children with Hemophilia A for:

1. On-demand treatment and control of bleeding episodes,
2. Perioperative management of bleeding, and,
3. Routine prophylaxis to reduce the frequency of bleeding episodes.

**Nuwiq is not indicated for the treatment of von Willebrand Disease.**

The dose and duration of therapy depend on the severity of the Factor VIII deficiency, the location and extent of the bleeding, and the patient's clinical condition.

Determine dose using the following formula for adolescents and adults:

- Required IU = body weight (kg) x desired Factor VIII rise (%) (IU/dL) x 0.5 (IU/kg per IU/dL).

Dosing for routine prophylaxis:

- Adolescents (12 - 17 years) and adults: 30 - 40 IU/kg every other day.
- Children (2 - 11 years): 30 - 50 IU/kg every other day or three times per week.

See package insert for full prescribing information.

**For Medicaid and NCHC Billing**

- The ICD-10-CM diagnosis code required for billing Nuwiq is D66 - Hereditary Factor VIII deficiency.
- Providers must bill Nuwiq with HCPCS code J7199 – Hemophilia clotting factor, not otherwise classified.
- One Medicaid unit of coverage for Nuwiq is one IU. NCHC bills according to Medicaid Units. The maximum reimbursement rate per unit is \$1.82700.

- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Nuwiq are 68982-0139-01, 68982-0140-01, 68982-0141-01, 68982-0142-01, 68982-0143-01, 68982-0144-01, 68982-0145-01, and 68982-0146-01.
- The NDC units for Nuwiq should be reported as “UN1”.
- For additional information, refer to the January 2012, Special Bulletin, [National Drug Code Implementation Update](#).
- For additional information regarding NDC claim requirements related to the PDP, refer to the [PDP Clinical Coverage Policy No. 1B](#), Attachment A, H.7 on DMA’s website.
- Providers shall bill their usual and customary charge for non-340-B drugs.
- PDP reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340-B participating providers who have [registered with the Office of Pharmacy Affairs \(OPA\)](#). Providers billing for 340-B drugs shall bill the cost that is reflective of their acquisition cost. Providers shall indicate that a drug was purchased under a 340-B purchasing agreement by appending the “UD” modifier on the drug detail.
- The fee schedule for the PDP is available on [DMA’s PDP fee schedule web page](#).

**CSRA, 1-800-688-6696**



## Attention: Pharmacists and Prescribers

### Prior Approval Requests for Select Hepatitis C Medications Now Online Only

As of **May 1, 2016**, Prior Approval (PA) requests for some hepatitis C medications – including Harvoni, Olysio, Sovaldi, and Viekira Pak - can only be submitted to NCTracks using the secure provider portal. On that date, fax and mail submission of paper forms to request PA for these hepatitis C medications will be discontinued and the forms removed from NCTracks.

PA for these hepatitis C medications can be requested via the secure provider portal using the HepC Drug Type screens. The new HepC Drug Type screens have questions that mirror the paper forms. When submitting a PA request for hepatitis C medications via the portal, the required supporting documentation outlined below must be uploaded via the attachment feature. Refer to the [User Guides page](#) of the provider portal for *How to Submit Prior Approval Attachments in NCTracks*.

**Note:** Requests for PEG-interferon and Ribavirin products are still found under the “non-preferred” drug type.

**Note:** Daklinza will continue to be accepted using the form currently available on the NCTracks website. When requesting Daklinza for genotype 3 HCV, be sure to also send a request for Sovaldi using the secure provider portal.

PA for hepatitis C medications requires that the provider submit medical records and documentation of the diagnosis of chronic hepatitis C with genotype and subtype if applicable. Specific drug requirements and needed documentation are outlined on the [Prior Approval Drugs and Criteria web page](#) of the NCTracks website, under the Hepatitis C medications link.

Below is a summary of the supporting documentation that **must be uploaded and attached** to the PA request, when it is submitted via the secure provider portal:

<b>Attachment 1</b>	Medical record documentation for diagnosis of chronic hepatitis C with genotype and subtype (if applicable)
<b>Attachment 2</b>	Medical record documentation for Fibrosis stage
<b>Attachment 3</b>	Actual lab results (not progress notes) showing HCV RNA levels. For initial requests, lab results must be collected in the previous six months. For continuation, lab results must be collected four or more weeks after the first prescription fill date.
<b>Attachment 4</b>	Additional information such as patient’s health status and history, treatment plan, contra-indications etc. (if applicable) The patient “readiness to treat” form is required for initial PAs, regardless of

	submission method, and must be signed and dated by the beneficiary and attached as well.
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A new Job Aid will be available soon in SkillPort to assist providers with submitting PA requests for hepatitis C medications using the new HepC Drug Type screens. To access the Job Aid once it is posted, logon to the secure NCTracks Provider Portal and click “Provider Training” to access SkillPort. Open the folder labeled **User Guides**. The course will be found in the sub-folder labeled **Reference Documents**. Refer to the [Provider Training page](#) of the public Provider Portal for specific instructions on how to use SkillPort.

**CSRA, 1-800-688-6696**

**Attention: Physicians****Ciprofloxacin Otic Suspension, for intratympanic use (Otiprio™)  
HCPCS code J3490: Billing Guidelines**

**Effective with date of service Feb. 1, 2016**, the N.C Medicaid and N.C. Health Choice (NCHC) programs cover ciprofloxacin otic suspension, for intratympanic use (Otiprio) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3490 – Unclassified drugs. Otiprio is currently commercially available as 1mL of 6 percent (60 mg/mL, w/v) ciprofloxacin in a single-patient use glass vial.

Otiprio is indicated for the treatment of pediatric patients with bilateral otitis media with effusion undergoing tympanostomy tube placement. Clinical studies were not performed on patients less than 6 months of age.

During tympanostomy tube placement, Otiprio is given as a single intratympanic administration of one 0.1 mL (6 mg) dose into each affected ear, following suctioning of middle ear effusion. The Otiprio vial is intended for single-patient use; however, a different needle and syringe must be used for each ear. See package insert for directions for Otiprio dose preparation and administration.

**For Medicaid and NCHC Billing**

- The ICD-10-CM diagnosis codes required for billing Otiprio are:
  - H65.03 - Acute serous otitis media, bilateral;
  - H65.06 - Acute serous otitis media, recurrent, bilateral ear;
  - H65.113 - Acute and subacute allergic otitis media (muroid) (sanguinous) (serous), bilateral ear; H65.116 - Acute and subacute allergic otitis media (muroid) (sanguinous) (serous), recurrent, bilateral ear;
  - H65.193 - Other acute nonsuppurative otitis media, bilateral;
  - H65.196 - Other acute nonsuppurative otitis media, recurrent, bilateral;
  - H65.23 - Chronic serous otitis media, bilateral;
  - H65.33 - Chronic muroid otitis media, bilateral;
  - H65.413 - Chronic allergic otitis media, bilateral;
  - H65.493 - Other chronic nonsuppurative otitis media, bilateral;
  - H65.93 - Unspecified nonsuppurative otitis media, bilateral;
  - H66.003 - Acute suppurative otitis media without spontaneous rupture of ear drum, bilateral; H66.006 - Acute suppurative otitis media without spontaneous rupture of ear drum, recurrent, bilateral;
  - H66.013 - Acute suppurative otitis media with spontaneous rupture of ear drum, bilateral; H66.016 - Acute suppurative otitis media with spontaneous rupture of ear drum, recurrent, bilateral;
  - H66.13 - Chronic tubotympanic suppurative otitis media, bilateral;
  - H66.23 - Chronic atticoantral suppurative otitis media, bilateral;
  - H66.3X3 - Other chronic suppurative otitis media, bilateral;
  - H66.43 - Suppurative otitis media, unspecified, bilateral;

- H66.93 - Otitis media, unspecified, bilateral;
  - H72.03 - Central perforation of tympanic membrane, bilateral;
  - H72.13 - Attic perforation of tympanic membrane, bilateral;
  - H72.2X3 - Other marginal perforations of tympanic membrane, bilateral;
  - H72.813 - Multiple perforations of tympanic membrane, bilateral;
  - H72.93 - Unspecified perforation of tympanic membrane, bilateral
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- Providers must bill Otiprio with HCPCS code J3490 – Unclassified drugs.
  - One Medicaid unit of coverage for Otiprio is one mL (1 vial). NCHC bills according to Medicaid Units. The maximum reimbursement rate per unit is \$305.85600.
  - Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Otiprio is 69251-0201-01.
  - The NDC units for Otiprio should be reported as “UN1”.
  - For additional information, refer to the January 2012, Special Bulletin, [National Drug Code Implementation Update](#).
  - For additional information regarding NDC claim requirements related to the PDP, refer to the [PDP Clinical Coverage Policy No. 1B](#), Attachment A, H.7 on DMA’s website.
  - Providers shall bill their usual and customary charge for non-340-B drugs.
  - PDP reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340-B participating providers who have [registered with the Office of Pharmacy Affairs \(OPA\)](#). Providers billing for 340-B drugs shall bill the cost that is reflective of their acquisition cost. Providers shall indicate that a drug was purchased under a 340-B purchasing agreement by appending the “UD” modifier on the drug detail.
  - The fee schedule for the PDP is available on [DMA’s PDP fee schedule web page](#).

**CSRA, 1-800-688-6696**

## Proposed Clinical Coverage Policies

According to NCGS §108A-54.2, proposed new or amended Medicaid clinical coverage policies are available for review and comment on the DMA website. To submit a comment related to a policy, refer to the instructions on the [Proposed Clinical Coverage Policies web page](#). Providers without Internet access can submit written comments to:

Richard K. Davis  
 Division of Medical Assistance  
 Clinical Policy Section  
 2501 Mail Service Center  
 Raleigh NC 27699-2501

The initial comment period for each proposed policy is 45 days. An additional 15-day comment period will follow if a proposed policy is substantively revised as a result of the initial comment period. If the adoption of a new or amended medical coverage policy is necessitated by an act of the N.C. General Assembly or a change in federal law, then the 45- and 15-day time periods will instead be 30- and 10-day time periods.

### Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
<b>May 2016</b>	05/05/16	05/10/16	05/11/16
	05/12/16	05/17/16	05/18/16
	05/19/16	05/24/16	05/25/16
	05/26/16	06/01/16	06/02/16
<b>June 2016</b>	06/02/16	06/07/16	06/08/16
	06/09/16	06/14/16	06/15/16
	06/16/16	06/21/16	06/22/16
	06/30/16	07/06/16	07/07/16

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**Paul Guthery**  
  
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 CSC**